

**Permanent & Stationary Comprehensive Medical Report
 Common Report Errors And How To Fix Them**

I Speaking The Same Language: Defining Permanent Disability (PD)

Work Capacity Functional Loss - Permanent Partial Disability To Permanent Total Disability

Disability percentages are progressive and compacting in nature as they move upwards. Analogies for a level of functional loss as represented by a rating standard (be it scheduled or not), cannot be based on the 'compounding and pyramiding' of fragmented functional factors of disability. The 'progressive cumulative nature' of The Rating Standards of PD has not changed even with the inclusion of multiple definitions of functional loss assigned to any given rating standard.

00	05	08	10	13	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100
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00% = Permanent Partial Disability = 99%

Work With A Minimum Of Demands For Physical Effort ↑ | Legal (PERMANENT) Total Disability ↓

Loss of Both Eyes or Sight Thereof = Loss of Both Hands or Use Thereof = Practically Total Paralysis ↓

No Repetitive, Strenuous or Heavy Work ↑ | Brain Injuries Resulting in Incurable Imbecility or Insanity ↓

Substantial Loss of All Work Ability ↑ | Loss Of Use of One or Both Legs ↓

LP Cordero (01/99)@

A Permanent Disability (PD) – LC Section § 4660 & (8 CCR 10151)

Workers Compensation (WC) represents a compromise between the interests of both employer and employee. The physician plays a critical role in helping all concerned parties in their 'good faith' effort to quantify disability to arrive at appropriate compensation for work-related injuries.

PD is the benefit segment of WC that deals with the residual effects of an industrial injury (partial or total loss as compared to its previous level of functioning). PD (%) is the degree to which the permanent effects of the injury have diminished the capacity of an employee to compete for/maintain employment.

1. **When determining PD we consider: (LC § 4660)**
 - a. The nature of the physical injury/disfigurement,
 - b. The occupation and age when injured,
 - c. The diminished ability to compete in an open labor market.
2. **A rating can range from 0% to 100%. Presumptions of Total Disability:** (a) Loss of Both Eyes or sight (b) Loss of Both Hands or their use thereof. (c) Total Paralysis (d) Insanity/Imbecility. All others are determined in accordance with the facts. (LC § 4662)
3. **We rate medically evaluated residuals of an industrial injury by the use of The Schedule of Rating Permanent Disabilities.** The Schedule creates an arrangement of disabilities and values, which stand in relationship to one another. It provides the structure necessary to assign a standard to a non-scheduled disability according to its seriousness. The *medical findings and conclusions translate into a Permanent Disability Rating Formula which can be based on:*
 - a. **Objective Physical Findings** - amputation/motion loss/orthopedic appliances
 - b. **Subjective Factors** - disabling when they affect function
 - c. **Loss of functional capacity** - expressed as a % of loss and/or a work restriction for a specific function or group of functions.

II Indexes of Disability (Functional Loss)

A OBJECTIVE MEASURABLE PHYSICAL FACTORS: Physical/Operational Loss.

Two correlating Indexes (and/or their components) are used to assist in the numeric rendering of equitable, predictable determination of PD. Either Index or both can be used to describe a particular condition. Each generates its own disability rating formulation. When both are used, the Index producing the higher rating is taken. **Clear and logical reasoning must support the evaluator's opinion of functional loss under either index. No level of residual permanent disability is immune from these requirements.**

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The Schedule provides standard ratings for much impairment, frequently at their most disabling extremes. Most scheduled objective factors of disability are for total loss of motion or amputation at a joint. **However, residuals from injuries are more often partial impairments.** The rating should reflect the proportional amount of loss appropriate to the condition. This is achieved by taking a fractional portion of the age adjusted rating [formula] for complete loss. **The use of Orthopedic Appliances is also given consideration, when medically prescribed.**

Reporting Measurable Findings: Physician must report measurable physical elements of disability in accordance with the standard method as described in the book - **Evaluation of Industrial Disability.** (Packard Thurber, MD)- California Code of Regulations 8 CCR 46 & 9725 **"Packard Thurber defines how the evaluator should measure the physical elements of disability; Packard discusses what should be measured."** –Industrial Medical Council

1. Reporting includes:¹

- a. **Relevant description of body habitus and any general observations such as obvious discomfort while sitting, standing, limping, etc.**

Example of Clear Reporting Language: *"Dexterity and hand strength were intact for handling papers and when opening the examination room door."*

- b. **Circumferential measurements & comments of the involved muscle groups and supporting tissues.**
- c. **Evaluation of all joints on an injured extremity, including the inhibited arc of motion as well as comments on rhythm/pattern (progression pace) of any given joint.**
- d. **The Notes & the Reasons for any limitations and/or discrepancies in formally measured vs. casually observed range of motion. If measurements or observations are normal, simply state 'normal.'**

Example of Clear Reporting Language: *"Pain was experienced with range on motion in all directions. Range appeared more restricted during the formal aspects of the examination, than during the interview. Range of motion was limited in a standing posture that was not commensurate with his ability to sit unsupported on an examination table. The loss or range of motion doesn't represent a factor of medical impairment."* (Dr. Alan Kimelman, PQME)

- e. **Grasping power measurements** - 3 successive tests of the right and left grips (with the wrist in moderate dorsiflexion); reporting all test results; commenting on exerted effort during testing; providing complete measurements of both upper extremities; giving a reasoned opinion logically explaining the causation for the grip loss, if any.

