# CHAPTER 3

# *Basic Concepts: Disability*

## Introduction

After a work-related injury or illness, most workers are able to return to work after a short period of temporary disability. However, each year in California nearly 100,000 workers sustain some level of permanent disability, a substantial number of whom are not able to return to their original jobs.

Most workers who are not able to return to work during a period of temporary or permanent disability must rely heavily on their workers' compensation payments. Physicians play a critical role in determining whether a worker will receive temporary or permanent disability payments, as well as how large the permanent disability payments will be. It is extremely important that both the medical-legal evaluator and treating physicians thoroughly understand the concepts and terms used in a disability evaluation.

This chapter will discuss the definitions of disability in the California Workers' Compensation System and will explain: how to conduct a disability evaluation to determine temporary and permanent disability; how disability is determined from the information you provide in your report; how to develop work restrictions and how to estimate loss of pre-injury capacity and other return-to-work issues. Chapter 4 will provide additional information on vocational rehabilitation for workers unable to return to their original jobs.

# Defining Terms: Impairment, Disability and Permanent and Stationary

When an organ, or part of the body loses all or part of its function, compared to its previous level of functioning, it is said to be ***impaired***. Some impairments can be defined in purely medical terms and can be objectively measured. Examples of such impairments are loss of vision or hearing, or a decrease in range of motion, muscle strength, or grip strength. Impairment also applies to less easily measured functions, such as emotional stability, loss of concentration, or pain that causes a handicap in performing activities of work or daily living.

***Disability*** is the inability, or reduced ability, to compete in the ***open labor market***, due to impairment. The open labor market consists of all jobs or occupations, not just an injured worker's usual and customary occupation. A physician's disability evaluation is used to calculate a disability rating, which determines the amount of permanent disability benefits awarded to an injured worker.

An ***impairment*** can cause a disability, even though it does not prevent an injured worker from doing the job. For example, a typist who injures his back in a fall and is precluded from heavy lifting obviously now has an impairment, but also has permanent disability, even if the current job does not involve any lifting. Therefore, any condition that restricts the worker's ability to get or to perform ***any*** reasonable job is considered to cause disability.

Generally, there can be no disability without impairment, however disfigurement may be a compensable disability. There can be impairment without a ratable disability. One example of an impairment that is currently considered "non-disabling," in the open labor market, is the loss of sexual or reproductive function when there is no residual emotional or psychiatric effect.

# What Is a Temporary Disability?

An injury can cause a worker to be ***temporarily disabled***. A temporary disability prevents the worker from performing all or part of their job. An injured worker who cannot work at their usual job, or at modified work assignments, is entitled to ***temporary total disability benefits***. An injured worker who is able to perform modified work assignments is considered to have a ***temporary partial disability*** and may be compensated for a portion of the difference between normal wages and any reduction the disability has created, either in pay rate or in hours worked. A worker is considered temporarily disabled until the worker has returned to their usual and customary work, or until the condition has become ***permanent and stationary*** (see pp. 38-39).

## Maximum Weekly Temporary Disability Payment

| Injury Date | Maximum Payment |
|---|---|
| 1/1/91 to 6/30/94 | $336/week |
| 7/1/94 to 6/30/95 | $406/week |
| 7/1/95 to 6/30/96 | $448/week |
| From 7/1/96 on | $490/week |

# What Is a Permanent Total Disability?

***Permanent total disability*** is the inability to compete for work in the open labor market. A worker with one of the following conditions is presumed to be totally disabled (Lab. Code § 4662):

- ▲ The loss of both eyes or loss of sight in both eyes;
- ▲ The loss of both hands or the loss of the use of both hands;
- ▲ An injury resulting in a practically total paralysis;

## Examples of Payments for Partial Disability

Payments depend on the date of injury and the disability rating. The number of weeks associated with each percentage of disability increases as the percentage of disability increases. See p. 47 for information on how disability rating is determined. It is not determined by the physician. Following are some sample payments.

