Luis Pérez-Cordero
PD Rating Specialist
pdrating@att.net

California Permanent Disability Ratings
WWW.PDRATINGS.COM
Voice: (415) 861-4040

Craig A. Lange
PD Rating Specialist
craigalange@att.net

The Evaluation Of Measurable Physical Elements Of Disability

California Code of Regulations – 8 CCR 46 & 9725

Permanent & Stationary Medical Reports and Substantial Medical Evidence

Le Vesque vs. WCAB (1970) 1 Cal. 3d 627, 35 CCC 16
Hegglin vs. WCAB (1971) 4 Cal 3d 162, 36 CCC 93
Minniear vs. Mt. San Antonio Community College District (1996) SBR257801, Cal. Comp. Cases 1055
Kuelen vs. WCAB (1998) 66 Cal. App. 4th. 1089,1096
Presumption cannot be rebutted solely by lay testimony – a medical opinion is required.
Boyd v. WCAB (1997) 62 CCC 498
Report internally inconsistent report consisted of assertions for which no supporting evidence was offered.
Rachel Daly v. WCAB, Stanford Hospital. 5 WCAB Rptr. 10,022
QME examination rebutted the PTP's presumption with a thorough evaluation of objective testing and records, and objective evidence did not support continuing disability. http://www.appealsboardreporter.com/

"The residual effects of an industrial injury are ascertained and described by physicians with the resultant medical findings and conclusions translated into a PD rating based on procedures and benchmarks set forth in The Schedule.' – 8 CCR 10151 -The Schedule for Rating Permanent Disabilities.

Substantial Medical Evidence:

1. **The complete and thorough evaluation of objective measurable and clinical factors of disability.**

2. **The foundation of Labor Code § 4660's 'implementing tool' The Schedule for Rating Permanent Disabilities.**

3. **The support for the reasoned/rational medical opinion requirements of 8 CCR WCAB § 10606(f)(h)(i)(k)(m)(n) as to the nature, extent and duration of disability and work limitations.**

4. **The validation for addressing the diminished ability to compete in an open labor market or the need for job modifications. (LC § 4660 [a])**

   "A PD rating is a numeric representation of the degree to which the permanent effects of the injury have diminished the capacity of the employee to compete for and maintain employment in an open labor market." *– Page 1-2 of 8 CCR 10151, The Rating Schedule.*

5. **LC§ 4620 –** Medical Legal Report must be capable of proving/disproving a disputed medical fact. In determining whether a report meets the requirements of the subdivision, a WCAB Judge shall give full consideration to the substance, as well as form of the report as required by applicable statues and regulations.

   a. **"A worker's compensation judge's determination based on a medical report that is just a string of unsubstantiated conclusions is no better than judicial dart-throwing. For the medical report to be usable, it should clearly explain how the medical conclusions are reached and in a way that someone who is not a medical expert can understand." – Honorable Alan Eskenazi, WC Judge.**

6. **Standards:** Factual History, Medical History, Medical Examination, Reasoned Opinion (the opinion must address the disputed issues).

   a. **"Where the physician addresses the disputed medical facts, applies the case facts, applies his expertise, and renders a rational opinion, then the expert medical opinion has 'probative value' to assist the court to resolve disputed issues."** - **Honorable W. Ordas & N S Udkovick, WC Judges**

7. **8 CCR § 10606** - The medical report must be clear as to any loss of work capacity, be it objective physical findings, disabling effects of pain, work restrictions or a percentage of pre-injury capacity functional loss. If there is no residual permanent disability or loss or work capacity, the report should state so.

8. **8 CCR § 9793 {c}** – **"Comprehensive Medical-Legal or Permanent Stationary Evaluation"** means an evaluation of an employee which {a} results in the preparation of a narrative medical report prepared and attested to in accordance with LC§ 4628, any applicable procedures promulgated under LC§ 139.2 and the requirements of 8 CCR § 10606, and {b} is either performed by a (QME), (AME), or (PTP). (Please read entire regulation.)

    a. **'Pass Through' Reports - " The physician has not bothered to perform any reasoned analysis at all. There are merely unsupported conclusions with no basis. In this type of report usually one or two sentences of 'conclusions' [reasoned medical opinion?] are usually hallmarked by having no factual or medical reasons expressed for the conclusion." Honorable W. Ordas & N S Udkovick, WC Judges**

