

Medical Arbitrator Resource

Oregon Workers' Compensation Division



community
Workers' Compensation
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The following forms are available online:

[Lower Extremity Range of Motion, form 440-4841](#)
[Shoulder Range of Motion, form 440-4842](#)
[Spinal \(Cervical\) Range of Motion, form 440-2278C](#)
[Spinal \(Lumbar\) Range of Motion, form 440-2278L](#)
[Spinal \(Thoracic\) Range of Motion, form 440-2278T](#)
[Upper Extremity Range of Motion, form 440-2279](#)
[Visual Impairment, form 440-2312](#)

Bulletin No. 239, Claim closing and other impairment-focused examinations and forms for reporting impairments

The bulletin is available online:

http://wcd.oregon.gov/Bulletins/bul_239.pdf

Introduction

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Welcome to the Medical Arbiter Program

Dear arbiter physician:

On behalf of the Oregon Workers' Compensation Division, welcome to the Medical Arbiter Program, which is unique in the field of workers' compensation. Briefly defined, the Medical Arbiter Program is a process committed to the impartial evaluation of residual impairment related to Oregon's injured workers.

The Department of Consumer and Business Services strives to give back to arbiter physicians through individual training, feedback on reports, and support on technical and medical issues. These, coupled with actual experience in the **evaluation** of permanent impairment, leave the physician with a broader perspective on workers' compensation and a series of clinical skills applicable to a variety of disability settings.

The Medical Arbiter Resource is valuable reading whether you are new to the program or a seasoned arbiter physician faced with an unusual situation. The Medical Arbiter Resource is designed to supplement the one-on-one training that physicians receive from the department before their initial arbiter evaluation.

If you do not find the information you need in this manual, contact the Appellate Service Team at 503-947-7816.

History of the Reconsideration Process and Medical Arbiter Program

The 1990s saw tremendous change in Oregon's workers' compensation system. Among the long-standing problems that lawmakers addressed at that time were several that proved instrumental in the creation of the Medical Arbiter Program and the process to which it is linked, the reconsideration. First, legislators sought a way for disputes to be resolved quicker than in the past. Second, they wanted to develop an appeal process that would ensure injured workers received their benefits with little or no litigation. Finally, it was widely perceived that Oregon suffered from the **dueling doctor syndrome** in which both the insurer and injured worker gathered to their side as many favorable medical opinions as possible. To avoid the resulting gridlock, the legislature envisioned a final, definitive assessment of impairment findings, the medical arbiter examination.

Reconsideration is an administrative process established for the review of disputed claim closures. If one of the issues raised by the parties (claimant or insurer) is a disagreement with permanent impairment findings, then a medical arbiter examination is arranged to help the department settle the dispute. The Appellate Review Unit (ARU) of the Workers' Compensation Division (WCD) administers both the Reconsideration and the Medical Arbiter Program. The most prevalent issue raised at reconsideration is disagreement with impairment findings, resulting in more than 200 arbiter examinations per month.

Because neutrality is essential, an arbiter physician who has no prior involvement in the evaluation or treatment of the injured worker is selected to perform the examination. The unbiased and objective findings the arbiter physician provides are relied upon by ARU to determine the extent of permanent partial disability.

At the conclusion of the reconsideration, ARU issues a legally binding order that references the arbiter physician and the arbiter's impairment findings. If either of the parties disagrees with the Order on Reconsideration, an appeal can be made to the Workers' Compensation Board, Hearings Division.

Role of the Arbiter Physician

Noncontractual relationships and medical arbiter liability

The Medical Arbiter Statement of Interest that physicians complete upon entering the Medical Arbiter Program is noncontractual. Most arbiter physicians prefer this arrangement since there is no obligation to perform a set quota of examinations. It also permits physicians to decline arbiter referrals or withdraw altogether from the Medical Arbiter Program without penalty. The department can terminate, suspend, or otherwise change the status of a participating physician if circumstances warrant.

While the Medical Arbiter Program maintains an informal, nonbinding relationship with participating physicians, it does afford physicians a certain degree of protection against malpractice and liability. Arbiter physicians are immune from these perils because of ORS 656.327(4), which appoints them as agents for the Department of Consumer and Business Services and not subject to administrative or civil liability. To date, the department is unaware of any incident in which an arbiter physician has undergone litigation of this sort because of work for the department.

Conflict of interest

Conflict of interest has become an increasingly important matter to the Medical Arbiter Program. A perception exists that a physician's personal, financial, or business relationships may influence the opinions expressed in the arbiter report.

In response to this issue, the ARU developed a Conflict of Interest Disclosure Statement designed for arbiter physicians to use in each case referred to them for evaluation. The goal is to address and avert many concerns about conflicts of interest by having the physician simply affirm that no conflict of interest exists.

The arbiter physician should call the Appellate Services Team before continuing with an examination if a potential conflict of interest is identified. What might appear to be a conflict of interest may not reach the threshold required for the arbiter examination to be terminated. For example, if an arbiter saw the worker in the distant past for an injury unrelated to the current claim, the arbiter examination may continue. However, if the worker was evaluated or treated for the current claim by one of the arbiter's clinic partners, this may constitute a conflict of interest.

The arbiter physician should avoid making a unilateral decision about conflict of interest. The department has ultimate responsibility for determining if the arbiter examination may proceed or should be rescheduled with a different physician. If guidance is not immediately available from the department, the arbiter physician should go forward with the examination.

A copy of the Conflict of Interest Disclosure Statement is found under the Sample Forms section. This statement will be included in the paperwork sent to your office with each referral. Please complete the form before conducting the arbiter examination and return it to the department along with your written report.

Legal involvement and depositions

The parties are denied both verbal and written access to the arbiter physician while the reconsideration proceeding is under way and until the Order on Reconsideration is issued. At that point, ARU's jurisdiction ends, and the arbiter physician can communicate with the parties.

Arbiter physicians are seldom drawn into the litigation phase. If an arbiter physician is contacted by one or both of the parties, it is important the physician refrain from discussing the case until obtaining confirmation from the department that the Order on Reconsideration has been issued.

The arbiter physician may be contacted, **post-reconsideration order**, to clarify technical and medical points in the arbiter report. More commonly, it is those arbiter reports that imprudently stray beyond the scope of the questions posed by the ARU that not only diminish and muddle the arbiter's report, but can also lead to the arbiter physician's prolonged involvement with interested attorneys.

The department is unable to provide legal advice to the arbiter physician, but we ask physicians to notify the department if an attorney or claims examiner approaches them to submit to any type of legal involvement pertaining to the arbiter process. This will help us to determine its prevalence and how to respond to future requests. For questions or concerns on this subject, call at 503-947-7816.

The Arbiter Evaluation

Purpose of the medical arbiter examination

The medical arbiter examination has three fundamental objectives:

- To help the department resolve disputes over compensable impairment findings resulting from the compensable injury (refer to the section titled “Compensable injury” below).
- To provide an impartial, comprehensive evaluation of the worker’s impairment.
- To report findings of impairment in conformance with the Disability Rating Standards (OAR 436-035).

Compensable injury

It is important for the arbiter physician to understand what components are included in the **compensable injury**. The term refers to a set of medical conditions, the scope of which depends on the type of claim made by the worker.

In an initial injury claim, **compensable injury** includes the following:

- Accepted conditions
- Direct medical sequela of accepted conditions

In a claim for a new condition or an omitted condition, **compensable injury** includes the following:

- Accepted new or omitted conditions
- Direct medical sequela of accepted new or omitted conditions

In an aggravation claim, **compensable injury** includes the following:

- Accepted worsened conditions
- Direct medical sequela of accepted worsened conditions

In an occupational disease claim, **compensable injury** includes the following:

- Accepted occupational diseases
- Direct medical sequela of accepted occupational diseases

Each time the term **compensable injury** is used in this resource or in the case-specific questions posed by ARU, please refer back to this list.

Medical record issues

Before the medical arbiter examination, physicians receive a packet of material from ARU consisting of general information about the referral, billing instructions, case-specific arbiter questions, and a copy of the worker’s medical record. The department must first screen any other medical information the parties want the arbiter physician to review, such as recent imaging studies or consultant reports to verify its appropriateness. Medical records brought in by the worker at the time of exam must not be reviewed. Refer the worker to the department regarding this exclusion. All medical records and file documents sent by the department for physician review should be stamped **Medical Arbiter** in the lower right-hand corner of each page. If you doubt the origin or appropriateness of written materials, contact the Appellate Services Team.

