Permanent Disability Rating

Presenters
Annalisa Faina
Barry Knight
Blair Megowan
Kathy Patterson
Tess Snaer
Rating Impairments of the Spine

Presented by
Annalisa Faina
Tess Snaer
Barry Knight

Spine

- Three Main Regions
  - Cervical
  - Thoracic
  - Lumbar

Rated similarly

Spine Rating Methods

- Two Methods for Rating the Spine
  - Diagnostic Related Estimate (DRE)
  - Range of Motion (ROM)

DRE is the principle method
When to Use DRE Method

- Injury (as opposed to illness)
- Single level within a spinal region
- First injury or repeat injury to a different region
- Corticospinal damage

When to Use ROM Method

- Impairment caused by illness, not specific injury
- Multilevel radiculopathy in same region
- Bilateral radiculopathy
- Recurrent radiculopathy in same region
- Multi-level alteration in motion segment integrity, e.g. a fusion at two or more levels
- Multilevel fracture

Radiculopathy

**Radiculopathy** is the significant alteration of function of a nerve root. (AMA, p.382)

- pain, numbness or paresthesia in a dermatomal pattern.
- Clinical findings ***must*** be confirmed by imaging study or EMG
- imaging alone does not make the diagnosis of radiculopathy
When Both Methods Apply

• In the small number of instances in which the ROM and DRE methods can both be used, evaluate the individual with both methods and award the higher rating.

Guides page 380

When Both Methods Apply

• DRE IV criteria for cervical and thoracic spine includes bilateral or multi-level radiculopathy

• ROM criteria includes radiculopathy bilaterally or at multiple levels

Example #1

Roofer fell off ladder, herniated disk at L4-5, had laminectomy.

Which method?
Example #2
Carpenter re-injures neck at C5-6 level and develops recurrent radiculopathy in right arm

Which method?

Lumbar DRE Category I
0 WP Impairment

- Subjective findings only
- No significant clinical findings
- An example is a back strain with no radiculopathy

Lumbar DRE Category II
5-8 WP Impairment

- Significant muscle guarding or asymmetric ROM
- Non-verifiable radicular pain
- History of verifiable radiculopathy no longer present
- Fracture < 25% compression one vertebrae
Lumbar Category III
10-13 WP Impairment

- Verifiable radiculopathy
- Surgery, e.g. diskectomy or laminectomy
- Fracture 25-50% compression of one vertebrae /posterior element fracture with displacement and disruption of spinal canal

Lumbar Category IV
20-23 WP Impairment

- Loss of motion segment integrity
  - Increased – spondylolisthesis
  - Decreased – fusion (most common)
- Fracture of > 50% compression of one vertebrae

Lumbar Category V
25-28 WP Impairment

- Loss of motion segment integrity with radiculopathy
- Fracture > 50% compression with neurologic compromise
AMA Guides New Math

• Category IV + Category III = Category V

Example #3

• Farm laborer, 46 years old, strained low back. Still has pain in low back, but no radicular symptoms.

Can there be an add-on for pain?

Example #4

• Roofer, 39 years old, fell off ladder, herniated disk at L3-4 with pain radiating into left leg. After disectomy pain was no longer present. No difficulty with ADL.
Pain and DRE Ratings

- “Each [DRE] category includes a range to account for the resolution or continuation of symptoms and their impact on the ability to perform ADL.” (p. 384)

- No express provision in spine or pain chapters which precludes application of pain add-on to DRE rating

Pain and DRE Ratings

- DEU position – up to 3% may be added to any DRE-based rating if it does not adequately encompass the pain experienced

- Potential issue of overlap if high end of DRE range is awarded solely for pain

Corticospinal Injury

- Injury to spinal cord
- Use DRE method
- Combine with Table 15-6
Corticospinal Tract Impairment

Table 15-6 (pages 396-97)

• Arm impairment
• Gait impairment
• Bladder and bowel impairment
• Sexual impairment
• Respiratory impairment

ROM Method

Three Components

• Diagnosis
• ROM
• Neurologic Deficit

ROM Method Overview
ROM Method Example #5

- Farm laborer, 25 years old
- L3-4, L4-5 disectomy
- ROM forward flexion 45 degrees (sacral flexion 50 degrees), extension 10 degrees, right and left lateral bending 15 degrees
- Grade 4 (25%) sensory and motor deficits in the L3 nerve root.