9. 8 CCR 9785(G) -Primary Treating Physician ((PTP))
Information may be submitted on Form PR-3, IMC -81556, or in such other manner as it provides all of the information required by Title 8, California Code of Regulations, Section [WCAB] 10606. When the (PTP) determines that the (EE) is P&S, he/she shall (unless good cause is shown) report within 20-days from the date of examination."
http://www.dir.ca.gov/dwc/DWCPropRegs/PTPRegsFinal.pdf

"Packard Thurber defines how the evaluator should measure the physical elements of disability; Packard discusses what should be measured." – IMC Councilman

Evaluation of Industrial Disability (Packard Thurber, MD) - **Physician must report measurable physical elements of disability in accordance with the standard method as described in the book.**

A. Objective Physical/Measurable Elements:

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. **Make comments 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:**

    a) If restriction of motion is present, evaluating physician must comment on the reason why: pain, muscle spasm, voluntary restriction, etc.,... *(Performs gentle passive range of motion in addition to active range of motion to determine whether the restriction is due to pain or mechanical block.)*

    b) Examination of injured workers, with spinal or spino-radicular difficulties, should also include, balance of: (1) Neuromusculoskeletal system, (2) physical examination [neurological exam], and (3) special neurovascular/provocative testing, as per L.C. 139.2 **;**

5. **State handedness for the Upper Extremities:** 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;
    - The word 'ambidextrous', used to designate someone who can use both hands equally, contains the root ***Dexter*** which means the right hand in Latin and implies that an ambidextrous person has two right hands. (To use one hand to write and another to throw a ball is not valid support to designate someone as ambidextrous.)
    - **The first left-handed president of the United States, James A. Garfield, was also ambidextrous and enjoyed dazzling people by writing in Latin with one hand and Greek with the other.** http://www.ac2w.com/en_anecdotes.htm
    -

6. **Evaluate all joints on an injured extremity. Includes the inhibited arc of motion and comments on rhythm pattern** (progression pace) **of any given joint. Notes and explains the reasons for any limitations and/or discrepancies in formally measured vs. casually observed range of motion.** *(Records abnormal, excessive or limited range of motion, including ankylosis. Gentle passive range of motion may be performed in addition to active range of motion to determine whether the restriction is due to pain, spasm, 'voluntary restriction or mechanical block*)**;**

7. **Provide circumferential measurements & comments of the involved muscle groups and supporting tissues**. *(Musculature atrophy or wasting, including atrophy of the thenar, hypothenar or intrinsic areas. Overall weakness in muscle strength testing felt to be a result of deconditioning, pain, disuse, aging...)* **If measurements or observations are normal physician should simply state 'normal';**

8. **State when the uninjured joints' measurements are normal for the injured worker even though they are less than the 'estimated normal' 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.,...).* When both extremities are injured, estimated normal ranges of motion can be found on pages 62-63 of Evaluation of Industrial Disability by Packard Thurber (8 CCR 9725);

9. **Measure grasping power with at least 3 successive tests of the right and left grips (the wrist in moderate dorsiflexion) and report all tests. Comments on exerted effort, the soundness of grip measurements & strength testing. States If the dynamometer (Jamar) readings do not reflect the actual grip loss:**

   a) If there are signs/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 disability. Evaluator should provide an estimate on a percentage basis and the reasons for his opinion. *(Estimated normal should not be based on pounds or kilograms, as per 8 CCR 9725.)*

   i. When taking dynamometer measurements, 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.**

   ii. State if the pattern of grip measurements are compatible with muscle physiology.

   For Example: "On Jamar testing, she reached zero pounds with both hands and this is incompatible with activities of daily living. I do not believe that this reliability represents the patient's grasping capacity. She has normal musculature, will full range of motion."

   "Forearm measurements are 8" bilaterally. Using a Jamar dynamometer, grip strength on the right was 23, 24, 24 pounds and on the left 6, 0, 0. Due to normal muscle bulk and strength with manual muscle testing, estimated loss on the left is 20%. Patient was giving less than full effort on the left." - Mark J. Sontag, MD

10. **Report grasping estimates considering the injured worker's individual characteristics, general physical condition, age, stature, weight, and range of motion of other joints in the affected extremities, atrophy of pertinent musculature, anomalies or other conditions.** (When maximal effort is not applied or both extremities are injured)**:**

    a) Normal range has to do with occupational demands and level of conditioning. 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: For Women, the range is 30-60. Depending in what they do, the range for Men is 70-100. http://www.bleng.com/pdf/grip1.pdf

11. **Adhere to the evaluating guidelines established by the Evaluation of Industrial Disability, when determining** estimates or reporting measurable physical elements of disability by the use of references, tables/charts or other information (identifying names and sources of the materials used).