Record review

In some cases, a medical arbiter examination may not be appropriate. For example, the parties may submit other medical information indicating the worker is no longer medically stationary with respect to the body area needing the medical arbiter evaluation. Also, your medical arbiter examination may reveal the worker is not medically stationary. In either event, you may be asked to perform a record review instead of or subsequent to the actual medical arbiter examination.

The purpose of a record review is to determine the likelihood of permanent impairment at the time of claim closure. You will be asked to comment if findings of impairment, such as range-of-motion loss or strength loss, were noted at the time of closure and if these findings are permanent and attributable to the compensable injury. A series of case-specific questions will be provided to guide you through this process.

Clinical examination

The arbiter physician's primary task is to perform an impartial examination of the worker. The cornerstone of an impartial examination is its steadfast adherence to objectivity, not only in conducting the physical exam, but in evaluating the examination findings as well. To the fullest extent possible, the medical opinions and conclusions presented by the arbiter physician should be predicated upon examination findings that are observable, measurable, and reproducible.

Unlike other disability settings where a global examination of the individual is required, the medical arbiter evaluation is a highly focused exam directed at a specific body area or body system. The arbiter physician should not gather clinical data beyond the examination parameters set by the department.

The arbiter physician is called upon to provide impairment findings in conformance with the Disability Rating Standards (OAR 436-035). Range-of-motion techniques with both goniometer and inclinometer are described in the Disability Rating Standards and WCD Bulletin 239, as are testing methods for strength and sensory loss. When measuring range of motion, the interaction between pain, fear of injury, or neuromuscular inhibition may limit mobility by diminishing effort. These limitations may provide inaccurate and inconsistent measurements that may lead to improper impairment estimates. The injured worker is asked to put forth full effort, which may create some discomfort. It is contingent upon the worker to determine when maximum effort is achieved, which should produce congruent measurements. Reproducibility of abnormal motion is the only criterion for validating optimum effort. In general, arbiter physicians are encouraged to perform the usual orthopedic, neurological, and other tests they would normally carry out, provided these are consistent with the Disability Rating Standards and WCD Bulletin 239 and do not exceed the examination parameters mentioned above.

Impairment, at times, proves elusive because its assessment is dependent not only on objective clinical tests, but also on the subjective responses obtained from the injured worker. The department recognizes the untenable position this puts the arbiter physician in and, therefore, allows clinical discretion in sorting through these factors. The arbiter physician's medical opinion can supersede raw clinical data if accompanied by a strong rationale (e.g., the arbiter can conclude that lumbar flexion is valid, even if the straight-leg-raising validity test is not met).

Arbiter physicians should convey a neutral tone at the outset of the arbiter examination, neither advocating for the injured worker nor promoting the interests of the insurer. The arbiter physician should explain to the worker that the arbiter evaluation is administered by the State of Oregon and is different than an independent medical examination.

The arbiter physician must refrain from sharing examination findings with the worker. The lone exception is when emergency treatment is indicated. In those instances, ARU should be advised immediately. Also, the arbiter physician should avoid discussions with the worker about other related topics, such as treatment options, compensability issues, reopening of the claim, levels of disability, or diagnoses undetected by previous examiners. Arbiter physicians who overextend themselves are usually disappointed when their efforts to educate or empathize with the worker backfire.

More testing is permitted to help the arbiter physician when clinical findings are equivocal. The arbiter physician may obtain plain X-rays without contacting the department; however, ARU must first approve other imaging studies and all other forms of testing. A recommendation for more testing should not wait on the arbiter's written report, but rather should be conveyed verbally to the department as soon as possible, even during the arbiter examination itself. ARU's sole purpose for approving more testing is to further describe those findings of impairment due to the compensable injury.

The Medical Arbiter Report

Essential components of the arbiter report

The arbiter physician's written report becomes the focal point of intense scrutiny by the parties. This is because arbiter physicians cannot testify at the hearings level, so the arbiter's report must stand on its own. Only the department has the ability to clarify the contents of the arbiter's report, but this jurisdictional privilege stops once the department issues its legal order (Reconsideration Order).

Arbiter physicians should become familiar with the following list of vital points and incorporate the points the arbiter report when appropriate:

- Address to the appellate review specialist.
- Note that you are conducting an impartial examination of the worker at the request of WCD to describe compensable impairment.
- In initial injury claims, list the formally accepted conditions and any denied conditions.
- In occupational disease claims, list the formally accepted conditions and any denied conditions.
- In claims for a new or omitted condition or a worsening, list the new, omitted, or worsened condition subject to arbiter review and all of the previously accepted and denied conditions.
- Indicate that no doctor/patient relationship was established.
- Include a summary of the significant events in treatment. Provide an accurate history of the current injury and any applicable past history. Also, identify any pre-existing or unrelated conditions that may contribute to the worker's clinical picture.
- Comment on the worker's present complaints, including the effect of any intervening incidents since claim closure. If the worker is not medically stationary at the time of the exam, contact the appellate review specialist.
- Specify what examination procedures (orthopedic and neurological tests, clinical tests, etc.) were undertaken and the results. Doing this reinforces that a comprehensive evaluation was carried out.
- Provide a description of all applicable physical or mental examination findings as requested in the case-specific questions posed by ARU.
- Document your medical reasoning. It is insufficient for the arbiter physician to state an impairment finding is normal for this individual, invalid, or not due to the compensable injury. By default, the department is obliged to award an impairment finding if the arbiter cannot attribute the finding to some cause unrelated to the compensable injury. An explanation based on sound medical principles must always accompany any discounting of impairment findings. Reference to the medical record should be made to explain conclusions that differ or agree with the opinions of previous medical examiners.
- Speculation about the worker's motivation is discouraged, particularly through phrases commonly used to impeach the credibility of the worker, such as functional disturbance, secondary gain, and malingering. Only in those instances in which a lack of cooperation or interference occurs should the medical arbiter comment on the worker's conduct or demeanor.
- If the department does not ask about the worker's ability to return to work, do not make comments about the worker's ability.
- If you viewed surveillance film in conjunction with the arbiter evaluation, state what affect the film had on your medical opinions.

- If the examination reveals a different diagnosis than the one accepted in the claim, you may include it under medical impressions. However, in all occupational disease claims and in injury claims for new, omitted, or worsened conditions, it is inappropriate for the arbiter physician to lobby for conditions not yet accepted to be included in the claim. These are referred to as compensability issues and are not within the scope of the medical arbiter. The scope of initial injury claims may include the accepted condition and direct medical sequela of the accepted condition.
- Do not express personal views about medical conditions. Often, such statements are dogmatic and generalize about a medical condition in a manner that predetermines the results of the examination. From the legal perspective, such statements are referred to as gratuitous remarks. For example: “All musculotendinous injuries resolve without residual effect is unfounded and fails to make allowance for individual variables.”
- At the conclusion, identify all parties (worker, worker’s attorney, insurer, insurer’s attorney) who were sent copies of the arbiter report.

Medical arbiter quality assurance

The medical arbiter examination is recognized under Oregon workers’ compensation law (ORS Chapter 656). It belongs to a unique category of evaluations in the field of workers’ compensation, referred to as **department-required examinations**. As mandated by statute, WCD is responsible for providing high-quality medical evaluations through the Medical Arbitrator Program. This requires continuous monitoring of arbiter reports to ensure participating physicians satisfactorily address the medical, administrative, legal, and technical components set forth in this manual.

WCD strives for long-term relationships with arbiter physicians, which is why the department invests in ongoing education and training of individual arbiters. While the department has the ability to temporarily or permanently remove physicians from the Active List of Medical Arbiters for failure to abide by the guidelines presented here, this is a last resort and has rarely occurred.

Components that WCD reviews include:

- The report is of sufficient quality, impartiality, and thoroughness to be relied upon by the appellate review specialist and other decision-makers.
- The report reflects:
 - Adequate physician knowledge of the worker’s history and treatment.
 - Comprehensive answers to the questions posed by the appellate review specialist, in accordance with this manual and Bulletin 239.
- The report **does not** address:
 - Current treatment recommendations, unless urgent or emergency care is needed or the physician feels ethically compelled.
 - Compensability issues.
 - Medically stationary status, unless the appellate review specialist specifically requested review of the worker’s status or it is clear the worker has suffered an intervening incident that has made the worker non-medically stationary at the time of the exam (e.g., a car accident).
- Personal philosophy is not appropriate in this process and is to be excluded from your report. Examples of personal philosophy include:
 - Challenging the validity of range-of-motion testing.
 - Textbook definitions that make no allowance for individual variance (e.g., the belief that all soft tissue/ musculotendinous injuries resolve without residual impairment).
 - The etiology of overuse or carpal tunnel syndrome.