For injuries from **Jan. 1, 1992 to June 30, 1994:**

| DISABILITY RATING | MAXIMUM PAYMENT |
|---|---|
| 10% | $140 per week for 30.25 weeks |
| 50% | $148 per week for 266.25 weeks |
| 70%* | $148 per week for 426.5 weeks |
| 100% **(Total Disability)** | $336 per week (for lifetime) |

For injuries from **July 1, 1994 to June 30, 1995**:

| | |
|---|---|
| 10% | $140 per week for 30.25 weeks |
| 50% | $158 per week for 266.25 weeks |
| 70%* | $168 per week for 426.5 weeks |
| 100% **(Total Disability)** | $406 per week (for lifetime) |

For injuries from **July 1, 1995 to June 30, 1996**:

| | |
|---|---|
| 10% | $140 per week for 30.25 weeks |
| 50% | $164 per week for 266.25 weeks |
| 70%* | $164 per week for 426.5 weeks |
| 100% **(Total Disability)** | $448 per week (for lifetime) |

For Injuries **on or after July 1, 1996**:

| | |
|---|---|
| 10% | $140 per week for 30.25 weeks |
| 50% | $170 per week for 266.25 weeks |
| 70%* | $230 per week for 426.5 weeks |
| 100% **(Total Disability)** | $490 per week (for lifetime) |

Total disability rate increased to $490/week (for lifetime) for injuries on or after July 1996.

* Workers with permanent disability ratings over 70% receive a small lifetime pension when the permanent partial disability payments are exhausted. For injuries occurring before 7/1/94, the maximum life pension payment is $64.21 per week. Between 7/1/94 and 7/1/95 the rate is $94.02 per week. As of 7/1/95 the rate is $123.84 per week. The current life pension rate is $153.65 per week.

▲ An injury to the brain resulting in incurable dementia or insanity.

A person does not have to be bedridden, or completely unable to perform any tasks that might be compensable, in order to be rated as 100 percent disabled. Disabilities that may be rated at 100 percent include: constant, severe back pain; severe vertigo or epilepsy; severe paralysis of one side of the body or severe paralysis of both lower extremities; severe post-traumatic head syndrome; severely impaired function of the spine, neck, or pelvis; spinal injuries causing incontinence of feces and urine; immobility of both hip joints; unilateral pronounced post-thrombophlebitic disability; and loss of both legs at or above the ankle, in which a reasonably satisfactory use of prosthesis is not possible.[1]

## What Is a Permanent Partial Disability?

If a worker's injury has diminished the ability to compete in the open labor market, but the worker is not permanently totally disabled, then that worker has a ***permanent partial disability***. As in the example of the typist who cannot lift, it is possible for the worker to be partially disabled, even if the worker has returned to the previous job and is doing the same work as before the injury.

A worker with a permanent partial disability will receive weekly payments for a period of time determined by the date of injury and the extent of the disability (see box p. 37). There are huge differences between the compensation received by a worker with a 99.75 percent disability and the compensation received by a worker with a 100 percent disability. For PD ratings of 100% compensation, the rate for temporary total compensation is paid for life.

## When Is a Worker's Condition Permanent and Stationary?

***Permanent and stationary (P&S)*** implies that the patient's condition has reached a plateau. A worker's medical condition is considered permanent and stationary after it has medically stabilized (this is sometimes called "maximum medical improvement," although some slight medical improvement might be anticipated in the future), or when the condition has been stationary for a "reasonable period of time" (8 Cal. Code Regs. § 10152). The judgment that a condition is permanent and stationary is usually made by the treating physician, but when the treater's determination is disputed, an evaluating physician's opinion is also sought.

It is the role of the primary treating physician to determine the injured worker's P&S status. When requested, the QME should state whether they agree or disagree with that P&S status and based on the evaluation, give the reasons for this determination. If the injured worker has not previously had a determination of P&S status, the QME should make a statement as to whether the patient's condition is, or is not, permanent and stationary and, again, give the reason for this determination.

The use of the term permanent and stationary means that the worker ***did not*** return to the previous pre-injury level and that there are residual effects of the injury. If you determine

that the patient has no continuing symptoms, no permanent disability, and is able to return to work with no restrictions or diminished capacity related to this injury, then the patient should be "*discharged as cured*," for this injury with the comment in your report that the patient has no new permanent disability.

When the primary treating physician reports that the worker's condition is permanent and stationary, the employer will terminate the worker's temporary disability benefits. This also starts the process for determining whether the worker should receive any permanent disability benefits.

In some cases, such as a worker with progressive lung disease in which significant deterioration is inevitable, a worker may be given an interim permanent disability award based on the condition at the time of maximum medical improvement. The WCAB will retain jurisdiction to amend the award, if the worker's condition deteriorates significantly.