Diagnosis Table 15-7, p. 404

<table>
<thead>
<tr>
<th>Diagnosis Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unoperated or with no residual signs or symptoms</td>
<td>0</td>
</tr>
<tr>
<td>Unoperated or with medically documented injury, pain, and rigidity* associated with radiculopathy or sciatica</td>
<td>6</td>
</tr>
<tr>
<td>Unoperated or with medically documented injury, pain, and rigidity* associated with radiculopathy or sciatica and other findings consistent with nerve root compression</td>
<td>7</td>
</tr>
<tr>
<td>Operative treatment</td>
<td>9</td>
</tr>
</tbody>
</table>

*Including herniated nucleus pulposus with or without radiculopathy

Measuring Lumbar ROM

- T12 – S1 = true lumbar flexion
- 60°-45° = 15 degrees
Lumbar ROM Template

ROM – Flexion
Table 15-8, p. 407

<table>
<thead>
<tr>
<th>Sacral Flexion</th>
<th>True Lumbar Spine Flexion</th>
<th>% Impairment of the Whole Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>0°</td>
<td>0°</td>
<td>0</td>
</tr>
<tr>
<td>10°</td>
<td>10°</td>
<td>10</td>
</tr>
<tr>
<td>15°</td>
<td>15°</td>
<td>15</td>
</tr>
<tr>
<td>20°</td>
<td>20°</td>
<td>20</td>
</tr>
<tr>
<td>25°</td>
<td>25°</td>
<td>25</td>
</tr>
</tbody>
</table>

Sacral flexion determines part of table used

ROM - Extension
Table 15-8, p. 407

<table>
<thead>
<tr>
<th>True Lumbar Spine Extension from Neutral Position (°) to</th>
<th>Degrees of Lumbar Spinal Motion</th>
<th>% Impairment of the Whole Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>15</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>20</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>25</td>
<td>0</td>
<td>25</td>
</tr>
</tbody>
</table>

Note: Table 15-8, p. 407
ROM – Lateral Bending

Table 15-9, p. 409

Abnormal Motion
Average range of left and right lateral bending is 50°; the proportion of total lumbar motion is 40% of the total spine.

<table>
<thead>
<tr>
<th>a.</th>
<th>Left Lateral Bending From Neutral Position (0°) to:</th>
<th>Degrees of Lumbar Motion Lost</th>
<th>% Impairment of Whole Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>25 0 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>15 10 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>10 15 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>5 20 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>0 25 0</td>
<td></td>
</tr>
</tbody>
</table>

ROM Method Example #5

ROM (Tables 15-8, p. 407 and 15-9, p. 409)

Forward flexion = 45
Extension = 10
Lt lateral bending = 15
Rt lateral bending = 15

Total ROM =

ROM Method Example #5

Combine the Diagnosis and ROM impairments
Neurological Deficits

Max sensory value \times \text{Percent deficit found by doctor} = \text{Actual sensory value}

Max motor value \times \text{Percent deficit found by doctor} = \text{Actual motor value}

Neurologic Sensory-Motor Maxima Table 15-18, p. 424

<table>
<thead>
<tr>
<th>Nerve Root Impaired</th>
<th>Maximum % Loss of Function Due to Sensory Deficit or Pain</th>
<th>Maximum % Loss of Function Due to Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>L4</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>L5</td>
<td>5</td>
<td>34</td>
</tr>
<tr>
<td>S1</td>
<td>5</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

Values in LE scale

*For description of the process of determining LE scale..."...

Neurologic - Sensory Table 15-15, p. 424

<table>
<thead>
<tr>
<th>Classification</th>
<th>% Sensory Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>No loss of sensitivity, abnormal sensation, or pain</td>
</tr>
<tr>
<td>4</td>
<td>Distorted superficial touch sensation, diminished light touch, pain without minimal abnormal sensations or pain, that is forgotten during activity</td>
</tr>
<tr>
<td>3</td>
<td>Distorted superficial touch sensation, diminished touch, pain without minimal abnormal sensations or pain, that is forgotten during activity</td>
</tr>
<tr>
<td>2</td>
<td>Increased superficial pain and with minimal sensation depressed, decreased discrimination with some abnormal sensations or slight pain, that may present some activities</td>
</tr>
<tr>
<td>1</td>
<td>0.1-25</td>
</tr>
<tr>
<td>2</td>
<td>25-60</td>
</tr>
<tr>
<td>3</td>
<td>60-80</td>
</tr>
</tbody>
</table>
### Evaluating Nerve Deficits

Nerve deficit (Table 15-18, p. 424)

**Sensory:**

**Motor:**

### ROM Method Example #5

Final formulas:

Diagnosis and ROM:

Neurologic – motor:

Combined result:
Requesting Ratings under EAMS

How to work effectively with the DEU in an EAMS environment

Overview

- EAMS Principles
- Rating requests
  - Panel QME summary rating
  - Treating physician summary rating
  - Supplemental rating
  - Consultative rating
- Requests for reconsideration of summary rating
- Commutation requests

EAMS Principles

- EAMS = Electronic Adjudication Management System
- Case structure
- Case numbering
- Requesting methods
EAMS Case Structure

Integrated Case

- ADJ
- DEU
- RSU

Product deliveries

Case Numbering - EAMS

INT555444

- ADJ555444
- DEU555444
- RSU555444

Product deliveries

Case Structure/Numbering - Legacy

- WCAB#
- DEU
- VOC

WCAB#:
- VND124589
- G50238
- 07 Q 10555
  or
- C1234567
Filing Methods

OCR – paper forms  E-form - electronic

OCR Forms

- Must use mandatory paper forms available at: http://www.dir.ca.gov/dwc/forms.html#EAMSForms
- Must submit with appropriate cover and separator sheets