Fees

Medical arbiter fees

Medical arbiter fees consist of three distinct components: 1) the clinical examination fee, 2) the medical record review fee, and 3) the arbiter report fee. Each of these components is broken down into levels according to complexity or difficulty.

The simplest or most straightforward cases are designated Level I and extend up to Level III for extremely complex clinical examinations and arbiter reports. Medical-record reviews have five levels to accommodate unusually large records and surveillance film. An arbiter referral often will have fee components of varying levels of complexity.

Preauthorized by the department, the fee ranges below are combined totals derived by adding the fee components mentioned earlier as modified by degree of complexity:

Fees effective April 1, 2016:

Simple to moderately complex	\$481 - \$631
Moderately complex to very complex	\$723 - \$1,091
Very complex to extremely complex.....	\$1,091 - \$1,676
No show/late cancellation charge*	50 percent of the examination fee

*When a no show/late cancellation has occurred, the medical arbiter may receive an additional payment for medical record review, if completed before the examination date.

Medical arbiter record review fees

The arbiter physician may be called upon to perform a record review because circumstances preclude a physical examination of the injured worker.

Review of the record and arbiter report (based on complexity).....	\$494 - \$1,079
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Direct questions about arbiter fees, payment of fees, and exam logistics to the Appellate Services Team at 503-947-7816.

Examination and Reporting Instructions

Soon after a medical arbiter referral is made, the department will send a comprehensive packet of information to the arbiter physician. In addition to practical material such as billing instructions, the packet contains an official copy of the medical record. However, the most vital information in this packet consists of a series of impairment-related instructions. The instructions address the findings commonly associated with an array of trauma-based medical conditions, occupational diseases, and mental illness and head injuries.

The medical arbiter examination and reporting instructions are instrumental in shaping the parameters of the arbiter evaluation itself. The appellate review specialists who prepare these instructions must take into account a number of factors beyond the contents of the official medical record. For example, denied conditions and conditions not under review should generally be disregarded by the arbiter physician. This creates situations in which the department may deliberately exclude instructions that appear relevant from a purely medical perspective. Legal and administrative constraints often cause the department to avoid investigating denied conditions via medical arbiter instructions.

The reporting instructions encourage arbiter physicians to report their clinical findings in a manner and format consistent with the Division 35 Disability Rating Standards and WCD Bulletin 239. The significance of this statement may not be readily apparent to readers from the medical field. The fact that each instruction accurately reflects the administrative rule from which it is derived is key to ensuring that arbiter physicians gather the correct clinical data as defined in Oregon's workers' compensation law.

The emphasis on neutrality plays an active role in the development of the medical arbiter examination and reporting instructions. The Medical Arbiter Program strives to convey a tone of neutrality in all its written material.

When a medical condition is not encompassed by the existing Disability Rating Standards, the department can develop **temporary standards**. Consideration of **temporary standards** may be indicated when a unique aspect of impairment is noted at the time of claim closure or subsequently described in the medical arbiter's report. In either event, the medical arbiter examination and reporting instructions play a crucial role in exploring the merits of **temporary standards**. Here, the generic instructions mentioned earlier are replaced by highly individualized instructions incisive enough to elicit a thorough description of impairment.

The department offers the following list of medical arbiter examination and reporting instructions.

Apportionment

The case-specific questions posed by ARU will include questions about apportionment of impairment. If the worker has impairment that is caused entirely by the compensable injury (refer to the section titled "Compensable injury" [on page 3](#)), the arbiter report should include a statement to that effect. If the worker has impairment that is not caused entirely by the compensable injury, the arbiter report must address apportionment of findings. The report should describe current total overall findings of impairment and describe specific findings and the percentage of permanent impairment due to each of the following conditions that apply:

- The compensable injury (refer to the section titled "Compensable injury" [on page 3](#))
- A condition that is not a pre-existing condition as defined in the section titled "Pre-existing conditions" below but that existed before any of the following:
 - The initial injury in an initial injury or omitted condition claim
 - The onset of the accepted new condition in a new condition claim
 - Before the onset of the accepted worsened condition in an aggravation claim
 - Before the onset of the claimed occupational disease
- A denied condition
- A superimposed condition
- A pre-existing condition as defined in the section titled "Pre-existing conditions" below
- Unrelated factors (specify)

If any impairment is due to a pre-existing condition as defined in the section titled "Pre-existing conditions" below, the arbiter report should explain how the condition meets the definition of pre-existing condition. In injury claims (initial injury, new condition, omitted condition, or aggravation), if the pre-existing condition is arthritis or an arthritic condition, the report should indicate if it involves inflammation of one or more joints, identify the affected joints, and explain whether the inflammation is due to infectious, metabolic, or constitutional causes.

Pre-existing conditions

In an injury claim (initial injury, new condition, omitted condition, or aggravation), a pre-existing condition is a condition that contributes to disability or need for treatment and is either of the following:

- Arthritis or an arthritic condition
- Treated or diagnosed before:
 - The initial injury in a claim for an initial injury or omitted condition
 - The onset of the new medical condition in a claim for a new medical condition
 - The onset of the worsened condition in a claim for an aggravation

In an occupational disease claim (initial occupational disease, new condition, omitted condition, or aggravation), a pre-existing condition is a condition that contributes to disability or need for treatment and precedes:

- The onset of the claimed occupational disease or omitted condition
- A claim for a worsened condition
- The onset of the new medical condition

Head-brain

1. Perform a **cranial nerve** examination and an informal cognitive assessment. On the basis of these tests, describe any findings of impairment due to the compensable injury.
2. Regarding the worker's **headaches**, provide the following:
 - Indicate frequency and severity of headaches.
 - Describe disruption, if any, of activities of daily living (ADL) due to headaches; required adjustments in work activity due to headaches.
 - Describe if any need for prescribed medication or therapy for headaches is due to the compensable injury.
3. If you think a neuropsychological evaluation is needed for determining the impairment findings, immediately contact the Appellate Services Team for authorization.
4. Provide your concurrence or comments if a neuropsychological evaluation was performed as an adjunct to your medical arbiter examination.
5. For **brain** injuries resulting in permanent impairment, use the criteria listed below based on the Rancho Los Amigos Scale-Revised. Review the following points before applying the Rancho Los Amigos Scale-Revised:
 - The existence and severity of the claimed residuals and impairments must be objectively determined by observation or examination or a preponderance of evidence, and must be within the range reasonably considered to be possible, given the nature of the original injury, based upon a preponderance of medical opinion.
 - The residuals must be a direct result of organic injury to the brain. For example, emotional or behavioral disturbances must result directly from injury to the brain. Emotional disturbances that are reactive to other residuals, but are not directly organically based, such as frustration or depressed mood about memory deficits or work limitations, are not included under these criteria and must be addressed separately.
 - The distinctions between disability classes are intended to reflect, at their most fundamental level, the effect of the residuals on two domains: impairment of activities of daily living and impairment of employment capacity.
 - If the residuals from the compensable injury place the worker between one or more classes, the worker is entitled to be placed in the highest class that describes the worker's impairment. There is no averaging of impairment values when a worker falls between classes.
 - As used in these rules, **episodic neurologic disorder** refers to and includes any of the following:
 - Seizure disorder
 - Vestibular disorder, including disturbances of balance, sensorimotor integration, or both
 - Neuro-ophthalmologic or oculomotor visual disorder, such as diplopia
 - Headaches

Class 1: Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 9 or 10 (the worker is alert and oriented, behavior is appropriate, and the worker is able to recall and integrate past and recent events). The worker is independent in activities of daily living. If there are cognitive or memory deficits, they are no more than minimal or "nuisance" level, and do not materially impair activities of daily living or the type of work the worker may perform.

Language: If there is a language deficit, it is no more than minimal (language comprehension or production might be less than normal, but it is adequate for daily living).

Emotions/behavior: If there are emotional disturbances or personality changes, they are minimal and occur only transiently during stressful situations and events.

Sleep/alertness: If there are episodic sleep disturbances, fatigue, or lethargy, they are minimal (any sleeping irregularity, fatigue, or lethargy does not interfere with daily living).

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is completely controlled and does not interfere with daily living.

The fundamental intent of this class is as follows: (1) ADLs: The worker has “nuisance” level residual effects of head injury, which may slightly impact the manner in which ADLs are performed, the subjective ease of performance, or both, but the worker remains fully independent in all activities of daily living; (2) Work capacity: The “nuisance” level residuals may affect the manner in which the worker performs work tasks, the subjective ease of performance, or both, but the worker is not materially limited in the types of work that can be performed, as compared with pre-injury abilities.