B. Evaluation Of Neurological & Clinical Elements

Labor Code Section § 139.2 & The California Code of Regulations, especially, 8 CCR 46, state that in order to produce a complete, accurate, uniform and replicable evaluation, the physician must support findings and opinions by clinical findings based on standardized examinations and testing techniques generally accepted by the medical community.

1. **8 CCR WCAB § 10606 outlines what should be included in a medical evaluation. The Industrial Medical Council (IMC) renders precise guidelines on how the information must be presented.** To produce a complete and replicable evaluation, the examiner must support opinions with clinical findings based on standardized examinations and testing techniques accepted by the medical community. Evaluator describes the purpose of the clinical tests, as well as the name or results. The function of a comprehensive P&S report is to enable those who are not physicians how to assess the case. **The report should be well reasoned, logical and objective.**

   a. **Motor Examination:** Includes general muscle bulk with a description of the specific muscles, or muscle group atrophy; muscle tone power with grading of muscle strength on a 0-to-5 scale as referenced in Walton's Aids to the Examination Of Peripheral Nervous System, 1988. If muscle weakness is noted, an opinion is stated as to the cause, such as: neurological deficit, pain, disuse atrophy or lack of effort. Muscle weakness (due to neurological deficit) should be documented on needle electromyographic testing.

   b. **Sensory Examination:** Includes a screening of light touch and pain sensation (pinprick) in pertinent dermatomal patterns, peripheral nerve distribution and of joint proprioception of any involved joints. Note if the pattern of sensory impairment is not physiological. Any abnormalities are described and fully correlated with peripheral nerve or dermatomal pattern. (Pinprick examination of the perianal region and assessment of sphincter tone may be indicated in certain cases.)

   c. **Deep Tendon Reflexes:** Outlines and grades on a 0 (absent) to 4+ (hyperactive), with the normal grade being 2. Testing with reinforcement may be indicated. Notes if clonus is present and whether any other abnormal reflexes were elicited.

   d. **Evaluation must include the 3 clinical elements outlined above (not merely one component). Evaluator must compare one side to the other in order to determine if pathology exists.**

2. **Provocative Tests for Neurological Entrapments/Joint & Soft Tissue Testing:** Requires the performance of necessary Provocative Tests. The evaluator determines the appropriate tests based on the history and other findings at time of examination. The use of these tests will assist in ruling-in/out diagnostic probabilities.
   http://www.musculoskeletalpaininstitute.com/pain_patient.cfm?click=lowback
3. **For example:**

➔ **Straight Leg Raising Test Rationale: The test primarily stretches the sciatic nerve and spinal nerve roots at the L5, S1 and S2 levels.**

- **70 to 90^0 of hip flexion** the nerve roots are fully stretched. If pain is elicited after 70^0 of hip flexion, then lumbar joint pain is suspect.
- **35 to 70^0 of hip flexion** the sciatic nerve roots tense over the intervertebral disc. If radicular pain begins at this level, then sciatic nerve root irritation by intervertebral disc pathology is suspect.
- **0 to 35^0 of hip flexion** there is no dural movement, and the sciatic nerve is relatively slack. If pain begins at this level, then, extradural sciatic involvement is suspect, [i.e., spastic piriformis muscle or sacroiliac joint lesions.] If dull posterior thigh pain is elicited then tight hamstring muscles should be suspect. [1]

[1] 3rd Edition – Regional Orthopaedic & Neurological Tests – Joseph J. Cipriano, D.C. – Williams & Wilkins, Baltimore – 1997.

For a more comprehensive particulars - IMC's Physician's Guide. - http://www.dir.ca.gov/IMC/guidelines.html - The Physician's Guide to Medical Practice in the California Workers' Compensation System (.pdf format, 1.6MB)

Luis Pérez-Cordero, MA, AAPMR
Permanent Disability Rating Specialist
Thursday, October 30, 2003