E-Forms

- Fill out forms online and attach enclosures
- Doing trial runs with limited groups. Not ready for general public yet.
- Advantage – eliminates paper and scanning
Mandatory Forms for OCR Filings

- 100 – Permanent Disability Questionnaire
- 101 – Request for Summary Rating of QME
- 102 – Request for Summary Rating of Tx Dr
- 104 – Consultative Rating Request
- 10232.1 – Cover Sheet
- 10232.2 – Separator Sheet

Prepping for an OCR Filing

- Fill out the forms
  - Request form e.g., 101 or 102 Form
  - Cover sheet
  - Separator sheet
- Assemble the forms and attachments
- File and serve the documents
Cover Sheet Hints #1

• Is this a new case? Yes □ No □
  – Yes
    • Translation – Yes, I am trying to create a new DEU case.
      (No DEU case currently exists.)
  – No
    • Translation – No, I do not need to create a new DEU case.
      (A DEU case already exists.)
    – The existence of an ADJ case does not matter

Cover Sheet Hints #2

• Companion cases exist □
  – Usually won’t apply to non-litigated cases
    (summary rating requests), but may apply to consults.
    Check only if there is a DEU companion case.
  – The best practice is to attach a separate list of
    companion ADJ cases to your request including
    ADJ case # and DOI for each.

Cover Sheet Hints #3

• Walkthrough Yes □ No □
  – Generally not applicable to DEU requests. Leave blank or check “No”.

• Date
  – Enter the date you fill out the form

• SSN
  – Enter the SSN in the form 123-45-6789
  – SSN not needed if you have entered the case number
Cover Sheet Hints #4

- Specific Injury
- Cumulative Injury
  - Check the applicable injury type
- Start date mm/dd/yyyy  End date mm/dd/yyyy
  - Enter start date only for specific injury, both dates for CT’s; note the req’d format
  - Injury dates not needed if you have entered the case number

Cover Sheet Hints #5

- Case number 1
  - Enter the EAMS case number or legacy case number if known
  - Leave blank if you are creating a new case
  - If known, you do not need to fill in the DOI or SSN
- Body part – not req’d for DEU filings
- Unit
  - Check DEU box

DOCUMENT SEPARATOR SHEET

- Product Delivery Unit
- Document Type
- Document Title
- Document Code
- Author
Separator Sheet Hints #1

- **Product Delivery Unit**
  - Choose “DEU” from the drop-down list

- **Document Type**
  - Choose from DEU Forms, DEU Doc’s, Medical Reports, Other
  - Each document type provides different options for document title

- **Document Title** – select appropriate title

Separator Sheet Hints #2

- **Document Date**
  - Enter the date on which you are creating the document

- **Author**
  - Enter the document author’s given name, e.g. Dr. William Shatner

Assembling Document Packages

- Cover sheet
- Separator sheet
- Form 101 - Request
- Separator sheet
- Form 100 – PD Quest.
- Separator sheet
- Medical report
Requests for Supplemental Ratings

- New QME rule requires parties requesting a supplemental report to send their requests directly to the Disability Evaluation Unit office where the report was served and not to the evaluator until after the initial summary rating has been issued. [AR 36(d) eff. 11/17/08]
Consultative Rating Request

Requests for Reconsideration
- Use if you disagree with summary rating of panel QME or treating doctor
- Time limit – 30 days from receipt of rating
- File with DWC Administrative Director – address is on form
- Serve on opposing party and DEU office that issued the rating
- Recommended form available at: http://www.dir.ca.gov/dwc/forms.html#EAMSForms

Requests for Reconsideration
- Recon Unit will not consider a supplemental medical report requested after issuance of initial summary rating [AR 10164(b)]
- AR 36(e) doesn’t permit supplemental request to physician until after rating issues
Commutation Requests

- Recommended form located at: http://www.dir.ca.gov/DWC/FORMS/DEU_CommutationRequest.xls
- Usually filed in person at local DEU
- SAWW-impacted commutations (DOI’s o/a 1/1/03) may take several days to complete
This form will aid the doctor in determining your permanent impairment or disability. Please complete this form and give it to the physician who will be performing the evaluation. The doctor will include this form with his or her report and submit it to the Disability Evaluation Unit, with a copy to you and your claims administrator.

Employee

First Name ___________________________ MI

Last Name ___________________________

SSN (Numbers Only) ___________________

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words) ___________________________

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words) ___________________________

International Address (Please leave blank spaces between numbers, names or words) ___________________________

City ___________________________ State ____________ Zip Code ____________

Date of Birth _______________ MM/DD/YYYY

Date of Injury _______________ MM/DD/YYYY

Employer

Nature of Employers Business

Claim Number 1 ___________________________
REQUEST FOR SUMMARY RATING DETERMINATION  
of Qualified Medical Evaluator’s Report

INSTRUCTIONS TO THE CLAIMS ADMINISTRATOR:

1. Use this form if employee is unrepresented and has not filed an application for adjudication.
2. Complete this form and forward it along with a complete copy of all medical reports and medical records concerning this case to the physician scheduled to evaluate the existence and extent of permanent impairment or disability.
3. Send the EMPLOYEE’S DISABILITY QUESTIONNAIRE, DEU FORM 100 to the employee in time for the medical evaluation.
4. This form must be served on the employee prior to the evaluation. Be sure to complete the proof of service.