Class 2: Cognition: The worker functions at the equivalent Rancho Los Amigos Scale-Revised level of 8 (the worker is alert and oriented, behavior is appropriate and the worker is able to recall and integrate past and recent events). The worker can independently perform all activities of daily living, but due to mild cognitive or memory deficits, may need to use compensatory strategies or devices such as multiple written reminders, alarms, or digital devices; may sometimes require more time than normal to complete activities of daily living; or may use occasional reminders, prompts, or minor assistance by others as a compensatory strategy, but is not dependent on others. For example, a spouse may be asked to double-check financial transactions for errors, but the worker can independently manage all transactions, if necessary, and is not fundamentally dependent on the spouse for this activity. The cognitive or memory deficits limit the worker’s ability to perform some types of jobs; for example, mild attention deficits may preclude work in a busy, multitasking environment, but the worker is still employable.

Language: Language deficit is mild (language comprehension or production might occasionally interfere with daily living or limit the worker’s ability to perform some types of jobs, but the worker is still employable).

Emotion/behavior: Emotional or behavioral disturbances or personality changes are mild. While they may be disproportionate to the stress or situation, they do not significantly impair the worker’s ability to relate to others or to live with others. They may limit the worker’s ability to perform some types of jobs, for example, irritability may preclude jobs with high public contact, but the worker is still employable.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are mild (any sleeping irregularity, fatigue, or lethargy only occasionally interferes with daily living). Sleep disturbance or mild or episodic fatigue or lethargy may limit the worker’s ability to perform some types of jobs; for example, shift work or commercial driving, but the worker is still employable.

Episodic neurologic disorder: Any episodic neurologic disorder is not completely controlled and results in limits in ADL performance or types of work that may be performed, but the worker is still independent in ADLs and is employable. For example, headaches may intermittently interfere with daily living; diplopia, which worsens with fatigue, may cause the worker to have driving restrictions; vestibular symptoms may limit the worker’s ability to operate industrial machinery, cause the worker to avoid heights, or both.

The fundamental intent of this class is as follows: (1) ADLs: The worker is independent in all activities of daily living, but may require significant adaptations or modifications in normal patterns or means of activities of daily living in order to achieve ADL independence; (2) Work capacity: The residuals result in some type of limitation on the worker’s employment capacity, restricting the range of employment options that were previously available to the worker, but the worker remains employable in most jobs for which he or she was qualified before injury.

Class 3: Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 7 (the worker is alert and oriented, behavior is appropriate but the worker has mild to moderate impaired judgment, mild to moderate functionally significant cognitive or memory deficits, or both). The judgment, cognitive, or memory deficits result in impairment sufficient that the worker regularly requires help or supervision in order to perform some activities of daily living. The deficits restrict the worker to a limited range of jobs at a level significantly below the worker’s pre-injury employment capacity.

Language: Language deficit is mild to moderate (language comprehension or production deficits frequently interfere with activities of daily living or restrict the worker to a limited range of jobs at a level significantly below the worker's pre-injury employment capacity).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate, disproportionate to the stress or situation, are present at all times, and significantly impair the worker's ability to relate to others or to live with others. The disturbances restrict the worker to a limited range of jobs at a level significantly below the worker's pre-injury employment capacity.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate. They frequently interfere with daily living or restrict the worker to a limited range of jobs at a level significantly below the worker's pre-injury employment capacity.

Episodic neurologic disorder: If there is an episodic neurologic disorder, it is not completely controlled. It markedly interferes with daily living. The worker cannot operate industrial machinery, and is restricted to a limited range of jobs at a level significantly below the worker's pre-injury employment capacity.

The fundamental intent of this class is as follows: (1) ADLs: The worker is not completely independent in all ADLs, and requires some type of supervision, help, or guidance from another person at some times for some aspects of ADLs; (2) Work capacity: The residuals result in major limitations on the worker's employment capacity with major restrictions or limitations on the worker's range of employment options.

Class 4: Cognition: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 6 (the worker has impaired judgment, significant memory deficit, or both, such that the worker needs assistance and supervision to perform most activities of daily living and can work only in a sheltered setting).

Language: Language deficit is moderate (language comprehension is often impaired or language production is often inappropriate or unintelligible).

Emotions/behavior: Emotional or behavioral disturbances or personality changes are moderate to severe, disproportionate to the stress or situation, present at all times, require the worker to be supervised, or seriously limit the worker's ability to live with others. The worker can work, if at all, only in a sheltered setting.

Sleep/alertness: Episodic sleep disturbances, fatigue, or lethargy are moderate to severe (they require supervision for daily living). The worker can work, if at all, only in a sheltered setting.

Episodic neurologic disorder: If there is episodic neurologic disorder, it is of such severity and constancy that activities have to be limited and supervised. The worker needs to live in a supervised setting such as a foster home, care facility, or supervised semi-independent residence.

The fundamental intent of this class is as follows: (1) ADLs: The worker is basically dependent on others for most aspects of ADLs, although the worker may not need direct supervision at all times. (2) Work capacity: The worker is incapable of competitive employment and can work, if at all, only in a sheltered setting.

Class 5: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 4-5 (the worker's behavior is inappropriate, the worker is confused, not reliably oriented to time and place; the worker may be agitated and has a severe memory deficit; and the worker requires assistance and supervision to perform all activities of daily living). Total supervision is required. The worker is incapable of any employment.

Class 6: The worker functions at the equivalent of Rancho Los Amigos Scale-Revised level of 1-3. The worker is comatose or the worker's responses to stimuli are localized, inconsistent, or delayed.

6. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.

7. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

NOTE: For the purpose of this section of this rule, the Rancho Los Amigos-Revised levels are based upon the *Eight States Levels of Cognitive Recovery* developed at the Rancho Los Amigos Hospital and co-authored by Chris Hagen, Ph.D., Danese Malkumus, M.A., and Patricia Durham, M.S., in 1972. These levels were revised by Danese Malkumus, M.A., and Kathryn Standenip, O.T.R., in 1974, revised by Chris Hagen, Ph.D., in 1999 to include 10 levels, referred to as Rancho-R.

Hearing

1. Confirm with the worker and mention in your written report that the worker was removed from significant noise for at least 14 hours before the medical arbiter examination.
2. Perform a complete otological evaluation and audiogram and report any permanent impairment including:
 - History, examination, diagnosis, opinion, and interpretation.
 - Air conduction frequencies at 500; 1,000; 2,000; 3,000; 4,000; and 6,000 HZ, based on *ANSI S3.6 (1989) Standards*.
3. When the injury results in **tinnitus**, opine if permanent job modifications are necessary.
4. When there are permanent disturbances of the **vestibular** mechanism resulting in **dysequilibrium**, indicate the effect it has on the worker’s usual activities of daily living from the following:
 - Performed without help
 - Performed without help, but the worker is unable to operate a motor vehicle
 - Cannot be performed without help
 - Cannot be performed without help, and confinement is necessary
5. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
6. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Hernia

1. Specify if there is permanent and **palpable defect** in the supporting structures of the **abdominal wall**, and, if so, identify which of the following classifications addresses the permanent impairment.
 - Class 1: A slight protrusion is present at the site of the defect with increased abdominal pressure that is readily reducible; or occasional mild discomfort is present at the site of the defect, which limits the worker in one or more activities of daily living (ADL).
 - Class 2: Frequent or persistent protrusion is present at the site of the defect with increased pressure that is manually reducible; or frequent discomfort is present, which limits the worker from heavy lifting, but does not hamper some ADL.
 - Class 3: Persistent, irreducible, or irreparable protrusion is present at the site of the defect and there is a limitation in the worker’s ADL.
2. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.

3. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Hips

- Provide the following six active (unassisted) **ranges of motion** of both **hips** expressed in retained degrees: forward elevation, backward extension, abduction, adduction, internal rotation, and external rotation.
- Determine if the contralateral joint has a previous history of injury or disease.
- Describe any muscle **strength loss** in the 0-5/5 method (see table). Identify the muscles that have valid diminished strength, the peripheral nerves and, if applicable, the nerve root innervating the muscles. Explain the etiology in detail and provide a contralateral comparison. (Please do not provide only the “motion,” e.g., flexion, extension.)