Example of Clear Reporting Language: *"Examination of the hands reveals no masses, deformities or scars. There is no intrinsic thenar or hypothenar atrophy, swelling, signs of disuse atrophy or areas of tenderness. The patient is able to make full grip, whereby all fingertips touch the midpalm crease and the patient extends all fingers fully. The patient is able to touch the fifth metacarpal head with the respective thumb. Carpal compression test, Phalen and Tinel are negative for median nerve entrapment in the carpal tunnel. There is excellent strength of opposition, without intrinsic tightness. There is no collateral ligament laxity in any of the digits, with all flexors/extensor tendons fully functional, without any extensor lag."* **Dr. R.G. Ghazal – PQME**

Example of Clear Reporting Language: *"In the Primary Treating Physician (PTP) P&S evaluation, (PTP) states that the patient is in need of a non-scheduled work preclusion of being able to sit or stand or otherwise move about to change position at will. She did not complain to me about problems with sitting. During my Evaluation, she sat for approximately 45 minutes during the history-taking portion of examination. I do not feel that she needs any work preclusion in that regard. Regarding standing, she describes no pain or impairment with her standing. Her primary pain aggravators are lifting, to a lesser extent repetitive bending, and twisting."* **Ross Chiropractic: Douglas Kyle, DC, D.A.B.C.O.**

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2. The Impact of Under-Reporting:

- a. **Medical Legal Report must be capable of proving/disproving a disputed medical fact.** In determining whether a report meets requirements, a WCAB Judge considers the substance, as well as 'form' of the report, as required by applicable statutes and regulations. (LC§ 4620) **Comprehensive Medical-Legal Evaluation:** Evaluation of an employee, which results in the preparation of a narrative medical report prepared and attested to in accordance with LC§ 4628. Follows any applicable procedures promulgated under LC§ 139.2 and the requirements of 8 CCR § 10606. Is either performed by a (QME), (AME), or (PTP). (8 CCR § 9793 {c}.)
- b. **Substantial Medical Evidence Is:**
 - i. **The complete and thorough evaluation of objective measurable and clinical factors.**
 - ii. **The complete description of Subjective Disability Factors and its relationship to the underlying pathological processes, while distinguishing the difference between 'complaints' and 'subjective disability' and it affects function.**
 - iii. **The foundation of Labor Code § 4660's 'implementing tool' - The Schedule for Rating Permanent Disabilities.**
 - iv. **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.**
 - v. **The validation for addressing the diminished ability to compete in an open labor market. (Need for job modifications) (LC § 4660 [a])**

3. Example: Under-Reporting Grip: No Comment On Readings or Effort

Body Habitus/ Measurable Objectives:	<p>Upper Extremities: Right hand dominance. Weighted cervical range of motion is within normal limits- palpable tenderness and spasms, right trapezius. No evidence of deformity or atrophy, right shoulder. Limitation of right shoulder flexion to 110/180⁰ and abduction 100/180⁰ - pain on active motion.</p> <p>Circumferences(R/L): Arms 13/12¾", forearms 8¼/7¾". Motor Power, Reflexes & Sensory: Within normal limits, with diffuse giving-away to muscle testing, of both the right upper and lower extremities.</p> <p>GRIP (R/L): 10/47 - 80% RATABLE REDUCTION OF GRASPING POWER.</p>
Reduction of Grasping Power would rate as follows:(Computer Operator – Age 43)	
3/4 (10.511 - 40% - 230 - G - 43 - 45) 34 = 34%	
<u>Pertinent Questions?</u>	
<p>Q: <i>Is the pattern of grip measurements compatible with muscle physiology? Are there signs of weakness or atrophy involving the dorsal interosseous thenar or hypothenar muscles in either hand? (Isn't the injured forearm circumference 8¼"?) (Left 7¼")</i></p> <p>Q: <i>Isn't an 80% reduction of grasping power contradictory to physician's own findings and measurable physical elements of disability - to include no atrophy of pertinent musculature?</i></p> <p>Q: <i>Since grip is accomplished entirely by lower arm musculature, without neurological involvement, is shoulder level pathology a valid foundation supporting such a substantial level of grip loss?</i></p>	
Work Capacity Index:	<p>Upper Extremities: No repetitive use of the right upper extremity at shoulder level or above. A 50% loss of pre-injury capacity for work at or above 90⁰.</p>
(Work Restriction Rates) 7.3 - 8% - 230 - F - 8 - 09 = 09%	

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4. Example: Under-reporting Grip: Estimated Normal (en)

Average Normal are to be used in cases of bilateral injuries or pre-existing disabilities; the individual characteristics are used to modify these figures, e.g. age, stature, weight, range of motion of other body joints, anomalies, or other abnormal conditions, etc.

Body Habitus/ Measurable Objectives:	Right hand dominance. Well-healed surgical scars, bilateral carpal tunnel releases. Normal posture, spinal curvatures and muscular symmetry. Slight palpatory tenderness and spasm, upper back. Weighted cervical range of motion is 92% of normal. Upper Extremities: Bilateral shoulders (R/L) abduction 170/160°/180 ^{en} forward flexion 165/170/180 ^{en} . Full range of motion of the elbows, forearms, wrists and hands. Q: Where are the Circumferences of Pertinent Musculature(R/L)? Jamar Readings: (R) 10-10-10 / (L) 35-35-30 Estimated Normal: (R) 60lbs. (L) 54lbs. (R) 10 / 60en = 85% (L) 33 / 54en = 40%
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Pertinent Questions?

Q: Doesn't normal range have to do with the employee's occupation and whether or not the employee is a well-conditioned person? (In other words, an individual can work on increasing grip strength, using various devices despite their work. Most people do not use their grip actively or frequently and would fall into what is considered normal range for relatively inactive people.)

Q: Both measurable and clinical findings are negative for any restriction of motion or neurological impairments – on testing of the lower arms, is the tenderness present the only support for the reduction of grasping power?

Q: Why has physician failed to provide the circumference of pertinent musculature for the bilateral upper extremities or comment on exerted effort?

Reduction of Grasping Power would rate as follows: (Accounting Clerk – Age 55)

38/70 (10.513 - 85% - 111 - E - 83 - 86) 47 = 47%

Work Capacity Index:	Upper Extremities: No Very repetitive strenuous (physical) and fine manipulation (dexterity) endeavors.
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7.7 - 15% - 111 - G - 17 – 20 = 20%

B Subjective Factors: (The Most Problematic Reporting Area.)