INSTRUCTIONS TO THE PHYSICIAN:

1. If the employee is unrepresented, review and comment upon the Employee’s Disability Questionnaire, (DEU Form 100), in your report. (If the employee does not have a completed Form 100 at the time of the appointment, please provide the form to the employee.)
2. Submit your completed medical evaluation and, if the employee is unrepresented, the DEU Form 100, to the Disability Evaluation Unit district office listed below. PLEASE USE THIS FORM AS A COVER SHEET FOR SUBMISSION TO THE DISABILITY EVALUATION UNIT.
3. Serve a copy of your report and the Form 100 upon the claims administrator and the employee.

Date of first medical report indicating the existence of permanent impairment or disability: MM/DD/YYYY
Last date for which temporary disability indemnity was paid: MM/DD/YYYY

Submit To: Disability Evaluation Unit

Address/PO Box (Please leave blank spaces between numbers, names or words)

City ___________________________ CA State Zip Code ________________________

Physician

Exam Date MM/DD/YYYY

Claim Number 1  
Claim Number 2  
Claim Number 3  
Claim Number 4  
Claim Number 5  
Phone No.  
Adjustor  
Employer  

Employee  
First Name  
Last Name  
Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)  
Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)  
International Address (Please leave blank spaces between numbers, names or words)
(Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is attached.)
PROOF OF SERVICE BY MAIL

On ___________________, I served a copy of this Request for Summary Rating Determination on

Name of Employee

Address

City_____________ State _____________ Zip ______________

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

__________________________________________

Signature
PLEASE ANSWER THE FOLLOWING QUESTIONS FULLY:

How was your evaluating doctor selected? (check one)

☐ From a list of doctors provided by the State of California, Division of Workers' Compensation.

☐ Other (explain) ________________________________________________________________

What is the name of the doctor who will be doing the evaluation? _______________________

When is your examination scheduled? _______________________________________________

What were your job duties at the time of your injury? _________________________________

What is the disability resulting from your injury? _________________________________

How does this injury affect you in your work? ______________________________________

Have you ever had a disability as a result of another injury or illness? __________________

If so, when? ____________________________________________________________________

Please describe the disability? _____________________________________________________

Date MM/DD/YYYY Signature ____________________________________________________
To be used for injuries which occur on or after January 1, 1994.

INSTRUCTIONS:
1. Complete this form and send it to the Disability Evaluation Unit along with a copy of the primary treating physician's report.
2. This form and any attachments including a copy of the primary treating physician's report must be served on the other party.
3. If you receive the completed form from the other party and you disagree with the description of the occupation or earnings, please attach the correct information to a copy of this form and send it to the Disability Evaluation Unit. You must also send a copy of your objection to the other party.

REQUEST IS MADE BY:  □ Employee  □ Claims Administrator

PHYSICIAN ________________________________

EXAM DATE _______________  MM/DD/YYYY

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

City ________________________________  State __________  Zip Code __________

Claim No. ________________________________

Phone Number ________________________________

Adjustor ________________________________
Employee

[ ] Mr.  [ ] Ms.  [ ] Mrs.

First Name ____________________________________________ MI

Last Name ____________________________________________

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

____________________________________________________

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

____________________________________________________

International Address (Please leave blank spaces between numbers, names or words)

City ____________________________________________ State ____________ Zip Code

Date of Injury ____________ MM/DD/YYYY

Date of Birth ____________ MM/DD/YYYY

SSN (Numbers Only) ____________________________

Case No. ________________________________________

Employer _________________________________________

Nature of Employers Business ________________________________________

Job Title _________________________________________

DESCRIBE THE GENERAL DUTIES OF THE JOB (Attach job description or job analysis, if available):

WEEKLY GROSS EARNINGS: $ ____________________________

Attach a wage statement/DLSR 5020 if earnings are less than maximum. Include the value of additional advantages provided such as meals, lodging, etc. If earnings are irregular or for less than 30 hours per week, include a detailed description of all earnings of the employee from all sources, including other employers, for one year prior to the date of injury. Benefits will be calculated at MAXIMUM RATE unless a complete and detailed statement of earnings is received.