0 - 5/5 Muscle Grading:

 - 5/5 = Retains range of motion against gravity with full resistance applied.
 - 4/5 = Retains range of motion against gravity with some resistance applied.
 - 3/5 = Retains range of motion against gravity without resistance applied.
 - 2/5 = Retains range of motion with gravity, but has to have help.
 - 1/5 = Slight muscle contractility, no joint motion.
 - 0/5 = No muscle contractility.
- Specify if, because of a permanent and chronic condition caused by the compensable injury, the worker is unable to repetitively use the **hips** for more than two-thirds of a period of time. If so, identify the specific body parts involved.
- For **fractures of pelvic structures**, identify the pelvic structures involved and specify if the fracture healed with displacement and deformity.
- Also, for hip fractures, describe any **leg length discrepancy** in inches, measured from the anterior superior iliac spine to the distal medial malleolus.
- Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
- State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Immunological

- Impairment to the **immune system** resulting from an **allergic response** to physical, chemical, or biological agents should be categorized using one of the following phrases to describe the reaction:
 - A nuisance, but does not prevent most regular work-related activities
 - Prevents some regular work-related activities
 - Prevents most regular work-related activities
- Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
- State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury,

address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Integumentary

1. Impairment to the **integumentary system** may or may not show signs or symptoms of **skin disorder** upon examination. Use the following classifications to describe the worker’s impairment, if any:
 - Class 1: With treatment, there is no or minimal limitation, in the performance of work-related activities, although exposure to certain physical or chemical agents might temporarily increase limitation.
 - Class 2: Intermittent treatment is required; there is mild limitation in the performance of some work-related activities.
 - Class 3: Continuous treatment is required and there is moderate limitation in the performance of many work-related activities.
 - Class 4: Continuous treatment is required, which may include periodic confinement at home or other domicile; there is moderate to severe limitation in the performance of many work related activities.
 - Class 5: Continuous treatment is required, which necessitates confinement at home or other domicile; there is severe limitation in the performance of work-related activities.
2. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
3. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Lower Extremity

1. Provide active (unassisted) **ranges of motion** in the following body parts expressed in retained degrees of:
 - Flexion of the interphalangeal, and dorsiflexion and plantar flexion of the metatarsophalangeal joints of both **great toes**. Complete and return the form.
 - Dorsiflexion and plantar flexion in the metatarsophalangeal joints of the second through fifth **toes** (including contralateral joint comparison). Complete and return the form.
 - Inversion, eversion, dorsiflexion, and plantar flexion of both **ankles**. Complete and return the form.
 - Flexion and extension of both **knees**. Complete and return the form.
 - Flexion, extension, abduction, adduction, and internal and external rotation of both **hips**. Complete and return the form.
2. If the conditions resulted in **ankylosis** of the joint, provide the plane motion (flexion) and the angle degree of fixation.
3. Determine if the contralateral joint has a previous history of injury or disease.
4. Describe any muscle **strength loss** in the 0-5/5 method (see table below). Identify the muscles that have valid diminished strength, the peripheral nerves and, if applicable, the nerve root innervating the muscles. Explain the etiology in detail and provide a contralateral comparison. (Do not provide only the “motion,” e.g., flexion, extension.)

0 - 5/5 Muscle Grading:

- 5/5 = Retains range of motion against gravity with full resistance applied.
- 4/5 = Retains range of motion against gravity with some resistance applied.
- 3/5 = Retains range of motion against gravity without resistance applied.
- 2/5 = Retains range of motion with gravity, but has to have help.
- 1/5 = Slight muscle contractility, no joint motion.
- 0/5 = No muscle contractility.

5. Specify if any **strength loss** is due to a loss in range of motion. If so, explain your rationale.
6. Describe any **sensation loss** or alteration of sensation (hypersensitivity) in the plantar surface of the **toes**, **foot**, or **feet** described as either partial or total.
7. Describe any **instability** of the **ankle** or **knee** as mild (Grade I), moderate (Grade II), or severe (Grade III) with identification of the specific ligaments involved.

NOTE: Knee joint instability is defined as follows:

 - Grade I is 1-5 mm
 - Grade II is 6-10 mm
 - Grade III is greater than 10 mm
8. Describe any **leg length discrepancy** in inches, measured from the anterior superior iliac spine to the distal medial malleolus.
9. Describe any **varus** or **valgus deformity** of the **knees** by degrees of angulation.
10. Describe any **angulation** or **malalignment** (rotational deformity) resulting from **tibial shaft** fracture as:
 - Mild (10° - 14°)
 - Moderate (15° - 19°)
 - Severe (20° +).
11. Describe any **chondromalacia/degenerative joint disease/arthritis** of the **knees** or **ankles**. If a diagnosis of Grade IV chondromalacia is made, indicate if any of the following are present:
 - Secondary strength loss
 - Chronic effusion
 - Varus or valgus deformity in degrees
12. Specify if the worker is prevented from being on his or her feet for more than two hours in an eight-hour period due to the compensable injury. If so, explain the necessity for this restriction.
13. Specify if, because of a permanent and chronic condition caused by the compensable injury, the worker is unable to repetitively use the **foot**, **ankle**, or **leg** for more than two-thirds of a period of time. If so, identify the specific body parts involved.
14. Describe using the following, the specific level of **amputation**:
 - Amputation at or above the **knee** joint (up to and including the femoral head).
 - Amputation of the **foot**:
 - At or above the tibio-talar joint but below the knee joint.
 - At the tarsometatarsal joints.
 - At the mid-metatarsal area.
 - Amputation of the **great toe**:
 - At the interphalangeal joint.
 - At the metatarsophalangeal joint.
 - Amputation of the second through fifth **toes**:
 - At the distal interphalangeal joint.
 - At the proximal interphalangeal joint.
 - At the metatarsophalangeal joint.
15. Using the following classification, describe any **lower extremity dermatological** findings that may or may not show signs or symptoms of skin disorder upon examination and:

Class 1: Treatment results in no more than minimal limitations in the performance of the activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations.

- Class 2: Requires intermittent treatments and prescribed examinations, and the worker has some limitations in the performance of activities of daily living.
- Class 3: Requires regularly prescribed examinations, continuous treatment, and the worker has many limitations in the performance of activities of daily living.
- Class 4: Continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of activities of daily living.
- Class 5: Continuous prescribed treatment is required. The treatment necessitates having the worker stay home or permanently admitting the worker to a care facility, and the worker has severe limitations in the performance of activities of daily living.
16. Describe any **lower extremity vascular** impairment findings using the following classifications:
- When the worker demonstrates any of the following:
- Loss of pulses in the foot.
 - Minimal loss of subcutaneous tissue.
 - Calcification of the arteries (as revealed by X-ray).
 - Transient edema.
- Class 2: When the worker suffers from any of the following:
- Limping due to intermittent claudication that occurs when walking at least 100 yards.
 - Vascular damage, as evidenced by a healed painless stump of a single amputated toe, with evidence of chronic vascular dysfunction or a healed ulcer.
 - Persistent moderate edema that is only partially controlled by support hose.
- Class 3: When the worker suffers from any of the following:
- Limping due to intermittent claudication when walking as little as 25 yards and no more than 100 yards.
 - Vascular damage, as evidenced by healed amputation stumps of two or more toes on one foot, with evidence of chronic vascular dysfunction or persistent superficial ulcers on one leg.
 - Obvious severe edema that is only partially controlled by support hose.
- Class 4: When the worker suffers from any of the following:
- Limping due to intermittent claudication after walking less than 25 yards.
 - Intermittent pain in the legs due to intermittent claudication when at rest.
 - Vascular damage, as evidenced by amputation at or above the ankle on one leg or amputation of two or more toes on both feet, with evidence of chronic vascular dysfunction or widespread or deep ulcers on one leg.
 - Obvious severe edema that cannot be controlled with support hose.
- Class 5: When the worker suffers from either of the following:
- Constant severe pain due to claudication at rest.
 - Vascular damage, as evidenced by amputations at or above the ankles of both legs or amputation of all toes on both feet with evidence of persistent vascular dysfunction or of persistent, widespread, or deep ulcerations on both legs.
17. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
18. State if exam findings are due to the compensable injury or to unrelated factors (refer to the section titled “Compensable injury” [on page 3](#)). If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Mental health

