



# **Permanent Disability Rating**

## **Presenters**

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**DWC 16<sup>th</sup> Annual Educational Conference**



## Rating Impairments of the Spine

*DWC Conference  
2009*



*Presented by  
Annalisa Faina  
Jess Snaer  
Barry Knight*

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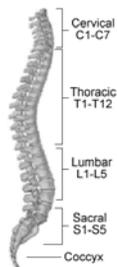
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## Spine

- Three Main Regions
  - Cervical
  - Thoracic
  - Lumbar

Rated similarly



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## Spine Rating Methods

- Two Methods for Rating the Spine

Diagnostic Related Estimate (DRE)

Range of Motion (ROM)

DRE is the principle method



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## 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



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## 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

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## 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

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## 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



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## 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

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## Example #1

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

Which method?

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## Example #2

Carpenter re-injures neck at C5-6 level and develops recurrent radiculopathy in right arm

Which method?

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## Lumbar DRE Category I 0 WP Impairment

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

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## 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

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### Lumbar Category III 10-13 WP Impairment

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

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### 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



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### Lumbar Category V 25-28 WP Impairment

- Loss of motion segment integrity with radiculopathy
- Fracture > 50% compression with neurologic compromise

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## AMA Guides New Math

- Category IV + Category III = Category V



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## 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?

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## Example #4

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

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## 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

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## 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

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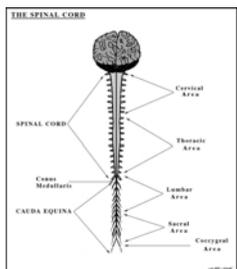
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## Corticospinal Injury

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



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## Corticospinal Tract Impairment

**Table 15-6 (pages 396-97)**

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

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## ROM Method

### Three Components

- Diagnosis
- ROM
- Neurologic Deficit

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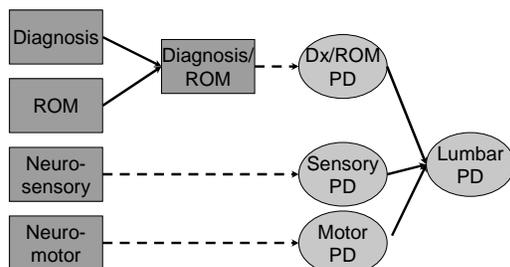
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## ROM Method Overview



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## ROM Method Example #5

- Farm laborer, 25 years old
- L3-4, L4-5 diskectomy
- 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.

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## Diagnosis Table 15-7, p. 404

<b>II. Intervertebral disk or other soft-tissue lesion</b>	
Diagnosis must be based on clinical symptoms and signs and imaging information.	
A. Unoperated on, with no residual signs or symptoms.	0
B. Unoperated on, with medically documented injury, pain, and rigidity* associated with none to minimal degenerative changes on structural tests.†	4
C. Unoperated on, stable, with medically documented injury, pain, and rigidity* associated with moderate to severe degenerative changes on structural tests;† includes herniated nucleus pulposus with or without radiculopathy.	6
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection.	7
E. Surgically treated disk lesion with residual, medically documented pain and rigidity.	9
F. Multiple levels, with or without operations and with or without residual signs or symptoms.	Add 1% per level
G. Multiple operations with or without residual signs or symptoms.	Add 2%
1. Second operation	Add 1% per operation
2. Third or subsequent operation	

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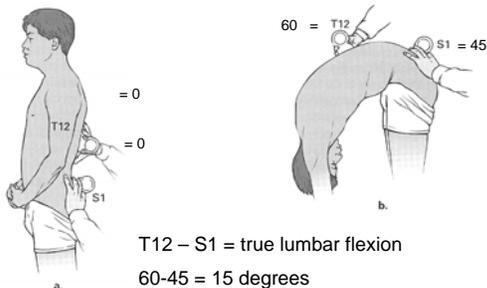
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## Measuring Lumbar ROM




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## Lumbar ROM Template

Figure 15-10 Lumbar Range of Motion (ROM)\*

Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Movement	Description	Range	
Lumbar flexion	T12 ROM		
	Sacral ROM		
	True lumbar flexion angle		
	±10% or 5°	Yes	No
	Maximum true lumbar flexion angle		
	% Impairment		

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## ROM – Flexion

Table 15-8, p. 407

Table 15-8 Impairment Due to Abnormal Motion of the Lumbar Region: Flexion and Extension\*

The proportion of flexion and extension of total lumbosacral motion is 75%.