DWC-AD form102 (DEU) (11/2008)
PROOF OF SERVICE BY MAIL

On ____________________, I served a copy of this Request for Summary Rating Determination on

Name of Employee: ________________________________________________________________

Address: ________________________________________________________________________

City ____________________________________ State _______ Zip Code __________

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare
under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____________________________________________________
Signature

DEU102
This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating issued by the Disability Evaluation Unit should be reconsidered pursuant to Labor Code section 4061(g).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) or Primary Treating Physician (PTP) has failed to address all issues, failed to completely address issues, failed to follow the medical evaluation procedures promulgated by the Administrative Director, or if the rating was incorrectly calculated. This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director
Division of Workers' Compensation
Attn: Summary Rating Reconsideration
P.O. Box 420603
San Francisco, CA 94142

INCLUDE: (1) This completed form;
(2) Other information supporting the request.

Employee

First Name

Last Name

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address 2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Employer / Adjusting Agency

Name (Please leave blank spaces between numbers, names or words)

Street Address 1/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code
REASON(S) FOR REQUEST: (Check reason and explain below. Attach additional sheets if necessary.)

☐ QME/PTP failed to address all issues
☐ QME/PTP failed to completely address issues
☐ Evaluation procedures not followed by QME/PTP
☐ Rating was incorrectly calculated

Explanation

Reconsideration of Summary Rating is being requested by:

☐ Injured worker
☐ Employer/Adjusting Agency

Name

PROOF OF SERVICE BY MAIL (Instructions on next page)

On ____________, I served a copy of this Request for Reconsideration of Summary Rating on

______________________________

Address ________________________________

City ___________________________________ State __________ Zip Code ___________

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature
INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the Proof of Service By Mail

PROOF OF SERVICE BY MAIL (SAMPLE)

On MM/DD/YYYY I served a copy of this Request for Reconsideration of Summary Rating on

(name of employee or claims administrator)

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

by placing a true copy enclosed in a sealed envelope with postage fully prepaid, and deposited in the U.S. Mail. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Signature

1) List on line #1 the date on which you mailed this form.

2) If you are the Injured Employee, list on line #2 the name of the Insurance Carrier or Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee.

3) List on line #3 the mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee you listed on line #2.

4) Sign your name on line #4.
REQUEST FOR CONSULTATIVE RATING

Indicate type of request:

☐ Mail-in  ☐ Walk-in

INSTRUCTIONS FOR MAIL-IN’S:
1. Attach a photocopy of the medical report(s) for which a rating is being requested, if not previously on file. Do not send original reports.
2. Serve a copy of this request on the representative for the opposing party.

INSTRUCTIONS FOR WALK-IN’S:
1. Attach this request form to copies of the medical reports that you wish to have rated.
2. List below the doctor’s names and dates of reports to be rated.
3. If a deposition is to be rated, mark or list the pages to be reviewed by the rater.

Date of Birth

SSN (Numbers Only)

Date of Injury 1

Case Number 1

Date of Injury 2

Case Number 2

Date of Injury 3

Case Number 3

Date of Injury 4

Case Number 4

Date of Injury 5

Case Number 5

Injured worker

First Name ___________________________ MI

Last Name ___________________________ Suffix (Jr, Sr, etc)

Occupation (attach description if unclear) ___________________________

DWC-AD form104 (DEU) (Rev. 11/2008) (Page 1)
Insurance Claim Number ________________________________
Date of report(s) to be rated and doctor’s name:

________________________________________

________________________________________

________________________________________

This case has been set on for: ____________________ for the type of hearing checked below:

☐ Rating MSC
☐ Trial
☐ Conference

Rating requested by:

Name of firm

Representing the

☐ Employee    ☐ Employer

A copy of this request has been served on

Firm Name

Firm Address 1/PO Box (Please leave blank spaces between numbers, names or words)

Firm Address 2/PO Box (Please leave blank spaces between numbers, names or words)

________________________________________

City

State    Zip Code

________________________________________
STATE OF CALIFORNIA  
DWC DISTRICT OFFICE  
DOCUMENT COVER SHEET

<table>
<thead>
<tr>
<th>Is this a new case?</th>
<th>Yes ☐</th>
<th>No ☐</th>
<th>Companion Cases Exist ☐</th>
<th>Walkthrough Yes ☐ No ☐</th>
<th>More than 15 Companion Cases ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date:** (MM/ DD/ YYYY)  
**SSN:**  
**Specific Injury** ☐  
**Cumulative Injury** ☐

**Case Number 1**  
(Start Date: MM/DD/YYYY)  
(End Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

**Body Part 1:**  
**Body Part 2:**  
**Body Part 3:**  
**Body Part 4:**  
**Other Body Parts:**  

---

**Please check unit to be filed on (check only one box)**

☐ ADJ  ☐ DEU  ☐ SIF  ☐ UEF  ☐ VOC  ☐ INT  ☐ RSU

**Companion Cases**

☑ Specific Injury

**Case Number 2**  
(Start Date: MM/DD/YYYY)  
(End Date: MM/DD/YYYY)  
(If Specific Injury, use the start date as the specific date of injury)