1. Perform a complete mental status examination and report any objective permanent impairment resulting from the compensable injury. Include the following information:
 - Personal and social history.
 - Any deficits in memory, concentration, judgment, and other cognitive functions.
 - Ability to adapt to ordinary activities and stresses of daily living.
 - Ability to avoid problems with social and personal relationships.
 - Ability to avoid harm to self and others.
 - Ongoing treatment required, if any.
 - Diagnosis and prognosis.
2. Use the following Mental Illness Standards derived from the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV (1994)* to assign a specific class for the worker's permanent impairment, if any. Identify the criteria used to assign the classification. Also, describe permanent changes in mental function in terms of their effect on the worker's ADLs, as defined in OAR 436-035-0005(1). Additionally, describe the effect on social functioning and deterioration or decompensation in work or work-like settings as outlined in the Disability Rating Standards.
 - A. Loss of function attributable to permanent worsening of **personality disorders** may be stated as impairment only if it interferes with the worker's long-term ability to adapt to the ordinary activities and stresses of daily living. Personality disorders are rated as two classes, with gradations within each class based on severity:
 - Class 1: (minimal, mild, or moderate). A worker belongs in Class 1 when:
 - The worker shows little self-understanding or awareness of the mental illness.
 - Has some problems with judgment.
 - Has some problems with controlling personal behavior.
 - Has some ability to avoid serious problems with social and personal relationships.
 - Has some ability to avoid self-harm.
 - Class 2: (minimal, mild, or moderate). A worker belongs in Class 2 when:
 - The worker shows considerable loss of self-control.
 - Has an inability to learn from experience.
 - Causes harm to the community or to self.
 - B. Loss of function attributable to permanent symptoms of **affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders** is rated according to the following classes, with gradations within each class based on the severity of the symptoms/loss of function:
 - Class 1: A worker belongs in Class 1 when one or more of the following residual symptoms are noted:
 - Anxiety symptoms: Require little or no treatment, are in response to a particular stress situation, produce unpleasant tension while the stress lasts, and might limit some activities.
 - Depressive symptoms: The activities of daily living can be carried out, but the worker might lack ambition, energy, and enthusiasm. There may be such depression-related, mentally caused physical problems such as mild loss of appetite and a general feeling of being unwell.
 - Phobic symptoms: Phobias the worker already suffers from may come into play or new phobias may appear in a mild form.
 - Psychophysiological symptoms: Are temporary and in reaction to specific stress. Digestive problems are typical. Any treatment is for a short time and is not connected with any ongoing treatment. Any physical pathology is temporary and reversible. Conversion symptoms or hysterical symptoms are brief and do not occur very often. They might include some slight and limited physical problems (such as weakness or hoarseness) that quickly respond to treatment.
 - Class 2: (minimal, mild, or moderate). A worker belongs in Class 2 when one or more of the following residual symptoms/loss of functions are noted:

- Anxiety symptoms: May require extended treatment. Specific symptoms may include (but are not limited to) startle reactions, indecision because of fear, fear of being alone, and insomnia. There is no loss of intellect or disturbance in thinking, concentration, or memory.
- Depressive symptoms: Last for several weeks. There are disturbances in eating and sleeping patterns, loss of interest in usual activities, and moderate retardation of physical activity. There may be thoughts of suicide. Self-care activities and personal hygiene remain good.
- Phobic symptoms: Interfere with normal activities to a mild to moderate degree. Typical reactions include (but are not limited to) a desire to remain at home, a refusal to use elevators, a refusal to go into closed rooms, and an obvious reaction of fear when confronted with a situation that involves a superstition.
- Psychophysiological symptoms: Require substantial treatment. Frequent and recurring problems with the organs get in the way of common activities. The problems may include (but are not limited to) diarrhea; chest pains; muscle spasms in the arms, legs, or along the backbone; a feeling of being smothered; and hyperventilation. There is no actual pathology in the organs or tissues. Conversion or hysterical symptoms result in periods of loss of physical function that occur more than twice a year, last for several weeks, and need treatment. Symptoms may include (but are not limited to) temporary hoarseness, temporary blindness, and temporary weakness in the arms, the legs, or both. These problems continue to return.

Class 3: (minimal, mild, or moderate). A worker belongs in Class 3 when one or more of the following residual symptoms/loss of functions are noted:

- Anxiety symptoms: Fear, tension, and apprehension interfere with work or the activities of daily living. Memory and concentration decrease or become unreliable. Long-lasting periods of anxiety keep returning and interfere with personal relationships. The worker needs constant reassurance and comfort from family, friends, and co-workers.
- Depressive symptoms: Include an obvious loss of interest in the usual activities of daily living, including eating and self-care. These problems are long-lasting and result in loss of weight and an unkempt appearance. There may be retardation of physical activity, a preoccupation with suicide, and actual attempts at suicide. The worker may be extremely agitated on a frequent or constant basis.
- Phobic symptoms: Existing phobias are intensified. In addition, new phobias develop. This results in bizarre and disruptive behavior. In the most serious cases, the worker may become home-bound, or even room-bound. People in this state often carry out strange rituals that require them to be isolated or protected.
- Psychophysiological symptoms: Include tissue changes in one or more body system or organ. These may not be reversible. Typical reactions include (but are not limited to) changes in the wall of the intestine that result in constant digestive and elimination problems. Conversion or hysterical symptoms include loss of physical function that occurs often and lasts for weeks or longer. Evidence of physical change follows such events. A symptomatic period (18 months or more) is associated with advanced negative changes in the tissues and organs. These include (but are not limited to) atrophy of muscles in the legs and arms. A common symptom is general flabbiness.

C. Loss of function attributable to permanent symptoms of **psychotic disorders** are rated based on perception, thinking process, social behavior, and emotional control. Variations in these aspects of mental function are rated according to the following classifications with gradations within each class based on severity:

Class 1: (minimal, mild, or moderate). A worker belongs in Class 1 when the following is established:

- Perception: The worker misinterprets conversations or events. It is common for people with this problem to think others are talking about them or laughing at them.
- Thinking process: The worker is absent-minded, forgetful, daydreams too much, thinks slowly, has unusual thoughts that recur, or suffers from an obsession. The worker is aware of these problems and may also show mild problems with judgment. It is also possible that the worker may have little self-understanding or understanding of the problem.

- Social behavior: Small problems appear in general behavior, but do not get in the way of social or living activities. Others are not disturbed by them. The worker may be overreactive or depressed or may neglect self-care and personal hygiene.
- Emotional control: The worker may be depressed and have little interest in work or life. The worker may have an extreme feeling of well-being without reason. Controlled and productive activities are possible, but the worker is likely to be irritable and unpredictable.

Class 2: (minimal, mild, or moderate). A worker belongs in Class 2 when the following is established:

- Perception: Workers in this state have fairly serious problems in understanding their personal surroundings. They cannot be counted on to understand the difference between daydreams, imagination, and reality. They may have fantasies involving money or power, but they recognize them as fantasies. Because people in this state are likely to be overly excited or suffering from paranoia, they are also likely to be domineering, peremptory, irritable, or suspicious.
- Thinking process: The thinking process is so disturbed that people in this state might not realize they are having mental problems. The problems might include (but are not limited to) obsessions, blocking, memory loss serious enough to affect work and personal life, confusion, powerful daydreams, or long periods of being deeply lost in thought to no set purpose.
- Social behavior: People in this state can control their social behavior if they are asked to do so. However, if left on their own, their behavior is so bizarre that others may be concerned. Such behavior might include (but is not limited to) overactivity; disarranged clothing; and talk, gestures, or both that neither make sense nor fit the situation.
- Emotional control: People in this state suffer a serious loss of control over their emotions. They may become extremely angry for little or no reason, they may cry easily, or they may have an extreme feeling of well-being, causing them to talk too much and to little purpose. These behaviors interfere with living and work and cause concern in others.

Class 3: (minimal, mild, or moderate). A worker belongs in Class 3 when the following is established:

- Perception: Workers in this state suffer from frequent illusions and hallucinations. Following the demands of these illusions and hallucinations leads to bizarre and disruptive behavior.
- Thinking process: Workers in this state suffer from disturbances in thought that are obvious even to a casual observer. These include an inability to communicate clearly because of slurred speech, rambling speech, primitive language, and an absence of the ability to understand the self or the nature of the problem. Such workers also show poor judgment and openly talk about delusions without recognizing them as such.
- Social behavior: People in this state are a nuisance or a danger to others. Actions might include interfering with work and other activities, shouting, sudden inappropriate bursts of profanity, carelessness about excretory functions, threatening others, and endangering others.
- Emotional control: Workers in this state cannot control their personal behavior. They might be very irritable and overactive or so depressed they become suicidal.