Sacral (Hip) Flexion Angle (°)	True Lumbar Spine Flexion Angle (°)	% Impairment of the Whole Person
45+	60+	0
	45	2
	30	4
	15	7
	0	10
30-45	40+	4
	20	7
	0	10
0-29	30+	5
	15	8
	0	11

Sacral flexion determines part of table used

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## ROM - Extension

Table 15-8, p. 407

True Lumbar Spine Extension From Neutral Position (0°) to:	Degrees of Lumbosacral Spine Motion		% Impairment of the Whole Person
	Lost	Retained	
0	25	0	7
10	15	10	5
15	10	15	3
20	5	20	2
25	0	25	0

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## ROM – Lateral Bending

Table 15-9, p. 409

### Abnormal Motion

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

a.	Left Lateral Bending From Neutral Position (0°) to:	Degrees of Lum-bosacral Motion		% Impairment of the Whole Person
		Lost	Retained	
	0	25	0	5
	10	15	10	3
	15	10	15	2
	20	5	20	1
	25	0	25	0

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## 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 =

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## ROM Method Example #5

Combine the Diagnosis and ROM impairments

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## Neurological Deficits

$$\text{Max sensory value} \times \frac{\text{Percent deficit found by doctor}}{100} = \text{Actual sensory value}$$

$$\text{Max motor value} \times \frac{\text{Percent deficit found by doctor}}{100} = \text{Actual motor value}$$

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## Neurologic Sensory-Motor

Maxima Table 15-18, p. 424

**Table 15-18** Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity\*

Nerve Root Impaired	Maximum % Loss of Function Due to Sensory Deficit or Pain	Maximum % Loss of Function Due to Strength
L3	5	20
L4	5	34
L5	5	37
S1	5	20

Values in LE scale

\* For description of the process of determining impairment, see text.

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## Neurologic - Sensory Table 15-15, p. 424

**Table 15-15** Determining Impairment Due to Sensory Loss

a. Classification		
Grade	Description of Sensory Deficit	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1-25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26-60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61-80

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## Neurologic – Motor Table 15-16, p. 424

**Table 15-16** Determining Impairment Due to Loss of Power and Motor Deficits

a. Classification		
Grade	Description of Muscle Function	% Motor Deficit
5	Active movement against gravity with full resistance	0
4	Active movement against gravity with some resistance	1–25
3	Active movement against gravity only, without resistance	26–50
2	Active movement with gravity eliminated	51–75
1	Slight contraction and no movement	76–99
0	No contraction	100

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## Evaluating Nerve Deficits

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

Sensory:

Motor:

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## ROM Method Example #5

Final formulas:

Diagnosis and ROM:

Neurologic – motor:

Combined result:

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**Requesting Ratings under EAMS**

How to work effectively with the DEU in an EAMS environment

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**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

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**EAMS Principles**

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

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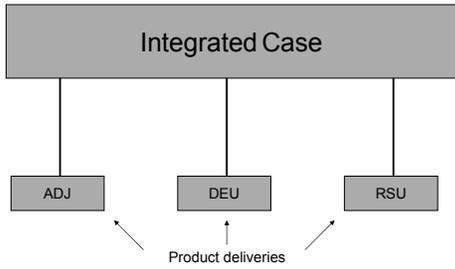
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### EAMS Case Structure



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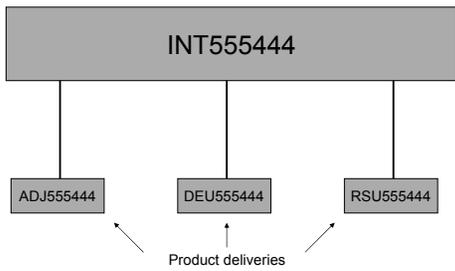
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### Case Numbering - EAMS