# Physicians' Disability Evaluations

Treating and evaluating physicians perform disability evalua tions when the workers' injuries have become permanent and stationary. The disability evaluation is used by the rater, in conjunction with a rating schedule that correlates impairment with disability *(Schedule for Rating Permanent Disabilities)*, to assign to the worker a ***permanent disability rating***, stated as a percentage, which represents the worker's diminished ability to compete in the open labor market. The physician's disability evaluation report may also be used to determine eligibility for future medical treatment and vocational rehabilitation services.

## How Disability Evaluations Are Obtained (The QME Process)

The process for obtaining a physician's disability evaluation depends on the date of the injury and whether the worker has retained an attorney. A worker who is represented by an attorney is referred to as a represented worker and a worker with no attorney is referred to as an unrepresented worker. Under the 1989 reforms, the kind of dispute that has triggered the need for an evaluation also will affect the process. (see Chapter 5).

**FOR INJURIES OCCURRING BEFORE JANUARY 1, 1994**

For injuries before January 1, 1991, all parties may obtain medical evaluations as needed to prove their case.

### *P & S: A Fluid Concept*

*Permanent and stationary means the injury has medically stabilized. It does not mean that the patient's symptoms are unvarying or that an aggravation or flare-up will never occur. Also, use of the term P & S does not necessarily define the date that the injured worker is capable of returning to work. Many injured workers are released by their physician to return to work prior to being P & S (for example, a return to light or modified work or shorter hours).*

### *Some Diseases (Asbestosis, AIDS) May Never Reach Permanent & Stationary Status*

*In General Foundry Service v. WCAB (Jackson) (1986) 42 Cal.App. 3d 331; 51 C.C.C. 375, the California Supreme Court held that in cases of insidious, progressive diseases, the Appeals Board may tentatively rate the injured workers disability and reserve jurisdiction until the injured worker is permanent & stationary or until the permanent disability is 100%. This procedure avoids the five year limit to alter an award of benefits as the disease continues to worsen.*

For injuries that occurred on or after January 1, 1991, and before January 1, 1994, a formal medical disability evaluation can be triggered by:

- The employee's request when the employer terminates temporary disability payments and informs the worker that permanent disability payments will or will not be made, *(because either the employer contests or is unsure whether there is permanent disability);*
- The primary treating physician's determination that the employee's condition is permanent and stationary;
- There is a dispute as to treatment, new and further disability, or rehabilitation.

**Represented worker**—If a worker is represented by an attorney, the employer and the employee may agree on a physician to perform an evaluation (Agreed Medical Evaluator, AME). If they fail to reach agreement, then each side may, at the employer's expense, obtain a formal medical evaluation from a Qualified Medical Evaluator (QME) selected from an appropriate specialty.

**Unrepresented worker**—An unrepresented worker will be given a form by the employer with which to request a formal medical evaluation by a QME in an appropriate specialty. The Industrial Medical Council (IMC) will furnish the worker with a panel of three physicians. The worker selects one physician from the panel to perform the medical evaluation.

**FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1994**

Under the 1993 workers' compensation reform, for injuries occurring on or after January 1, 1994, ***the primary treating physician performs a disability evaluation when the physician determines that the condition is permanent and stationary.*** The treating physician may use a form developed by the IMC (Form 81556) or one developed by DWC (PR-3) for the report. The physician's report may be used for settlement of the claim or serve as the trigger for the medical-legal process. See Chapter 5, p. 86-89 for more information on the medical-legal process.

If either the worker or the employer wishes to contest the treating physician's evaluation, including the need for continuing medical care, or the description of the disability, arrangements will be made for a ***comprehensive medical evaluation by an Agreed Medical Evaluator (AME) or a Qualified Medical Evaluator (QME)*** depending on whether the injured worker is represented or unrepresented.

**Represented worker**—If a worker is represented by an attorney, the employer and the employee may agree on a physician to perform an evaluation (an AME). If they fail to reach agreement, then each side may, at the employer's expense, obtain one comprehensive medical evaluation from a QME.

**Unrepresented worker**—An unrepresented worker will be given a form by the employer with which to request a comprehensive medical evaluation by a QME. Within 15 days, of receipt of the request, the IMC will furnish the worker with a panel of three physicians in the speciality requested by the *worker*.

The primary treating physician's report, the QME and/or AME report are the only reports that a workers' compensation judge can consider in making a permanent disability award to an unrepresented worker.