Class 4: Workers who belong in Class 4 usually need to be placed in a hospital or institution. Medication may help them to a certain extent. A worker belongs in Class 4 when the following is established:

- Perception: Workers become so obsessed with hallucinations, illusions, and delusions that normal self-care is not possible. Bursts of violence may occur.
- Thinking process: Communication is either very difficult or impossible. The worker is responding almost entirely to delusions, illusions, and hallucinations. Evidence of disturbed mental processes may include (but are not limited to) severe confusion, incoherence, irrelevance, refusal to speak, the creation of new words or using existing words in a new manner.
- Social behavior: The worker's personal behavior endangers both the worker and others. Poor perceptions, confused thinking, lack of emotional control, and obsessive reaction to hallucinations, illusions, and delusions produce behavior that can result in the worker being inaccessible, suicidal, openly aggressive and assaultive, or even homicidal.

- Emotional control: The worker may have either a severe emotional disturbance in which the worker is delirious and uncontrolled or extreme depression in which the worker is silent, hostile, and self-destructive. In either case, lack of control over anger and rage might result in homicidal behavior.
3. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
 4. State if exam findings are due to the compensable injury or to unrelated factors (refer to the section titled “Compensable injury” [on page 3](#)). If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Respiratory

Respiratory system: If, in your opinion, the medical record is inadequate for the diagnosis and classification of current functioning, you may (with approval from ARU) perform any more testing necessary, including methacholine inhalation testing. If the methacholine inhalation testing will leave the worker at risk, do not perform the test. When more testing can not be performed, the physician may determine the level of impairment based on review of the medical record. Use the criteria listed below for classifying permanent impairment, if any, to the respiratory system:

1. Use the following classifications to describe **lung impairment, asthma**, or both:
 - Class 1: FVC greater than or equal to 80 percent of predicted, and FEV1 greater than or equal to 80 percent of predicted, and FEV1/FVC greater than or equal to 70 percent and Dco 25 ml/(kg x min).
 - Class 2: FVC between 60 percent and 79 percent of predicted, or FEV1 between 60 percent and 79 percent of predicted, or FEV1/FVC between 60 percent and 69 percent, or Dco between 60 percent and 79 percent of predicted, or VO2 Max greater than or equal to 20 ml/(kg x min) and less than or equal to 25 ml/(kg x min).
 - Class 3: FVC between 51 percent and 59 percent of predicted, or FEV1 between 41 percent and 59 percent of predicted, or FEV1/FVC between 41 percent and 59 percent, or Dco between 41 percent and 59 percent of predicted, or VO2 Max greater than or equal to 15 ml/(kg x min) and less than 20 ml/kg x min).
 - Class 4: FVC less than or equal to 50 percent of predicted, or FEV1 less than or equal to 40 percent of predicted, of FEV1/FVC less than or equal to 40 percent, or Dco less than or equal to 40 percent of predicted, or VO2 Max less than 15 ml/(kg x min).
2. Use the following classifications to describe a recognized **air passage defects**:
 - Class 1: Dyspnea does not occur at rest. Dyspnea is not produced by walking or climbing stairs freely, performance of other usual activities of daily living, stress, prolonged exertion, hurrying, hill climbing, recreation requiring intensive effort, or similar activity.
Examination reveals one or more of the following: Partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to fourth ring), lower trachea, bronchi, or complete obstruction of the nose (bilateral), or nasopharynx.
 - Class 2: Dyspnea does not occur at rest. Dyspnea is not produced by walking freely on the level, climbing at least one flight of ordinary stairs, or the performance of other usual activities of daily living.
Dyspnea is produced by stress, prolonged exertion, hurrying, hill climbing, recreation except sedentary forms, or similar activity.
Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to fourth ring), lower trachea, bronchi; or complete obstruction of the nose (bilateral), or nasopharynx.

- Class 3: Dyspnea does not occur at rest. Dyspnea is produced by walking more than one or two blocks on the level or climbing one flight of ordinary stairs even with periods of rest; performance of other usual activities of daily living, stress, hurrying, hill-climbing, recreation, or similar activity.
Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to fourth ring), lower trachea, or bronchi.
- Class 4: Dyspnea occurs at rest, although worker is not necessarily bedridden. Dyspnea is aggravated by the performance of any of the usual activities of daily living beyond personal cleansing, dressing, grooming, or equivalent.
Examination reveals one or more of the following: partial obstruction of oropharynx, laryngopharynx, larynx, upper trachea (to fourth ring), lower trachea, or bronchi.
3. Use the following classifications to describe impaired **speech**:
- Class 1: Can produce speech of sufficient intensity and articular quality to meet most of the needs of everyday speech communication; some hesitation or slowness of speech may exist; certain phonetic units may be difficult or impossible to produce; and listeners may require the speaker to repeat.
- Class 2: Can produce speech of sufficient intensity and articular quality to meet many of the needs of everyday speech communication; speech may be discontinuous, hesitant, or slow; can be understood by a stranger but may have numerous inaccuracies; and may have difficulty being heard in loud places.
- Class 3: Can produce speech of sufficient intensity and articular quality to meet some of the needs of everyday speech communication; often consecutive speech can only be sustained for brief periods; can converse with family and friends but may not be understood by strangers; may often be asked to repeat; has difficulty being heard in loud places; and voice tires rapidly and tends to become inaudible after a few seconds.
- Class 4: Can produce speech of sufficient intensity and articular quality to meet few of the needs of everyday speech communication; consecutive speech limited to single words or short phrases; speech is labored and impracticably slow; can produce some phonetic units but may use approximations that are unintelligible or out of context; and may be able to whisper audibly, but has no voice.
- Class 5: Complete inability to meet the need of everyday speech communication.
4. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
5. State if exam findings are due to the compensable injury or to unrelated factors (refer to the section titled "Compensable injury" [on page 3](#)). If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled "Apportionment" and "Pre-existing conditions" [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Shoulders

1. Provide the following six active (unassisted) **ranges of motion** of both shoulders expressed in retained degrees: forward elevation, backward elevation, abduction, adduction, internal rotation (with arm in abduction), and external rotation.
2. Determine if the contralateral joint has a previous history of injury or disease.
3. If the conditions have resulted in **ankylosis** of the joint, provide the plane of motion (flexion) and the angle degree of fixation.
4. Describe any muscle **strength loss** in the 0-5/5 method (see table). Identify the muscles that have valid diminished strength, the peripheral nerves and, if applicable, the nerve root innervating the muscles. Explain the etiology in detail and provide a contralateral comparison. (Do not provide only the "motion," e.g., flexion, extension.)

0 - 5/5 Muscle Grading:

5/5 = Retains range of motion against gravity with full resistance applied.

- 4/5 = Retains range of motion against gravity with some resistance applied.
 3/5 = Retains range of motion against gravity without resistance applied.
 2/5 = Retains range of motion with gravity, but has to have help.
 1/5 = Slight muscle contractility, no joint motion.
 0/5 = No muscle contractility.

5. Specify if, because of a permanent and chronic condition caused by the compensable injury, the worker is unable to repetitively use the **shoulders** for more than two-thirds of a period of time. If so, identify the specific body parts involved.
6. If applicable, describe any chronic **shoulder dislocations** that necessitate a reduction in the strength/lifting capabilities of the worker as compared to the job-at-injury capabilities.
7. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
8. State if exam findings are due to the compensable injury or to unrelated factors (refer to the section titled "Compensable injury" [on page 3](#)). If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled "Apportionment" and "Pre-existing conditions" [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Spine

1. Provide active (unassisted) **ranges of motion** in the following body parts, as measured by inclinometer in accordance with Bulletin 239, expressed in retained degrees of:
 - True **cervical** flexion and extension, right/left lateral flexion, and right/left rotation. Complete and return the form.
 - True **thoracic** flexion and right/left rotation. Complete and return the form.
 - True **lumbar** flexion, extension, and right/left lateral flexion. Complete and return the form.
2. Describe any muscle **strength loss** in the 0-5/5 method (see table). Identify the muscles that have valid diminished strength, the peripheral nerves, and, if applicable, the nerve root innervating the muscles. Explain the etiology in detail and provide a contralateral comparison. (Do not provide only the "motion," e.g., flexion, extension.)

0 - 5/5 Muscle Grading:

- 5/5 = Retains range of motion against gravity with full resistance applied.
 4/5 = Retains range of motion against gravity with some resistance applied.
 3/5 = Retains range of motion against gravity without resistance applied.
 2/5 = Retains range of motion with gravity, but has to have assistance.
 1/5 = Slight muscle contractility, no joint motion.
 0/5 = No muscle contractility.