Subjective Disability is characterized in terms of affected body part, intensity, frequency, and activity giving rise to the pain. Disabling pain should be described by the activity or activities that produces the pain. Other subjective factors can include numbness, weakness, tenderness, paresthesias and increased/decreased sensitivity. All of these factors may or may not cause a degree of disability. They become disabling when they affect function.

List the employee's complaints at the time of examination. Describe any subjective complaints, which the employee attributes to the industrial injury, and then give your medical opinion regarding validity and the reasons for conclusions.

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1. **Reporting of Subjective Disability Factors includes:** a description of the activity that produces the symptoms (heavy work, repetitive use, heavy lifting, etc.), the duration or frequency of the symptoms (occasional, intermittent, frequent, constant), the level (intensity) of the symptoms (severe, moderate, slight, minimal), the activities precluded as well as those that can be performed with the symptoms. ***Comment on the means necessary to relieve the symptoms and all other subjectives whether they are pain, tenderness, sensitivity, sensory disturbances, weakness, fatigue or neurogenic residuals. (8 CCR 46, 9725, & 9727)***
2. **Example: How Identifying Language Becomes Inconsistent Language:** In the Same Medical Report Physician describes the following conflicting levels of disability.

Subjective Factors	“The subjective factors for the lumbar spine are valid and should be rated as follows: Constant moderate lower back pain that rises to a severe level on an occasional basis. Inciting activities include lifting, bending, stooping, pushing, pulling, climbing and standing in one place.”
Subjective Disability Would Rate: (Cook – Age 42)	
12.1 - 55% - 322 - F - 55 – 57 = 57%	
Work Capacity Index:	“The subjective and objective factors of disability for the spine contemplate a 50% loss of pre-injury capacity for performing such activities as bending, stooping, lifting, pushing, pulling, climbing or other activities involving comparable physical effort. The above subjective and objective factors contemplate a disability precluding heavy work.”
Work Restrictions Would Rate (Cook – Age 42)	
12.1 - 30% - 322 - F - 30 – 32 = 32%	
Supplemental Response when clarification was requested:	
Work Capacity Index:	“He does have a relative disparity between Objective Factors and Subjective Factors of Disability which is not an uncommon finding of patients with chronic musculoskeletal pain syndrome. The relationship of the reported pain to the underlying pathological processes is direct and anatomic.” J. Wallace, DCPA-C QME The response fails to address the inconsistency between the described levels of work capacity functional loss.

3. **Identify both Complaints & Subjective Disability:**
 - a. **Describe any complaints the patient attributes to the injury and then give opinion regarding validity and the reasons for conclusions.** Describe the pain and report complaints of radiating pain into other areas, using the injured worker’s own words, particularly if this results in a separate physical impairment. Describe collateral symptoms, such as itching, cramping, tingling, etc., in regards to location, severity, and frequency in relation to motion, effort and activity. Outline factors or treatments, which tend to relieve the pain or symptoms.

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- b. Describe how the symptoms affect performance/ability to work, rather than how severely the injured worker perceives the symptoms.
- c. Then, “translate” into ratable language in the Subjective Factors of Disability Section.
 - i. Disability cannot be based on the complaints. Complaints are not ‘Subjective Disability’. Disability is based on the objective medical opinion as to the subjective factors of disability after the completion of the medical evaluation. The reasons supporting the subjective disability must go beyond a listing of diagnoses or findings.
 - ii. **Example:** *“Once again, I do not feel that any additional therapy and or intervention at this point would improve this patient’s current pain complaints. For a person who complains of moderate-to-severe pain subjectively, he has no pain guarding and/or evidence of disuse atrophy, he appears very comfortable and is able to participate in his physical exam without any complaints.”* – Northern California Rehabilitation Associates

4. Complete Identifying Language: (Incomplete Language = Assumptions/Conjecture)

By Severity/Frequency/Activities Precipitating the Pain		
Example # 1: Constant slight pain that increases to moderate with heavy lifting and to moderate-to-severe intermittently with Heavy Work.		
(1) First Level of Pain	Constant Slight Pain	10
(2) Next Level of Pain	Moderate	50
(3) Subtract #1 from # 2:		<u>-10</u>
(4) Modify Result by Value Of Activities Precipitating # 2	Heavy Lifting 20%	20% = 1/5 (40) = 08
(5) Add Result of # 4 to # 1	10 + 08% = 18%	
(6) Next Level: Moderate-to-severe Pain	Moderate-To-Severe (75%)	75
(7) Subtract The Result of # 5:		Minus - <u>-18</u>
(8) <u>Modify Result by Frequency</u> in which # 6 occurs: (Intermittently) = 50%		½ (57) 28.5
(9) <u>Modify Result by % value for activities precipitating the pain</u> – Heavy Work (30%)		30% (28.5) = 8.55
(10) Add result of #9 to #5 After rounding, the addition becomes the subjective disability rating standard .	18 + 8.55 = 26.55 = 25%*	Standard After Rounding: 25%

By Activity That Precipitates The Pain		
Example # 2: Intermittent slight-to-moderate pain with sedentary type activities.		
(1) Level of Pain	Intermittent Slight-to-Moderate	15
(2) Values of Activities Precipitating the Pain	Sedentary Type Activities	70%
(3) Multiply # 1 by X 2		15 X 70 = <u>11</u>
(3) Round result of # 3. After rounding, the addition becomes the subjective disability rating standard.	11 = 10% ¹	Standard After Rounding: 10%

¹ The Resulting standard should be expressed as one of the following values: 1,2,3,5,8,10,13,15 & multiples of 5% thereafter, before modification for age and occupation. (See Page 1-13 of The Schedule.)

C Work Capacity Index: Justifiable Limitations of Functional Loss.

The overall loss of pre-injury capacity should be discussed, identified and explained with references to the factors and functional tasks used in the formulation of the estimate.