## How Disability Evaluations Are Used

If a case goes to trial before the WCAB, a judge will determine the factors of disability and request that the Disability Evaluation Unit (**DEU**) issue a rating (called a "**Formal Rating**") based on those factors. For represented workers, if the parties decide to pursue settlement negotiations, then those involved (applicant or defense attorney, claims administrator, or other worker or employer representatives) may use the physician's report and the DEU rating schedule to calculate the worker's disability rating. Either party may decide not to use the treating physician's report and may agree to an AME or obtain a QME evaluation. Either party may request a **consultative** rating on a QME report from the DEU. In no case does the physician calculate the disability rating.

If an unrepresented worker does not agree with the claims adjuster's rating of the treating physician's report, the worker may request a rating from the DEU. If the worker chooses not to use the treating physician's report, the worker may obtain one QME evaluation. All QME disability evaluations for unrepresented workers are rated by DEU raters.

A worker's disability evaluation can have a major effect on the worker's life, because it will be a key factor in determining the amount of compensation the worker will receive. Because there is a limit on the number of evaluations a worker may have at the employer's expense, your evaluation may be the only evaluation for a particular worker. For this reason, it is critical that your report be comprehensive and fair. The process of rating a disability is described on pages 47-49.

## Guidelines for Conducting a Disability Evaluation

There are four categories of information, called ***factors of disability,*** that must be covered in a disability evaluation:

- ▲ Objective factors;
- ▲ Subjective factors;
- ▲ Work restrictions;
- ▲ Loss of pre-injury capacity.

In a disability evaluation, the physician describes, for each injured part of the body, the objective and subjective factors, any devices or prostheses that should be used, work restrictions, and the loss of pre-injury capacity. This information becomes the basis for the worker's permanent disability rating. For example, in describing lifting capacity, the physician should consider endurance, body position, weight that can be carried, and the distance that it can be carried. In describing a back injury, the physician should consider the ability to climb, sit, stand, lift, carry, stoop, bend, squat, twist, turn, push, pull, and maintain awkward positions. It is very important for the physician to give clear, detailed, consistent information on the extent of disability. The physician should have a clear

### *Estimated Normals Serve as Baselines*

*In an arm injury case, the physician should give an 'estimated normal' range of motion to represent the arm before the injury, or what the uninjured arm's range would be absent the industrial injury. If the injured worker has a bilateral injury (i.e. both arms are injured), the physician should give an 'estimated normal' range of motion. If the physician fails to give an 'estimated normal' range of motion, the rater will use Packard Thurber.*

*- Shirley James, Rating Specialist*

understanding of the worker's occupation, including the specific tasks that the worker performs, and how the impairment will affect the worker's ability to return to work. The physician also needs to elicit a clear picture of the worker's capacity before the injury, both in work and in daily life (see pp. 46-47, for more information on loss of pre-injury capacity). Although these issues are related, you must consider each one separately in order to elicit the information you need to address each of these issues in your report.

**FACTORS OF DISABILITY**

***Objective factors*** are those that can be directly measured, observed, or demonstrated. They include physical findings such as range of motion, strength, disfigurement, findings on x-ray, and the results of laboratory or other diagnostic tests. The physician should conduct a complete physical exam of the affected body part and any related body parts. For example, if the patient is complaining of wrist pain, the entire arm, neck, and shoulder should be examined. Laboratory tests, x-rays, and other tests should only be conducted if relevant and necessary. The report should fully describe the physical exam, and should include all test results, both normal and abnormal. List the positive physical findings and test results under the objective factors. The Industrial Medical Council's evaluation protocols (see Appendix C for more information).

## Describing Disability

The following are two descriptions of right wrist impairment. The patient's major hand is the right hand.

**INCOMPLETE DESCRIPTION**

*Objective Factors*

- Decreased range of motion, 15 degrees flexion, 5 degrees extension.
- Decreased grip strength.

*Subjective Factors*

- Wrist pain at extremes of flexion with decreased sensation over the hand.

**COMPLETE DESCRIPTION**

*Objective Factors*

- Decreased range of motion. Active motions are: (take measurements of both wrists and report them as injured/uninjured) dorsal flexion 60/65, palmar flexion 45/60, radial deviation 20/20 and ulnar deviation 30/30.
- Grip testing on the Jaymar dynamometer on three trials are 85, 80, 75 on the right and 90, 85, 80 on the left.
- X-ray findings consistent with degenerative changes secondary to post-traumatic arthritis.
- Decreased sensation over the distribution of the median nerve of the involved side.
- Decreased nerve conduction velocities as compared to the uninvolved side as measured by electrodiagnostic studies.