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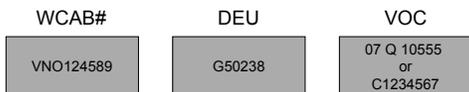
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### Case Structure/Numbering - Legacy



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## Filing Methods



OCR – paper forms



E-form - electronic

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## 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
- OCR Instruction Manual: [http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS\\_OCR%20handbook.pdf](http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf)



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## 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



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## 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



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## 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

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STATE OF CALIFORNIA  
DWC DISTRICT OFFICE  
DOCUMENT COVER SHEET



Is this a new case? Yes  No  Companion Cases Exist  Walkthrough Yes  No

More than 15 Companion Cases

Date: (MMDDYYYY) \_\_\_\_\_ SSN: \_\_\_\_\_

Specific Injury

Case Number 1 \_\_\_\_\_  Cumulative Injury (Start Date: MMDDYYYY) (End Date: MMDDYYYY)  
(If specific injury, use the start date as the specific date of injury)

Body Part 1: \_\_\_\_\_ Body Part 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_ Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

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

ADJ  DEU  SIF  UEF  VOC  INT  RSU

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### 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

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### 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.

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### 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

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### 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

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### 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

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### DOCUMENT SEPARATOR SHEET



Product Delivery Unit \_\_\_\_\_

Document Type \_\_\_\_\_

Document Title \_\_\_\_\_

Document Date \_\_\_\_\_  
MMDD/YYYY

Author \_\_\_\_\_

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## 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

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## 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

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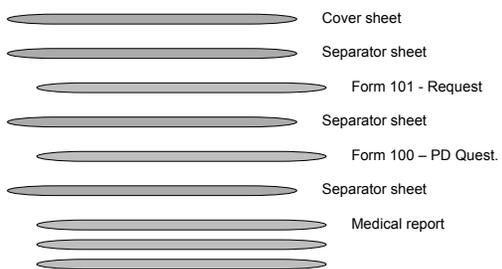
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## Assembling Document Packages



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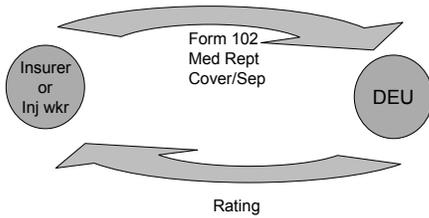
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## Treating Doctor Request



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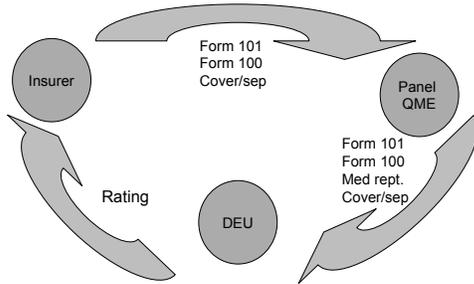
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## Panel QME Request



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## 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]

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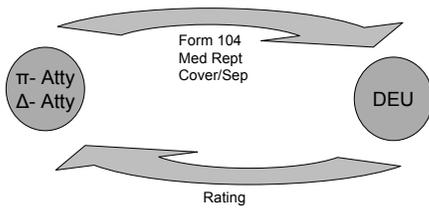
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## Consultative Rating Request



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## 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>

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## 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

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## Commutation Requests

- Recommended form located at:  
[http://www.dir.ca.gov/DWC/FORMS/DEU\\_CommutationRequest.xls](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

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STATE OF CALIFORNIA  
Division of Workers' Compensation  
Disability Evaluation Unit

Reset Form

Print Form



EMPLOYEE'S DISABILITY QUESTIONNAIRE

DEU Use Only

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

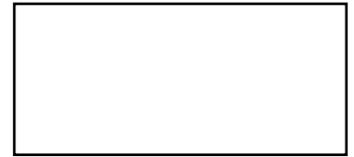
Employer

Nature of Employers Business

Claim Number 1



State of California  
Division of Workers' Compensation  
Disability Evaluation Unit