Functional loss is correlated with work history, findings, & examination, and is indicated in terms of a percentage loss of pre-injury capacity for the specific individual. A **Scheduled or Analogized Work Restriction** (an identifiable word description of functional loss for pre-determined values) can be an equivalent counterpart.

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D Work Capacity Index: Justifiable Limitations of Functional Loss.

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Functional loss is correlated with work history, findings, & examination, and is indicated in terms of a percentage loss of pre-injury capacity for the specific individual. A Scheduled or Analogized Work Restriction (an identifiable word description of functional loss for pre-determined values) can be an equivalent counterpart.

In order to prevent further injury/disability (whether specifically relevant to the current occupation), **work restrictions establish limits of specific activities or tasks due to a disability that impedes an activity, body position & motion**, to avoid an exposure such as to chemicals, substances, heat, etc.

1. **Percentage Loss of Pre-injury Capacity: Based on a comparison of what the worker could do before and after the injury. The loss of pre-injury capacity is reported as a percentage. The medical evidence relied on must be clearly described. (AD No. 4061-02-18899 – Rocha vs. C.C.I.)**

Loss of pre-injury work capacity can be estimated broadly in four main levels addressing the 25%, 50%, 75%, and 100% levels of functional loss. **When sufficient information is available, the physician should be able to estimate the overall level of functional loss more precisely.**

Prolonged/Very Heavy /Very Forceful Tasks: 25% loss of pre-injury capacity	Substantial Loss: 75% loss of pre-injury capacity
Repetitive/Forceful/Strenuous/Heavy Tasks 50% loss of pre-injury capacity	Sustained Tasks 100% loss of pre-injury capacity

- a. **Integrating vs. Fragmenting Functional Loss in The Extremities:**
Upper Extremity Chart - <http://pdratings.com/singleuec.htm>
Lower Extremities Chart - <http://pdratings.com/lowerextremities.htm>

Joint function doesn't occur in total isolation, but rather as an integral component of the extremity's kinetic chain. For example, in an upper extremity the elbow joint serves as the anatomic link between the shoulder (arm) and hand, thereby allowing hand placement as well as upper extremity force transmission and absorption. Keeping in mind the anatomy and biomechanics of the injured extremity, the physician can express loss of pre-injury work capacity by referring to the "loss of function" dealing with placement, movement, manipulation, dexterity, pinching, grasping, gripping, torquing, pushing, pulling, lifting, carrying, repetitive movements, fine manipulation, and/or other activities involving comparable physical effort.

For the lower extremities, the overall % loss of pre-injury capacity should address the activities pertaining to the anatomical functioning of the lower extremities as it pertains to weight bearing activities derived from the primary anatomical function of the lower extremities, which involves the support of the full weight of the body by the legs. Weight bearing preclusions include such activities as standing, walking, squatting, kneeling, crouching, crawling, pivoting, climbing, walking on uneven ground or other activities of comparable physical effort, such as lifting, carrying, pushing/pulling, etc.

- b. **General Examples For The Extremities:**

40% loss of pre-injury capacity for lifting, pushing-pulling, grasping, pinching, holding, torquing, finger dexterity/manipulation and other activities of comparable physical effort.

50% loss of ability for manipulation or repetitive tasks.

75% loss of ability for forceful grasping. (Power gripping) (Sustained Grasping)

25% loss of pre-injury capacity for weight bearing

50% loss of pre-injury capacity for knee flexion and extension.

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2. **Preventive Work Restrictions (PWR):** Stated in order to prevent further injury when an injured worker cannot/should not perform a specific function or a similar group of functions. Based on medical impairment, PWR are stated to prevent undue pain or harmful symptoms. The type of limitations can be both 'temporary' (to allow employee to return to modify work during healing process) and permanent. They facilitate job or ergonomic modifications, helping to determine levels of PD functional loss as well as job retraining plans for Vocational Rehabilitation Benefits.

PWR are always based on a sound medical opinion that takes into account all aspects of the medical evaluation, medical history and measurable physical/clinical findings. They are imposed when warranted by the findings and when the physician feels that further performance of a specific work function or group of functions will lead to: (1) increased symptoms, (2) excessive increase in the need for treatment, (3) excessive flare-ups, (4) a greater level of residual permanent disability. If no work preclusions are needed and the residual disability is best expressed by either the objective or subjective factors alone, it should be so stated

“Disability may be expressed in terms of limitations of work activities. The Schedule provides a framework of work capacity guidelines for individual torso (i.e., neck, back, pelvis, abdomen, heart, chest and lungs), and separate guidelines for lower extremity disabilities.” [Page 1-8 of The Schedule.]

3. **Paradoxical Use of The Word Prophylactic:** The word prophylactic means 'to-guard-against'. When used with a work restriction, it implies that without the work restriction, the injured employee would be harmed.
- a. When substantiated by realistic findings identified in the formulation of the medical opinion, valid work restrictions don't need to be obscured by the use of the word prophylactic.
- b. **The word prophylactic is not in itself 'objective evidence' capable of proving, disproving, or supporting disability. It only serves to disguise the lack of material findings, in turn building the facade of 'reasonable medical probability', creating both impairment and disability.** (LC§ 4620, 8 CCR WCAB § 10606 [f] [h] [i] [k] [m] [n], 8 CCR 9793[c].)

III **Consonance: Between Discussion of Disability (PD) and The Need For Job Modifications.**

A **The Job & Its Functions: Your Descriptions as to job duties and activities.**

There should be no inconsistencies between statements addressing an injured employee's need for job modifications and the described levels of functional loss under Permanent Disability.

Understanding Scheduled terminology and their corresponding levels of functional loss avoids misunderstandings and inconsistencies when describing multiple factors of disability: loss due to subjective factors, work restrictions and/or the 'opinion' on the need for job modifications or alternative work.

A Job Description or Job Analysis helps with the Medical Eligibility for Determination and the loss of functional capacity. If not provided, ask the employee to describe duties and incorporate the description in the report. The description then becomes a qualifier for the physician's eligibility determination and description of functional loss.