*Subjective Factors*

- Occasional minimal pain at rest, increasing to intermittent slight to moderate pain on repetitive fingering activities, such as keystroking continuously for over 30 minutes.

and Packard Thurber's Evaluation of Industrial Disability detail how the findings, such as range of motion, should be presented.)

***Subjective factors*** are those that cannot be directly measured or observed, such as pain. Subjective factors should be identified by a description of the activity that produces the symptoms, the duration of the symptoms, the activities that are precluded and those that can be performed with the symptoms, and the means necessary for relief (8 Cal. Code Regs. § 9727). In describing subjective factors, the following terms are used. All of these terms carry very specific implications in disability rating; it is important that you use them correctly.

# PAIN AND DISABILITY

Pain can be defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage It is a complex multifactorial phenomenon defined by bio-psycho-social components. Although a genuine human experience, it is not readily measurable or objectively validated. Consequently the evaluation, management, and disability evaluation of pain disorders depend on the assessment of an individual's verbal and non-verbal pain behavior. This presumes a reasonable degree of expertise and competence in the field. Physicians should be aware of the concepts of eudynia (symptomatic pain resulting from nociceptive stimuli) and maldynia (a neuro-biological brain entity) and the spectral interaction of both occurring in most instances of persistent pain disorders.

Persistent pain, present in many serious work-related injuries, represents a major cause of disability. In evaluating pain disorders, physicians should review pertinent past medical records and data. The pain history should include references to etiology, location, quality, intensity, duration, aggravating and ameliorating factors, and impact of the pain problem. A detailed focused physical examination should emphasize neurological and emotional assessment.

Although fraud and malingering are uncommon, over-elaboration, symptom magnification, and embellishment often characterize pain complaints. The credibility of the injured worker must be assessed. This can be accomplished with reasonable medical probability, but requires sound clinical judgment by experienced physicians. Pain is a bona fide subjective factor of disability, but this is not synonymous with the patient's pain behavior or complaint. It must be based on an independent assessment of the severity of the pain disorder. Disability resulting from pain must be related to functional capacity that is task related.

The disability rating of pain should address the following points within reasonable medical probability:

- Relationship between the pain and the underlying pathological process.
- Establishment of a multi-axial classification.
- Determination that all appropriate treatment has been attempted and the condition is permanent and stationary.
- Assessment of the injured worker's credibility, giving proper weight to pain language and behavior.
- Determination of the extent to which the pain interferes with the performance of work related tasks. Disability cannot be predicated solely on consideration of pain intensity and duration as reported by the patient, but requires independent and objective physician judgment.

***Philipp M. Lippe, MD., American Academy of Pain Medicine***

***Subjective Factors*** *- Subjective factors of disability are your impressions or characterizations of the importance and magnitude of the patient's symptoms. Significant subjective complaints are those which are usually supported by objective findings. When converting the subjective complaints to subjective factors, always indicate what activity precipitates the pain. Lastly, the evaluator should address the severity and frequency of the complaint and, by using ratable language, translate these subjective complaints into subjective factors of disability.*

- A ***minimal*** (mild) pain would constitute an annoyance, but would cause no handicap in the performance of the particular activity and would be considered a nonratable permanent disability.
- A ***slight*** pain could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain;
- A ***moderate*** pain could be tolerated, but would cause marked handicap in the performance of the activity precipitating the pain;
- A ***severe*** pain would preclude the activity precipitating the pain;

To describe the frequency with which symptoms occur you may use percentages or the "words of art".

- ***Occasional*** means approximately 25 percent of the time;
- ***Intermittent*** means approximately 50 percent of the time;
- ***Frequent*** means approximately 75 percent of the time; and
- ***Constant*** means approximately 90-100 percent of the time.

You may combine these terms to describe your patient's condition more precisely, for example "slight to moderate pain, occurring occasionally to intermittently." Subjective factors can be the only ratable factor for an injured worker. In training, such as medical school, physicians are often taught to use the **"SOAP" (Subjective, Objective, Assessment, Plan)** format. In this form of reporting, the "subjective" heading is used for the patient's complaints, often quoting the complaints verbatim. In the context of a medical-legal report, you are expected to translate the injured worker's complaints, in the context of the rest of the findings, into ratable language. If you believe that the injured worker might be understating or overstating complaints, you should discuss your opinion and indicate why.