DEU Use Only

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 State Zip Code

Physician \_\_\_\_\_

Exam Date \_\_\_\_\_  
MM/DD/YYYY



**Claims Administrator**



Company Name

Street Address1/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

Claim Number 1

Claim Number 2

Claim Number 3

Claim Number 4

Claim Number 5

Phone No. \_\_\_\_\_

Adjustor \_\_\_\_\_

Employer \_\_\_\_\_

**Employee**

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 \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

SSN (Numbers Only) \_\_\_\_\_

Case No (if any) \_\_\_\_\_

OCCUPATION \_\_\_\_\_

(Please 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 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



Claim Number 2 \_\_\_\_\_

Claim Number 3 \_\_\_\_\_

Claim Number 4 \_\_\_\_\_

Claim Number 5 \_\_\_\_\_

**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 \_\_\_\_\_



State of California  
Division of Workers' Compensation  
Disability Evaluation Unit



**REQUEST FOR SUMMARY RATING DETERMINATION  
of Primary Treating Physician Report**

DEU Use Only



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.

**PROOF OF SERVICE BY MAIL**



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

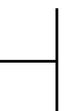
Name of Employee \_\_\_\_\_

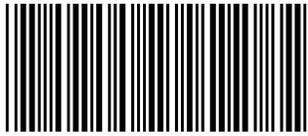
Address \_\_\_\_\_

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





**DIVISION OF WORKERS' COMPENSATION  
REQUEST FOR RECONSIDERATION OF SUMMARY RATING  
BY THE ADMINISTRATIVE DIRECTOR**

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 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 \_\_\_\_\_

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**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 \_\_\_\_\_



Disability Evaluation Unit Case Number \_\_\_\_\_

Claim Number \_\_\_\_\_

SSN (Numbers Only) \_\_\_\_\_

Date of Injury \_\_\_\_\_  
MM/DD/YYYY

**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)

# 1

On \_\_\_\_\_  
MM/DD/YYYY

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

\_\_\_\_\_  
(name of employee or claims administrator)

# 2

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

# 3

\_\_\_\_\_  
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 \_\_\_\_\_

# 4

- 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.



Insurance Claim Number \_\_\_\_\_

Date of report(s) to be rated and doctor's name:

\_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
MM/DD/YYYY

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

MM/DD/YYYY

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)

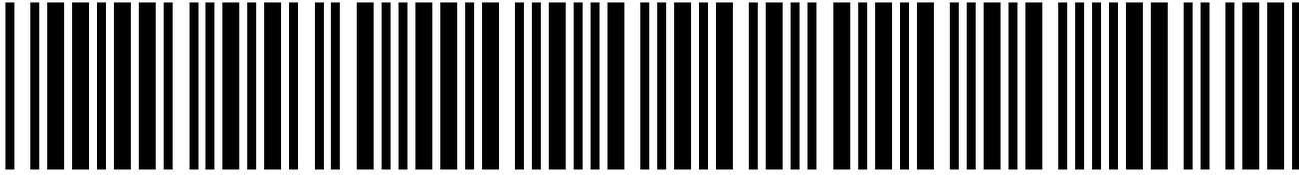
\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

STATE OF CALIFORNIA  
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET



Is this a new case? Yes  No  Companion Cases Exist  Walkthrough Yes  No   
More than 15 Companion Cases

Date:(MM/DD/YYYY)

SSN: \_\_\_\_\_

Specific Injury

Case Number 1

Cumulative Injury (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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

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

Cumulative Injury (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 3: \_\_\_\_\_

Body Part 2: \_\_\_\_\_

Body Part 4: \_\_\_\_\_

Other Body Parts: \_\_\_\_\_

## District office codes for place of venue

<b>Legend</b>	
<b>Abbreviation</b>	<b>Office</b>
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
GRO	Grover Beach
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