Correlation of functional loss (PD) to the need for current modifications or job functions helps all parties understand if the injured employee can return to the position they were engaged at the time of the injury.

Helpful identifiers of a realistic level of functional capacity or loss: (1) actual deportment and bearing (prior, during and after) the examination, (2) current job functions/duties (if now engaged in a different occupation). Like PD, the determination for job modifications must include not only the conclusion, but also the rationale.

1. **Examples of Integrating Language**

- *“The Patient works at Aeromat involved in battery assembly. She states that the batteries would weigh about ten pounds. Her work was repetitive in that she would hold the battery in her left hand and use an air driven screwdriver in her right hand. She would do 60 to 70 batteries a day. There would be 8 to 10 batteries in a box. Each battery had a number of screws per battery. She also welded wires for the batteries. She began work on 6/92. She denied concurrent work or home activities that aggravated her hands. She denied prior symptoms.”*

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- *“26-year old right-handed worker works as a legal processing assistant for Orange County for 10-months. Job duties at the time of the injury included lifting up to 25lbs., pulling, pushing of the file shelves, stooping, occasional kneeling, bending, working overhead with extended reach for retrieving and filing, as well as performing the scanning tasks. Works on a computer for 7-hours per day, performs fine hand manipulation 8-hours a day. He states he answered the phone, occasionally writes phone messages. Does document scanning in a separate scanning room/area. Job information was obtained from the patient.” – Kaiser Occupational Medicine Dept.*

A Reporting Functional Loss and/or Work Modifications

Lifting Capacity: Without information about the employee’s pre-injury lifting capacity, restrictions addressing a ‘poundage -range’ can produce multiple results. Under the Spine/Torso Guideline of No Very Heavy Lifting, you find the general guidelines for determining ‘loss of lifting capacity’.

1. A statement “**inability to lift 50 pounds**” is **not meaningful**. Determine loss of pre-injury capacity due to an inability to lift, by comparing the individual's pre-injury lifting capacity with the current lifting capacity. Take into consideration, the total lifting effort, weight, distance, endurance, frequency, body position and comparable physical factors with reference to a particular individual.

“What is the specific information of what the person lifted and carried at work? A general statement is insufficient. [15- pound maximum lift and carry limit] The example opinion generally states applicant had to “lift and carry things” (presumably) at work. However, there must be facts about the nature of the work in order to support an opinion that lifting and carrying things caused injury. What kinds of items were lifted and carried? How much did the items weigh? How often were the items carried? How far were the items moved? The questions are numerous. If the person is lifting and carrying two 2-ounces of paper clips, once a day, cumulative trauma to the low back from lifting and carrying would seem highly unlikely. If the person were carrying 100-pound blocks of granite 12 hours a day, cumulative trauma would seem more plausible. The Judge’s Perspective: Writing Usable Medical Reports, by William J. Ordas / Nikki S. Udkovich.

1. **Reporting Consonant Loss of Pre-injury lifting capacity:**
Understanding Scheduled Levels of Pre-injury Capacity Functional Loss

Spine/Torso ‘Benchmarks’ address percentages of work capacity functional loss to perform a specific function or groups of functions. **Once the core of physical activities (lifting, bending, stooping, etc.) has reached a level of loss as defined by a Limitation to Light Work, additional guidelines address limitations of weight bearing functions.**

- **No Very Heavy Lifting:** Approximately a 25% loss of pre-injury capacity for lifting.
- **No Very Heavy Work:** Approximately a 25% loss of capacity for lifting and other arduous demands.
- **No Heavy Lifting:** Approximately a 50% loss of lifting capacity.
- **No Heavy Work:** Approximately a 50% loss of lifting capacity and other arduous physical demands. (No Sustained Work)
- **No Repetitive Motions of The Neck/Spine:** Approximately 50% loss for the weighted spinal motions.
- **No Substantial Work:** Approximately a 75% loss of pre-injury capacity for lifting and demanding physical activities.
- **Limitation to Light Work:** - Can work with a minimum of demands for physical effort.

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2. Example of Consonant Reporting:

- Preclusion from **No Heavy Lifting**: Approximately 50% loss of pre-injury capacity for lifting. LC§ 4660
- Example: Employee’s lifting pre-injury capacity as per the Job Description (RU-91) was 80 pounds. Employee’s current lifting ability is now limited to between 40-50 pounds. LC§ 4636