**Body Part 1:**  
**Body Part 2:**  
**Body Part 3:**  
**Body Part 4:**  
**Other Body Parts:**  

---

DWC-CA form 10232.1 Rev. 11/2008 - Page 1 of 8
<table>
<thead>
<tr>
<th>Legend</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHM</td>
<td>Anaheim</td>
</tr>
<tr>
<td>ANA</td>
<td>Santa Ana</td>
</tr>
<tr>
<td>BAK</td>
<td>Bakersfield</td>
</tr>
<tr>
<td>EUR</td>
<td>Eureka</td>
</tr>
<tr>
<td>FRE</td>
<td>Fresno</td>
</tr>
<tr>
<td>GOL</td>
<td>Goleta</td>
</tr>
<tr>
<td>GRO</td>
<td>Grover Beach</td>
</tr>
<tr>
<td>LAO</td>
<td>Los Angeles</td>
</tr>
<tr>
<td>LBO</td>
<td>Long Beach</td>
</tr>
<tr>
<td>MDR</td>
<td>Marina del Rey</td>
</tr>
<tr>
<td>OAK</td>
<td>Oakland</td>
</tr>
<tr>
<td>OXN</td>
<td>Oxnard</td>
</tr>
<tr>
<td>POM</td>
<td>Pomona</td>
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<td>Redding</td>
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<td>San Francisco</td>
</tr>
<tr>
<td>SJO</td>
<td>San Jose</td>
</tr>
<tr>
<td>SRO</td>
<td>Santa Rosa</td>
</tr>
<tr>
<td>STK</td>
<td>Stockton</td>
</tr>
<tr>
<td>VNO</td>
<td>Van Nuys</td>
</tr>
</tbody>
</table>

Use this document to complete forms, but do not file this document with your forms.
### Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Head - not specified</td>
</tr>
<tr>
<td>110</td>
<td>Brain</td>
</tr>
<tr>
<td>120</td>
<td>Ear - not specified</td>
</tr>
<tr>
<td>121</td>
<td>Ear - external</td>
</tr>
<tr>
<td>124</td>
<td>Ear - internal including hearing</td>
</tr>
<tr>
<td>130</td>
<td>Eye - including optic nerves and vision</td>
</tr>
<tr>
<td>140</td>
<td>Face - not specified</td>
</tr>
<tr>
<td>141</td>
<td>Jaw - including chin and mandible</td>
</tr>
<tr>
<td>144</td>
<td>Mouth - including lips, tongue, throat and taste</td>
</tr>
<tr>
<td>145</td>
<td>Teeth</td>
</tr>
<tr>
<td>146</td>
<td>Nose - including nasal passages, sinus and smell</td>
</tr>
<tr>
<td>148</td>
<td>Face - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>149</td>
<td>Face - forehead, cheeks, eyelids</td>
</tr>
<tr>
<td>150</td>
<td>Scalp</td>
</tr>
<tr>
<td>160</td>
<td>Skull</td>
</tr>
<tr>
<td>198</td>
<td>Head - multiple injury any combination of above parts</td>
</tr>
<tr>
<td>200</td>
<td>Neck</td>
</tr>
<tr>
<td>300</td>
<td>Upper extremities - not specified</td>
</tr>
<tr>
<td>310</td>
<td>Arm - above wrist not specified</td>
</tr>
<tr>
<td>311</td>
<td>Arm - upper arm humerus</td>
</tr>
<tr>
<td>313</td>
<td>Arm - elbow head of radius</td>
</tr>
<tr>
<td>315</td>
<td>Arm - forearm radius and ulna</td>
</tr>
<tr>
<td>318</td>
<td>Arm - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>319</td>
<td>Arm - not specified</td>
</tr>
<tr>
<td>320</td>
<td>Wrist</td>
</tr>
<tr>
<td>330</td>
<td>Hand - not wrist or fingers</td>
</tr>
<tr>
<td>340</td>
<td>Fingers</td>
</tr>
<tr>
<td>398</td>
<td>Upper extremities - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>400</td>
<td>Trunk - not specified</td>
</tr>
<tr>
<td>410</td>
<td>Abdomen - including internal organs and groin</td>
</tr>
<tr>
<td>411</td>
<td>Hernia</td>
</tr>
<tr>
<td>420</td>
<td>Back - including back muscles, spine and spinal cord</td>
</tr>
<tr>
<td>430</td>
<td>Chest - including ribs, breast bone and internal organs of the chest</td>
</tr>
<tr>
<td>440</td>
<td>Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks</td>
</tr>
<tr>
<td>450</td>
<td>Shoulders - scapula and clavicle</td>
</tr>
<tr>
<td>498</td>
<td>Trunk - use for side; multiple parts any combination of above parts</td>
</tr>
<tr>
<td>500</td>
<td>Lower extremities - not specified</td>
</tr>
<tr>
<td>510</td>
<td>Legs - above ankles, not specified</td>
</tr>
<tr>
<td>511</td>
<td>Thigh femur</td>
</tr>
<tr>
<td>513</td>
<td>Knee Patella</td>
</tr>
<tr>
<td>515</td>
<td>Lower leg tibia and fibula</td>
</tr>
<tr>
<td>518</td>
<td>Leg - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>519</td>
<td>Leg - not specified</td>
</tr>
<tr>
<td>520</td>
<td>Ankle malleolus</td>
</tr>
<tr>
<td>530</td>
<td>Foot not ankle or toe</td>
</tr>
<tr>
<td>540</td>
<td>Toes</td>
</tr>
<tr>
<td>598</td>
<td>Lower extremities - multiple parts any combination of above parts</td>
</tr>
<tr>
<td>700</td>
<td>Multiple parts more than five major parts use only in fifth position of listing of body parts</td>
</tr>
<tr>
<td>800</td>
<td>Body system - not specific</td>
</tr>
<tr>
<td>801</td>
<td>Circulatory system - heart - other than heart attack, blood, arteries, veins, etc.</td>
</tr>
<tr>
<td>802</td>
<td>Circulatory system - Heart attack</td>
</tr>
<tr>
<td>810</td>
<td>Digestive system - stomach</td>
</tr>
<tr>
<td>820</td>
<td>Excretory system - kidneys, bladder, intestines, etc.</td>
</tr>
<tr>
<td>830</td>
<td>Musculo-skeletal system - bones, joints, tendons, muscles, etc.</td>
</tr>
<tr>
<td>840</td>
<td>Nervous system - not specified</td>
</tr>
<tr>
<td>841</td>
<td>Nervous system - stress</td>
</tr>
<tr>
<td>842</td>
<td>Nervous system - Psychiatric/psych</td>
</tr>
<tr>
<td>850</td>
<td>Respiratory system - lungs, trachea, etc.</td>
</tr>
<tr>
<td>860</td>
<td>Skin dermatitis, etc.</td>
</tr>
<tr>
<td>870</td>
<td>Reproductive systems</td>
</tr>
<tr>
<td>880</td>
<td>Other body systems</td>
</tr>
<tr>
<td>999</td>
<td>Unclassified - insufficient information to identify body parts</td>
</tr>
</tbody>
</table>