***Work restrictions*** *- Work restrictions can be actual or prophylactic. They are a restriction of specific activities, body positions, motions, or exposure and time limitations, that have been placed on the injured worker by the treating or consulting physician to facilitate recovery from the injury; or on a permanent basis because of the effects of an injury. Permamnent work restrictions are imposed relative to jobs in the 'open market' and <u>not</u> to the injured worker's usual and customary job. Permanent work restrictions are ratable disabilities.*

# Work Restrictions

Work restrictions are limits that the physician places on job tasks or working conditions. Work restrictions may be imposed to allow a worker to return to the job during the healing process or they may be permanent. Some work restrictions are ***actual***, in that the worker *cannot* do a task (*e.g.,* work a foot pedal with a foot in a cast or do repeated bending because it causes severe pain). Other restrictions are ***prophylactic***, in that they are designed to:

- Avoid or prevent undue pain;
- Avoid causing an increase in symptoms that would lead to a period of temporary disability.

- ▲ Avoid causing increased permanent disability.
- ▲ Prevent exacerbations that would increase the need for medical care.

It is important to be clear about the type of work restriction that you are defining. Raters will have difficulty interpreting ambiguous statements such as "The pain is intermittently slight to moderate on heavy lifting." A better sentence would read: "He has slight, intermittent pain on light work, increasing to constant, moderate pain when lifting heavy objects."

> *"Work restrictions should be clear, realistic, and consistent with the objective and subjective disability factors you have described."*
>
> ***- DEU Disability Evaluator***

**TEMPORARY WORK RESTRICTIONS**

Many injured workers are able to perform some, but not all, of their job tasks at some point during the healing process. When the treating physician believes that it is possible for an injured worker to return to work in some capacity, the physician is required to delineate the tasks or working conditions that must be avoided. It is essential that the physician have a clear understanding of the nature of the work and working conditions to which the injured worker will be returning and that the physician makes the restrictions clear in that context. Temporary work restrictions refer to the current job. If the worker does not fully recover from the injury or illness, the physician will develop permanent work restrictions once the worker's condition is permanent and stationary.

**PERMANENT WORK RESTRICTIONS**

Permanent work restrictions are ratable disabilities that are effective in the open labor market. Disability raters look closely at the physician's reported work restrictions to help determine a worker's overall disability rating. Permanent work restrictions are also an important consideration in the vocational rehabilitation process (see Chapter 4).

**HOW TO DEVELOP WORK RESTRICTIONS**

When developing work restrictions, you should keep in mind their multiple uses. Work restrictions are used to make appropriate modified work assignments, to determine the permanent disability rating, and to develop an appropriate vocational rehabilitation plan. Your guiding principles should be clarity and consistency. Work restrictions should be clear, realistic, and consistent with the objective and subjective disability factors you have described. Work restrictions should not focus only on the worker's current job, (for example, you may prescribe lifting restrictions for a data entry clerk) because they may well affect the worker in seeking future or different employment, and so are important for rating and vocational rehabilitation purposes. Your report should always provide clear justification for all work restrictions. In Medical-legal report writing there needs to be internal consistency between the subjective factors, the objective factors, and the work restrictions. (i.e. the work restrictions need to be supported with objective medical findings).

> ***The Importance of Internal Consistency***
>
> *All too often we get reports where findings are not consistent with other sections of the report. For example, we had one where the report said 'constant severe pain' for a worker with a back problem. Well, constant severe pain is a 100 percent disability in workers' comp. However, the evaluator had put NO work restrictions. Even when called to explain this discrepancy, the physician insisted there were no work restrictions. This just doesn't make sense!*
>
> ***—DEU Disability Evaluator***

In the course of the evaluation, you should take a thorough occupational history that includes information on the worker's job tasks, how much time the worker spends on different tasks, the kinds of hazardous material and physical demands to which the worker is exposed, and other information important to understanding the way in which the worker spends the day at work. It is important to review a detailed job description usually supplied from the employer, which you can go over with the injured worker for accuracy.