Loss of Pre-Injury Lifting Capacity Calculation:													
(1) Pre-injury lifting capacity: 80Lbs. (2) Residual Lifting Capacity 40-50lbs													
80lbs (minus) – 45 (average of 40-50lbs limitation) = 35 (divided) ÷ 80 = 45% loss of pre-injury capacity for lifting.													
Spine/Torso ‘Benchmark’ Percentages of Disability & Functional Loss:													
Multiple factors of disability will have some redundancy in how the elements of disability affect specific abilities or overall function. If added together, they would create a greater amount of Permanent Disability than actually exists. General guidelines for determining “loss of lifting capacity” are found under the Spine/Torso benchmark for No Very Heavy Lifting . (Page 2-14 of The Schedule). Without information about the employee’s pre-injury lifting capacity, restrictions addressing a ‘poundage - range’ can produce two different results. 8 CCR Evaluation Guidelines: 8 CCR 46, 9725 & 9727.													
00	03	05	08	10	13	15	20	25	30	35	40	45	50
Pre-Injury Loss:	10%	15%	20%	25%	30%	40%	45-50%	55-60%	65-70%	75-80%	85-90%	95-100%	
Spine/Torso Motion:				↑ 20-25%		↑ ↑		50%		↑		80+	
Back Braces:				↑ Canvas with Metal				↑ Chairback Brace		Taylor Type Brace ↓			
No Repetitive Motions of the Neck or Spine ↓ Approximately 50% loss of pre-injury capacity for flexing, extending, bending, and rotating the neck or back.							↑		↑ (By Analogy) Work with Minimal Spinal Movement. (Sustained Movement)				
Residual Lifting Capacity for: 76-100lbs.				↑ 51-75		↑		↑ 26-50		↑ 11-25		↑ 0-10	
Residual Lifting Capacity for: 51-75lbs				↑ 26-50		11-25		↑ 0-10		↑			
↑ Disability Precluding Very Heavy Lifting: Approximately 25% loss of pre-injury capacity for lifting.													
No Very Heavy Work: ↓ Approximately a 25% Loss Of Pre-Injury Capacity For Bending, Stooping, Lifting, pushing, pulling, climbing or other activities involving comparable physical effort.							↑ Disability Precluding Heavy Lifting: Approximately 50% loss of pre-injury capacity.						
No Heavy Lifting and Repeated Bending and Stooping: ↓ Approximately 50% loss of pre-injury capacity for lifting bending and stooping.							↑ NO HEAVY WORK: 50% loss of pre-injury capacity for bending, stooping, lifting, pushing, pulling, climbing or other activities of comparable physical effort.						
Approximately 75% loss of pre-injury capacity for performing bending, stooping, lifting, pushing, pulling, climbing or other activities of comparable effort.										No Substantial Work: ↓			
↑ Limitation to Light Work: ↓ Work in a standing or walking position, with a minimum of demands for physical effort.													
Functional Loss Key: Prolonged (25%) Repetitive (50%) Substantial (75%) Sustain (100%)													
Frequency Key: Rare (1/5) Occasional (1/4) Intermittent (1/2) Frequent (3/4) Constant (4/4)													
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3. Under-Reporting lifting capacity: Open Ended Statements (Vagueness leads to disputes.)

A Avoid inconsistencies and reporting inadequacies by considering the already scheduled terminology for loss of pre-injury capacity as it relates to the injured employee’s functional loss.

Estimate more exactly (the overall level of functional loss) when sufficient information is available: i.e. - your own description of job functions, RU-91, Job Analysis, current job functions, department, etc.

- Example of Open Ended Language: Lifting Capacity is now 30-45lbs**
 - 6A 50%-60% loss of pre-injury lifting capacity?
 - A 15-20% Loss of Pre-injury lifting capacity?

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4. Avoiding Identifying Language Becoming Problematic:

“Employee began working in September 1994, in the capacity of general laborer. Never returned to work to the same job. Now finishing rehabilitation courses to become an eco-systems technician.”

The Heaviest of Strength & Physical Demands?			
DWC: (1 st Digit of Group #)	REQUIREMENT S	Strength Factors / (DOT Pages 1012-1013)	Heaviest Item
Heavy Work	In Excess of Those for Medium Work	50-100 ^{lbs} Occasionally 50+ ^{lbs} Frequently Greater than 10-20 ^{lbs} of force CONSTANTLY	??

“Job duties consisted (but not limited to) of preparing a mixed salad with croutons.”

General Laborer: The Lightest of Strength & Physical Demands			
DWC: (1 st Digit of Group #)	REQUIREMENT S	Strength Factors / (DOT Pages 1012-1013)	Heaviest Item
Very Light Work (Sedentary Type Work)	Sitting Most of the Time	0-10 lbs. of force Occasionally/ Negligent Force CONST Walking/Standing Occasionally	??

“Would work on a conveyor belt, placing, salad, chicken, croutons or dressing in a small box. Placing the completed boxes in a table next to the conveyor belt so other employees could reach them and pack them.”

Food Worker, Maintaining a Production Rate (?)			
DWC: (1 st Digit of Group #)	REQUIREMENT S	Strength Factors / (DOT Pages 1012-1013)	Heaviest Item
Light Work	In Excess of Those for Sedentary Work	20 lbs. of force Occasionally 0-10 lbs. of force Frequently Negligible force constantly to move objects. Can Include Maintaining a Production Rate Pace	??

“Employee began working in September 1994, in the capacity of general laborer. Never returned to work to the same job. Now finishing rehabilitation courses to become an eco-systems technician. Job duties consisted (but not limited to) of preparing a mixed salad with croutons. Would work on a conveyor belt, placing, salad, chicken, croutons or dressing in a small box. Placing the completed boxes in a table next to the conveyor belt so other employees could reach them and pack them. “Required to lift/carry boxes of supplies weighing up to 30lbs. Worked in a standing/bending position during her shift.”

Food Worker – Light to Medium Work –Maintaining a Production Rate			
DWC: (1 st Digit of Group #)	REQUIREMENTS	Strength Factors / (DOT Pages 1012-1013)	Heaviest Item
Medium Work	In Excess of Those for Light Work	20-50 ^{lbs} Occasionally 10-25 ^{lbs} Frequently Greater than 10 ^{lbs} of force CONSTANTLY to Move Objects	30lbs

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III Avoiding Misconceptions When Supporting Work Capacity Functional Loss: ☹

☺ **Support all disability: identify and define medical impairment, subjective disability and the need for work restrictions.**

☹ **The word ‘prophylactic’ and other ‘buzz words’ should not ‘disguise’ the lack of findings or be the only support for any of your descriptions of functional loss.**

Cumulative Trauma: Not in itself a diagnostic validation - but rather an identifier of a heterogeneous group of diagnoses. There must be a causal relationship between work activities and the diagnosis, **not merely the presence of the diagnosis, in order to determine work-relatedness.** It is the physician’s responsibility to identify the occupational risk factors – specific information regarding repetition, force, vibration, cold exposure, other risk factors, and combinations thereof.

“A 61% PD Rating based on a limitation to Semi-Sedentary Work for an employee who suffered a sprained ankle with residual disability only of minimal to slight subjective complaints, becoming more than moderate on prolonged weight bearing, was not supported by substantial evidence in light of the entire record, and was fundamentally unmerited. The WCAB Judge did not weigh the Medical Examiner’s conclusion against other competent evidence, which either diminished or contradicted the conclusion. Universal City Studios, Inc. vs. WCAB (Lewis), 44 CCC 113.