Use this document to complete forms, but do not file this document with your forms.
**COMMUTATION REQUEST**

Directions: Fill in the section under All Cases as completely as possible. Remaining sections only need to be filled in if you are requesting a commutation of those benefits.

### All cases:

<table>
<thead>
<tr>
<th>IW:</th>
<th>Requested by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAMS#:</td>
<td>Contact number:</td>
</tr>
<tr>
<td>WCAB#:</td>
<td>Request Date:</td>
</tr>
</tbody>
</table>

| DOI: | If DOI is o/a 1/1/03, then any LP or PTD benefits would be subject to annual SAWW-based increases. |
| P&S date: |  |

| Attorney fee% (if applicable): | Will use 4.7% unless otherwise specified. |
| Annual SAWW increase (if appl.): |  |

### Permanent Disability:

| PD Rating: |  |
| PD duration (in weeks): |  |
| Initial PD weekly rate: |  |

| Is PD subject to ±15% adjustment under LC 4658(d)? (Y/N) |  |

### Life Pension:

| Date of birth: |  |
| PD start date (P&S): |  |
| PD duration (in weeks): |  |
| Initial rate of LP benefits: |  |
| Gender: |  |

### Death Benefit:

| Average weekly earnings: |  |
| Start date of benefits: |  |
| Initial benefit rate: |  |
| Death benefit am't (LC 4702): |  |
| DOB of youngest child: |  |

### 100% Permanent Total Disability:

| Date of birth: |  |
| PTD start date (P&S): |  |
| Initial rate of PTD benefits: |  |
| Gender: |  |

### Additional Comments:

________________________________________________________________________
Common Rating Issues

Presented By
Annalisa Faina
Tess Snaer
Barry Knight

2009 Annual State Bar Conference

Strength Evaluation

Discouraged by AMA Guides

- Guides emphasis on objective anatomical findings
- Strength measurements are influenced by subjective factors

AMA Guides Page 507

- “Because strength measurements are functional tests influenced by subjective factors...the Guides does not assign a large role to such measurements.”

Just the objective facts ma’am
"In a rare case, if the examiner believes the individual’s loss of strength represents an impairing factor that has not been considered adequately by other methods in the Guides, the loss of strength may be rated separately."

An example is a severe muscle tear leaving a palpable defect.

When Grip Not Used

When maximum application of force prevented by

- Decreased motion
- Pain
- Deformity
- Amputation

"Decreased strength cannot be rated in presence of decreased motion, painful conditions, deformities, or absence of parts…that prevent effective application of maximal force…"
When Grip Not Used

- In peripheral nerve injuries

"In compression neuropathies, additional values are not given for decreased grip strength” – AMA Guides page 494

When Grip Not Used

- Complex Regional Pain Syndrome

"No additional impairment is given for decreased pinch or grip strength.” – AMA Guides page 497 under 16.5 CRPS section

When Grip Not Used

- Weakness of the shoulder or elbow muscles
  - Manual muscle testing used for weakness of elbow and shoulder (Table 16-35)
- Tenosynovitis
When Grip Strength Used