Although you need a good understanding of the worker's occupation to write the work restrictions, it is usually best to describe the restrictions in terms of the actual functional limitations, rather than referring specifically to the worker's current job. For example, it is better to write "may do work requiring repetitive motions of the hand and fingers, such as keyboarding, no more than 45 minutes out of every hour, and may not work on tasks requiring prolonged or repetitive use of pinch grip," than to write simply "limit keyboard operation to 45 minutes per hour." This protects the worker from being given a task that the worker should not do and that you did not know to prohibit. It will make it easier for the raters to rate the disability based on the worker's ability to compete in the open labor market (and not just on the ability to do one particular job), and will also be helpful in developing a vocational rehabilitation plan or developing modified and alternative work assignments. The 1993 workers' compensation reforms place a high priority on modified and alternative work assignments to help injured workers return to work and the treating physician's clear and prompt description of functional limitations is key to the development of an appropriate modified or alternate job. (See Chapter 4, p. 64 for a description of these terms.)

### LOSS OF PRE-INJURY CAPACITY

Once you have clearly defined the actual work restrictions, you should also ***separately*** describe, to the best of your ability, the worker's loss of pre-injury capacity. This requires the physician to not only have a clear understanding of the tasks that a worker actually performed in the pre-injury job, but also of the other activities that the worker did outside of work. This estimate must be based on reasonable indicators of the worker's pre-injury physical and/or mental status, such as the kind of activities the

## Case Example: Writing Clear Work Restrictions and Estimate of Loss of Pre-Injury Capacity

The patient has sustained a back injury and has recovered from a laminectomy. Following are the work restrictions a well-written report might contain.

**Work restrictions:**

- No repetitive bending or stooping;
- No frequent lifting over 25-35 pounds from floor to shoulder;
- No occasional lifting over 50 pounds from floor to shoulder;
- No repetitive lifting over shoulder level;
- No lifting requiring twisting of the trunk.

To determine loss of pre-injury capacity, consider the above lifting restrictions and compare them to the patient's pre-injury lifting capacity. One could then estimate that the patient has lost overall approximately 60 percent of his pre-injury capacity to lift and approximately 50 percent of his pre-injury capacity to bend or stoop.

## Case Example: Estimating Loss of Pre-Injury Capacity

In estimating loss of pre-injury capacity, the physician must look at how an injury has changed an individual worker's capacity, both on and off the job. For example, two accountants, Joe and Bob with back injuries, both post-laminectomy, may have the same prophylactic work restrictions, which do not allow lifting over 20 pounds. But before their injuries, these two individuals had very different lifting capacities.

After discussion with Joe, the physician has determined that, even before the injury, he could not lift more than 40 pounds. Joe's loss of pre-injury lifting capacity is 50 percent.

Bob, on the other hand, is in great physical condition, which corresponds to his description of his usual daily weightlifting activities. Before his injury, he lifted 100 pounds regularly. Therefore, Bob's loss of pre-injury lifting capacity is 80 percent.

Although Bob and Joe have the same work restrictions, their individual pre-injury differences result in different estimates of loss or pre-injury capacity in the disability evaluation process.

worker used to do, time spent on these activities, or comparisons with the uninjured side of the body, when relevant. Simply examining the injured worker and guessing about the worker's pre-injury capacity is ***not*** sufficient. You should describe what the worker could do before the injury, as compared to what the worker can do after the injury. The loss of pre-injury capacity can be estimated fairly broadly (25 percent, 50 percent, 75 percent), but if you have sufficient information, you should be able to estimate more exactly (see box page 46).

# How Disabilities Are Rated

***Disability evaluators***, also called disability raters, from the Disability Evaluation Unit (DEU) use the ***factors of disability*** (objective and subjective factors, work restrictions, and loss of pre-injury capacity) from the physician's report to determine an overall disability rating. A factor is considered ***ratable*** if it interferes with the worker's ability to compete in the open labor market. The disability rater assesses the occupational impact of the worker's impairment and restrictions. In considering this impact, the disability rater is required to consider the worker's occupation at the time of the injury and the worker's age.

Factors of disability are assigned percentages of disability in the California rating schedule. If two different impairments produce overlapping or duplicating factors of disability, the disability rating should not combine the disabilities. As an example, consider the situation in which a worker has fallen and injured her knee and back. The knee injury alone would have produced a permanent restriction on lifting more than 50 pounds. The back injury would have produced a permanent restriction from lifting more than 20 pounds. Because the back injury work restriction totally overlaps or duplicates the knee injury restriction, there is no additional disability for the lifting aspect of the knee injury. However, other aspects of the knee injury, such as restricted range of motion, do not overlap or duplicate the back injury, and will be considered separately in the disability rating.