A Misconceptions:

- ☹ **Following established guidelines for the format of the medical-legal report, and listing diagnoses, surgical procedures, testing results and need for treatment, relieves the examiner from the burden of providing a reasoned opinion supported by examination findings.**
- ☹ **Objective Measurable Physical Elements and Subjective Disability don’t have to be in consonance or correlate to the work capacity functional loss addressed under the work restrictions. Injured Worker’s Subjective Complaints are sufficient to support all functional loss.**
- ☹ **The use of the terms ‘Cumulative Trauma’ dispenses the need for supporting objective findings.**

B Consonant ☺ or Discordant ☹ Descriptions of Disability:

1. **Example # 1 Factors:** “26-year old right-handed worker works as a legal processing assistant for Orange County for 10-months. Job duties at the time of the injury included lifting up to 25lbs., pulling, pushing of the file shelves, stooping, occasional kneeling, bending, working overhead with extended reach for retrieving and filing, as well as performing the scanning tasks. Works on a computer for 7-hours per day, performs fine hand manipulation 8-hours a day. He states he answered the phone, occasionally writes phone messages. Does document scanning in a separate scanning room/area. Job information was obtained from the patient.” – HMO Occupational Medicine Dept.

a. P&S Report description of Factors:

- **Objective Factors** – Mild Tenderness at the extensor wad bilaterally, right ulnar and trapezius muscle. Full range of motion of the shoulders, elbows, forearms, wrists and hands. No evidence of atrophy in any of the major groups of the bilateral upper extremities.
- **Subjective Factors:** At rest occasional mild stiffness and pain in the right arm, hand and fingers, increasing to slight-to-moderate with prolonged gripping, grasping, lifting and reaching out.

√ **Rater’s Calculation: Einstein-Horner Formulation (for Overlapping Subjective Factors of Disability): Basic Pain: 00% = [30%(slight-to-moderate) x (20% prolonged activities) = 06% ≈ 05%**

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b. P&S Report description of Factors: (Continued)

- **Work Restrictions:** *“Prophylactically, he is precluded from scanning more than 1-hour in the morning and one hour in the afternoon as this requires prolonged gripping, grasping and reaching out tasks. He may perform other work during the rest of the workday. He may be able to perform more scanning if the work station in the scanning area is ergonomically corrected as previously recommended.”*

√ **Rater’s Calculation for The Loss of Pre-injury Capacity:**

- No Prolonged Activities 25% loss ≈ 1/8 weighted fraction from page 7-6 of The Schedule.

- **Appliances Required: Bilateral Soft Braces. ??**

***To be used at work? To be used intermittently? Occasionally? To be used night?
 Where are the measurable and clinical findings supporting the need for these
 devices during working hours?***

PROVISIONAL RATING – PERMANENT DISABILITY RANGE: MEDICAL REPORT IS INTERNALLY INCONSISTENT
1. Physician fails to describe if the required appliances are clinically prescribed and or required to be use during working hours.
Rating Loss Of Pre-Injury Capacity In The Upper Extremities <i>“Two distinct systems are used to describe disability – (1) The Objective/Subjective Index and the (2) Work Capacity Index. When both are used, <u>the index producing the higher rating is used.</u>” Schedule: Page 1-3 (Indexes of Disability)</i>
√ Calculation must take into consideration the scheduled differences for handedness. √ Ratings require more Precise Calculation Than the Use of ‘Plateau Guidelines.’
(1) There Are No Ratable Measurable Factors of Disability. *
(2) Rating Calculation Under The Subjective Factors of Disability would rate: $7.1 - 5\% - 111 - G - 6 - 6 = 06\%$
(3) Disability under the Work Capacity Index Rates: $1/8 (9.5112 - 41\% - 111 - G - 44 - 44) 6 = 06\%$
* Orthopedic Appliances, <u>when prescribed,</u> may be given consideration in the determination.
$37/92 (9.5113 - 90\% - 111 - G - 91 - 91) 37 = 37\%$

<u>Weighted Fraction Calculation For Formula 9.5113- 90%</u> The Need To Wear Bilateral Soft Wrist Splints During Working Hours. 1.Equivalent Fractions are obtained from Page 7-6 of The Schedule.		
Fraction	Hand Formulas Only Modified for Occupation	Weighted Loss
2/5	(9.511 - 45% - 111 - G - 48)	19
2/5	(9.5112 - 41% - 221 - G - 44)	18
	92	37
LPC (06-05-1998)©		Denominator ↑ Numerator ↑

- 2. **Example # 2 Factors:** ☺ *“Objective factors of disability include pain on supraspinatus testing, a positive Hawkins-Kennedy sign on the right (which improved following a subacromial injection and shoulder arthroscopic surgery). Shoulder elevation is to 160°. Also, right grip weakness of approximately 20% as per physical examination. The patient is right hand dominant. The grip weakness was noted on Jamar Testing in pounds and is listed under Physical Examination. Pain is minimal-to-slight without provocation.”*

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3. **Example # 2 Factors:** ☺ “Objective factors of disability include pain on supraspinatus testing, a positive Hawkins-Kennedy sign on the right (which improved following a subacromial injection and shoulder arthroscopic surgery). Shoulder elevation is to 160°. Also, right grip weakness of approximately 20% as per physical examination. The patient’s right hand dominant. The grip weakness was noted on Jamar Testing in pounds and is listed under Physical Examination. Pain is minimal-to-slight without provocation.”

→ **Work Restrictions:**

1. **Upper Arms:** “No repetitive work at or above shoulder level including lifting, reaching, pushing, pulling.”
 - a. 50% loss ≈ 1/2 weighted fraction from page 7-4 of The Schedule
2. **Lower Arms:** “Should avoid very forceful torquing with his right upper extremity and should avoid very heavy lifting with the right upper extremity. He has lost approximately 25% of his total pre-injury capacity for lifting
 - a. 25% loss ≈ 1/8 weighted fraction from page 7-6 of The Schedule.