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

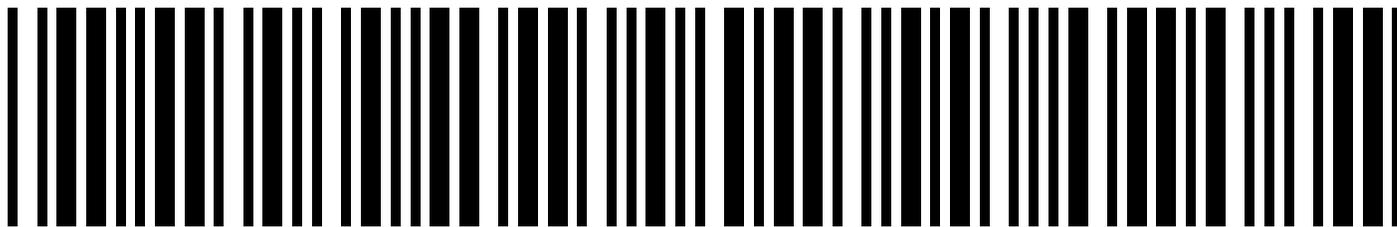
## Body Part Code List

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.

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

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

# DOCUMENT SEPARATOR SHEET



Product Delivery Unit

\_\_\_\_\_

Document Type

\_\_\_\_\_

Document Title

\_\_\_\_\_

Document Date

\_\_\_\_\_

MM/DD/YYYY

Author

\_\_\_\_\_

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## Office Use Only

Received Date

\_\_\_\_\_

MM/DD/YYYY



## 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:

IW: \_\_\_\_\_  
EAMS#: \_\_\_\_\_  
WCAB#: \_\_\_\_\_

Requested by: \_\_\_\_\_  
Contact number: \_\_\_\_\_  
Request Date: \_\_\_\_\_

DOI: \_\_\_\_\_  
P&S date: \_\_\_\_\_

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

Attorney fee% (if applicable): \_\_\_\_\_  
Annual SAWW increase (if appl.): \_\_\_\_\_

Will use 4.7% unless otherwise specified.

### Permanent Disability:

PD Rating: \_\_\_\_\_  
PD duration (in weeks): \_\_\_\_\_  
Initial PD weekly rate: \_\_\_\_\_

If DOI is o/a 1/1/05, then PD may be subject to adjustment under LC 4658(d). If applicable, enter the effective date of adjustment and rate after adjustment in Additional Comments section below.

Is PD subject to  $\pm 15\%$  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

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## Strength Evaluation

### Discouraged by AMA Guides

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



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## 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

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## AMA Guides Page 508

- "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

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## When Grip Not Used

When maximum application of force prevented by

- Decreased motion
- Pain
- Deformity
- Amputation



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## AMA Guides Page 508

- "Decreased strength cannot be rated in presence of decreased motion, painful conditions, deformities, or absence of parts...that prevent effective application of maximal force..."



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### When Grip Not Used

- In peripheral nerve injuries

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



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### 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



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### 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



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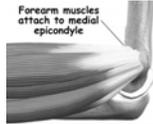
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## When Grip Strength Used

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



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## 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

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## Sleep Arousal Impairment

- Is there a central nervous system diagnosis?
- Is there a sleep study to support sleep arousal impairment?



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### 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

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### 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



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### Gait Derangement

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



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## 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...”



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## 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

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## 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?



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## 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)

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## 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

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## 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



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## 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



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## 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

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## 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



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## 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



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## Hernias

- 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

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**Table 6-9**

Table 6-9 Criteria for Rating Permanent Impairment Due to Herniation

	Class 1 0%-9% Impairment of the Whole Person	Class 2 10%-19% Impairment of the Whole Person	Class 3 20%-30% Impairment of the Whole Person
A	Palpable defect in supporting structures of abdominal wall <b>and</b>	Palpable defect in supporting structures of abdominal wall <b>and</b>	Palpable defect in supporting structures of abdominal wall <b>and</b>
B	slight protrusion at site of defect with increased abdominal pressure, readily reducible	frequent or persistent protrusion at site of defect with increased abdominal pressure, manually reducible	persistent, irreducible, or irreparable protrusion at site of defect <b>and</b>
C	or occasional mild discomfort at site of defect but not precluding most activities of daily living	or frequent discomfort, precluding heavy lifting but not hampering some activities of daily living	limitation in activities of daily living

Option 1 = A + (B or C)

Option 2 = (A + B) or C

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## 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

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