- Severe Muscle Tear
- Tendon Rupture
- Epicondylitis with surgical release

Sleep Disorders

- Table 13-4
- Central and Peripheral Nervous System
  - Typical disorders include: central sleep apnea, Parkinson’s disease, multiple sclerosis
  - Support by formal study in a sleep laboratory expected

Sleep Arousal Impairment

- Is there a central nervous system diagnosis?
- Is there a sleep study to support sleep arousal impairment?
Sleep Disorders – Example 13-17

- Worker gained 45 pounds following crush injury to foot which prevented exercise
- Diagnosis of obstructive sleep apnea (OSA) based on polysomnogram
- 9 WP given based on ability to complete most necessary work but works less efficiently
- About 1 in 5 American adults have at least mild OSA

Sleep Disorders

- Back pain-induced sleep disturbances normally reflected in back rating
  - Sleep is an activity of daily living
  - ADL deficits are reflected in placement within DRE ranges
  - Pain-induced ADL deficits are reflected in pain add-on

Gait Derangement

- Table 17-5
  - One of 13 lower extremity impairment methods
  - Cannot be combined with other lower extremity method
Gait Derangement

- "Whenever possible, the evaluator should use a more specific method." (p. 529)
- "...does not apply to abnormalities based only on subjective factors, such as pain or sudden giving-way, as with, for example, and individual with low-back discomfort..."

Gait Derangement – Example 17-2

- 61-year-old woman falls on steps, developing severe hip pain
- Cannot walk more than 5 blocks, must use cane outside home, cannot run
- Hip arthritis = 3 WP
- 20 WP given for requirement to use cane routinely
- Higher rating more accurately represents clinical condition; rationale required

Pain Add-on

- When is a pain add-on warranted?
- Is a formal pain assessment required?
- What if there are multiple body parts experiencing excessive pain?
- Can pain be added to a DRE rating? 0% rating?
**Generic Pain Add-on Criterion**

- "If the body system impairment rating appears to adequately encompass the pain experienced...[the] rating is as indicated..." (p. 573 of errata)

- "If the individual appears to have pain-related impairment that has increased the burden of his or her condition slightly...the examiner may award...impairment of up to 3%..." (p. 573 of errata)

---

**Formal Pain Assessment**

- "If the individual appears to have pain-related impairment that has increased the burden of his or her condition substantially, perform a formal pain-related impairment assessment" (p. 573 of errata)

- Still 3 WP maximum add-on
- DEU does not require formal pain assessment
- Description of ADL impact is encouraged

---

**Pain in Multiple Body Parts**

- Limit of 3% per injury
- Doctor must allocate between injured body parts, for example:
  - Knee arthritis – 2% add-on
  - Shoulder instability – 1% add-on
Pain Add-on to Zero Rating

- “…a whole person impairment rating based on the body or organ rating system of the AMA Guides…may be increased by up to 3% WPI…”

- Criterion assumes an underlying body system impairment rating greater than zero

Headaches

- No method for rating most headaches in Chapters 3-17

- Listed a well-established pain syndrome without identifiable organ dysfunction in Table 18-1

- Allow up to 3 WP if result of head trauma

Patellofemoral Pain

- Classified under degenerative joint disease (DJD) (Table 17-31, p. 544)

- Patellofemoral joint is the joint between the kneecap (patella) and thigh bone (femur)

- Footnote to Table 17-31 allows up to 5 LE for patello-femoral pain with crepitation following direct trauma to knee – joint space narrowing not required
Hernias

- Rating criteria in Table 6-9, pg 136
- Impairment ranges from 0 – 30 WP
- Based on Example 6-31, the rating is for unilateral or bilateral hernia

Impairment is divided into classes (10-point ranges) based on palpable defect, reducibility of protrusion and impact on ADL’s

Evaluating physician has to give a specific value within a class

Table 6-9

<table>
<thead>
<tr>
<th>Option 1= A + (B or C)</th>
<th>Option 2 = (A + B) or C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1: 5%-10% impairment of the Whole Trunk</td>
<td>Class 2: 10%-15% impairment of the Whole Trunk</td>
</tr>
<tr>
<td>Case 3: 15%-50% impairment of the Whole Trunk</td>
<td>Case 3: 15%-50% impairment of the Whole Trunk</td>
</tr>
</tbody>
</table>

- Palpable defect in supporting structures of abdominal wall and right protrusion or left protrusion increased abdominal pressure, newly reducible or persistent protrusion or abscess of detect without establishing root cause of daily living
- Frequently persistent protrusion or abscess of detect without increased abdominal pressure, manually reducible or frequent protrusion, excluding heavy lifting by maintaining some activities of daily living
- Frequently protrusion, excluding heavy lifting and reduction or abscess of detect and limitation in activities of daily living
Hernia Impairment

Can hernia impairment be rated solely on discomfort affecting ADL?

- Depends how the “and” and “or” is read on Table 6-9.
- General principle of the Guides is to have objective basis for rating impairment