Recommended Rating (Bus Driver # 250) Age 45 ☺
1/2 (7.331 - 15% - 250 - F - 15 - 16) 08 Upper Arm
1/2[1/8 (10.511 - 40% - 250 - F - 40 - 42) 05] 03 Lower Arms
Weighted Subjectives: 03 Basic Pain At Rest
14 = 14%
*Combining Disabilities in a Single Extremity: Subjective factors due to the disabling effects of pain, if any, are added after gradation of their value due to the nature and magnitude of the overall disability.” [Schedule, page 1-4.)

4. **Example # 3 Factors:** ☹ ☺

“She worked at a mini storage unit. She opened up in the mornings. Her job consisted of showing units, cleaning, units, ledgering accounts, preparing late and legal notices, and cleaning the yard. Once a week she moved a commercial dumpster, on Wednesdays. She tripped and fell on the sidewalk the day she was injured.”

- **Objective Factors** – Normal posture and stance. No muscle wasting or evidence of atrophy. Full range of motion of the shoulders, elbows, forearms, wrists and hands. **Palpatory tenderness over the base of the right little finger. Grip (R/L): 70 / 70 (Rapid Exchange) 69/63 – no ratable reduction of grasping power. Average grip strength for a 57-year old as per Mathiowatz: 57-pounds.** X-rays: No arthritis is noted. Joint alignment, intact.
- **Subjective Factors:** Occasional slight pain in the right hand that is exacerbated with **lifting and gripping** (Q: All lifting and gripping? Forceful Gripping? Repetitive Gripping?). Should be rated as occasional moderate pain.
- √ **Rater’s Calculation: Einstein-Horner Formulation (for Overlapping Subjective Factors of Disability): Basic Pain: 01% = [25%(moderate) – 01 = 24 x 1/4 (occasional) 06 x 40 (activities-full value of not grasping) =2.4] 3.4 = 03%**
- **Work Restrictions:** “I agree with Dr. Williamson’s work restrictions. The work restrictions are no lifting more than 15-pounds with the right upper extremity and occasional gripping, grasping with the right hand and occasional typing.”
- **Vocational Rehabilitation/ Job Modifications:** Not QIW – can return to her job at Security Public Storage.
- √ **Rater’s Calculation for The Loss of Pre-injury Capacity:**
 - 75% loss of pre-injury capacity for grasping ≈ 4/9 weighted fraction.
 - No typing/Fine Manipulation – 50% loss of pre-injury capacity 1/3 weighted fraction
 - Can do Occasionally – 75% loss (3/4) x 1/3 = 3/12 ≈ 3/10

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**PROVISIONAL RATING – PERMANENT DISABILITY RANGE:
MEDICAL REPORT IS INTERNALLY INCONSISTENT**

2. Physician fails to describe if the required appliances are clinically prescribed and or required to be use during working hours.

(1) There Are No Ratable Measurable Factors of Disability.

(2) Rating Calculation Under The Subjective Factors of Disability would rate:
7.1 - 3% - 111 - G - 4 - 5 = 05%

(3) Disability under the Work Capacity Index Rates: No Grasping
4/9 (10.511 - 40% - 111 - E - 37 - 41) 18 = 18%

(4) For Comparison Purposes Only: 75% loss of Keyboarding Ability
~~3/10 (9.511 - 45% - 111 - G - 48 - 52) 16 = 16%~~

**Rating Loss Of Pre-Injury Capacity In The Upper Extremities
Calculation must take into consideration the scheduled differences for major/minor hands.
Upper Extremity Ratings Require more Precise Evaluation Than the Use of 'Plateau
Guidelines.'**

1. **Lower Arm (elbow to hand):** The Schedule provides for ratings under multiple indexes such as strength (grip), limitation of motion (manipulation) or amputation, with the proviso that these indexes are not in addition to each other. Because or the inherent nature of finger mobility is inseparable from the strength functions of the hand, to avoid 'duplication' among factors of disability, we weight the percentages loss of function with the use of The Hand Scale for Rating Reduction of Grip Strength on page 7-6 of the Schedule.

2. **Strength/Forceful Activities (Grip):**

a. 75% loss of pre-injury capacity for grasping ≈ 4/9 weighted fraction from page 7-6 of The Schedule.

3. **Manipulation & Dexterity (Motion):** ~~No typing/Fine Manipulation - 60% loss of pre injury capacity 1/3 weighted fraction. Can do Occasionally - 75% loss (3/4) x 1/3 = 3/12 ≈ 3/10 now weighted fraction from page 7-6 of The Schedule.~~

Lower Arm – Strength Or Dexterity Functions

Weighted Fractions To Be Applied To Formulas:

10.511-10.512 - 10.513 – 85% / (Forceful Activities/Gripping/Torquing/Pushing, Pulling)

9.5111- 9.812 - 9.5113- 90% / (Manipulation/Dexterity/Mobility/Flexion & Extension)

Functional Loss	Weighted Percentage of Loss	Weighted Fraction:	Functional Loss	Weighted Percentage of Loss	Weighted Fraction:
	10%	1/30		40%	1/4
	15%	1/20	Example # 3 75% loss of pre-injury capacity for Fine Manipulation	45%	3/10
Occasional Use of Wrist Braces	20%	1/12	Repetitive Activities No Fine Manipulation No Sustained Activities	50%	1/3
Example # 2 Prolonged Activities	25%	1/8	Example # 1 Soft/Molded Braces	55%-65%	2/5
No Repetitive Typing	30%	1/6	Example # 3 75% loss of grasping ?	(70-75%)	4/9
Intermittent Use of Wrist Braces	35%	1/5	Light	Minimal Demands	5/10

*Maintains objective correlation among rating standards of disability (Immobility & Amputation: 7.143.)

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