3. Describe **sensation** in the palmar surface of the **hands, thumbs, and fingers** based upon two-point discrimination measured in mm, with identification of the specific nerve root injured.
4. Describe **sensation loss** in the plantar surface of the feet described as either partial or total due to nerve root injury.
5. Describe **spinal fractures** using the following guidelines:
 - For compression fractures, identify each fractured vertebral body and provide the percentage of compression.
 - For fractures to the posterior elements, identify each vertebra affected and the fracture site (spinous process, pedicles, laminae articular processes, or transverse processes).
6. Specify if, because of a permanent and chronic condition caused by the compensable injury, the worker is unable to repetitively use the **spinal area** for more than two-thirds of a period of time. If so, identify the specific body regions (cervical, thoracic, or lumbar spine) involved.

7. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards; include anatomic findings, if applicable.
8. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Upper Extremities

1. Provide active (unassisted) **ranges of motion** in the following body parts expressed in retained degrees of:
 - Flexion and extension of the interphalangeal and metacarpophalangeal joints, and flexion and extension of the carpometacarpal joints of both **thumbs**. Complete and return the form.
 - Flexion and extension in the DIP, PIP, and MP joints of the **fingers**, including contralateral joints. Complete and return the form.
 - Dorsiflexion, palmar flexion, and radial and ulnar deviation of both **wrists**. Complete and return the form.
 - Flexion, extension, pronation, and supination of both **elbows**. Complete and return the form.
2. If the conditions have resulted in **ankylosis** of the joint, provide the plane motion (flexion) and the angle degree of fixation.
3. Describe any rotational, lateral, dorsal, or palmar **deformity** of the **fingers** and fully explain the etiology.
4. Determine whether the **contralateral** joint has a previous history of injury or disease.
5. Describe any muscle **strength loss** in the 0-5/5 method (see table below). Identify the muscles that have valid diminished strength, the peripheral nerves, and, if applicable, the nerve root innervating the muscles. Explain the etiology in detail and provide a contralateral comparison. (Do not provide only the “motion,” e.g., flexion, extension.)

0 - 5/5 Muscle Grading:

 - 5/5 = Retains range of motion against gravity with full resistance applied.
 - 4/5 = Retains range of motion against gravity with some resistance applied.
 - 3/5 = Retains range of motion against gravity without resistance applied.
 - 2/5 = Retains range of motion with gravity, but has to have assistance.
 - 1/5 = Slight muscle contractility, no joint motion.
 - 0/5 = No muscle contractility.
6. Specify if any **strength loss** is due to a loss in range of motion. If so, explain your rationale.
7. Describe **sensation** in the palmar surface of the **hands** and **fingers** based upon two-point discrimination measured in mm, with identification of the specific nerves (ulnar or median) injured. Complete and return the form.
8. Specify if there is any **hypersensitivity** resulting in a loss of use in the **digits** or **palm**. If so, identify the specific body parts involved and describe the loss as mild, moderate, or severe.
9. Specify if, because of a permanent and chronic condition caused by the compensable injury, the worker is unable to repetitively use the **hand**, **wrist/forearm**, or **arm** for more than two-thirds of a period of time. If so, identify the specific body parts involved.
10. Using the following classifications, describe any **upper extremity dermatological** findings that may or may not show signs or symptoms of skin disorder upon examination and:
 - Class 1: Treatment results in no more than minimal limitations in the performance of the activities of daily living, although exposure to physical or chemical agents may temporarily increase limitations.
 - Class 2: Requires intermittent treatments and prescribed examinations and the worker has some limitations in the performance of activities of daily living.
 - Class 3: Requires regularly prescribed examinations, continuous treatments, and the worker has many limitations in the performance of activities of daily living.

- Class 4: Continuous prescribed treatments are required. The treatment may include periodically having the worker stay home or admitting the worker to a care facility, and the worker has many limitations in the performance of activities of daily living.
- Class 5: Continuous prescribed treatment is required. The treatment necessitates having the worker stay home or being permanently admitted to a care facility, and the worker has severe limitations in the performance of activities of daily living.
11. Describe any **upper extremity vascular** impairment findings using the following classifications when the worker experiences:
- (NOTE: More questions specific to cold intolerance follow this classification.)
- Class 1: Only transient edema; and on physical examination, the findings are limited to the following: loss of pulses, minimal loss of subcutaneous tissue of fingertips, calcification of arteries as detected by radiographic examination, asymptomatic dilation of arteries or veins (not requiring surgery and not resulting in curtailment of activity), or cold intolerance (Raynaud's phenomenon) that results in a loss of use or function that occurs with exposure to temperatures below freezing (0° Centigrade).
- Class 2: Intermittent pain with repetitive exertional activity; or there is persistent moderate edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed stump of an amputated digit, with evidence of persistent vascular disease, or a healed ulcer; or cold intolerance (Raynaud's phenomenon) that results in a loss of use or function that occurs on exposure to temperatures below 4° Centigrade.
- Class 3: Intermittent pain with moderate upper extremity usage; or there is marked edema incompletely controlled by elastic supports; or there are signs of vascular damage such as a healed amputation of two or more digits, with evidence of persistent vascular disease, or superficial ulceration; or cold intolerance (Raynaud's phenomenon) that results in a loss of use or function that occurs on exposure to temperatures below 10° Centigrade.
- Class 4: Intermittent pain upon mild upper extremity usage; or there is marked edema that cannot be controlled by elastic supports; or there are signs of vascular damage such as an amputation at or above the wrist, with evidence of persistent vascular disease, or persistent widespread or deep ulceration involving one extremity; or cold intolerance (Raynaud's phenomenon) that results in a loss of use or function that occurs on exposure to temperatures below 15° Centigrade.
- Class 5: Constant and severe pain at rest; or there are signs of vascular damage involving more than one extremity such as amputation at or above the wrist, or amputation of all digits involving more than one extremity with evidence of persistent vascular disease, or persistent widespread deep ulceration involving more than one extremity; or cold intolerance such as Raynaud's phenomenon that results in a loss of use or function that occurs on exposure to temperatures below 20° Centigrade.
12. Using the following questions, describe any **cold intolerance** resulting from the compensable injury.
- Does the cold intolerance result in a loss of use or function?
 - What is the approximate temperature or the above-referenced class at which the cold intolerance produces the loss of use or function?
 - What are the specific body parts that are affected by the cold intolerance (whole hand or fingers)?
- NOTE:** Cold intolerance due to **neurological dysfunction** should be described using the same vascular classification presented above.
13. Describe the specific level of **amputation** using one of the following descriptors. Complete and return the form.
- Thumb**
- Significant tissue loss only (no bone)
 - Bone loss to mid-shaft of distal phalanx
 - Bone loss mid-shaft of distal phalanx to head of proximal phalanx
 - Bone loss proximal to head of proximal phalanx
- Fingers**
- Significant tissue loss only (no bone)

-
- Bone loss to mid-shaft of distal phalanx
 - Bone loss mid-shaft of distal phalanx to distal epiphysis of middle phalanx
 - Bone loss distal epiphysis of middle phalanx to mid-shaft of middle phalanx
 - Bone loss mid-shaft of middle phalanx to distal epiphysis of proximal phalanx
 - Bone loss proximal to distal epiphysis of proximal phalanx
14. Describe any arm **length discrepancy** in inches.
 15. Describe any increased **lateral deviation** at or above the elbow, with the elbow in maximum active extension, expressed in degrees. Specify if fracture has resulted in **angulation** or **malalignment** other than at or above the elbow.
 16. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
 17. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Vision

1. Perform a complete ophthalmological evaluation and report any objective permanent impairment resulting from the compensable injury, including:
 - A. Central visual acuity for distant and near vision, with best correction, as follows:
 - Distance acuity in standard increments of Snellen notation for English or Metric 6.
 - Near acuity in standard increments of Snellen 14/14 notation, Revised Jaeger Standard, or American Point-type notation.
 - B. Integrity of peripheral visual fields based upon the results of field measurements of each eye separately, using the Goldmann perimeter with a III/4e stimulus. Report the results on either of the following:
 - A monocular Esterman Grid
 - A perimetric chart, which indicates the extent of retained vision for each of the eight standard 45-degree meridians
 - C. Impairment due to abnormal ocular motility resulting in **binocular diplopia**, reported in degrees along the standard eight 45-degree meridians.
2. When **stereopsis** (depth perception), **glare disturbance** (photophobia), or **monocular diplopia** impair visual function, identify the cause, and opine if the effect on function is moderate or severe.
3. If the **lacrimal (tearing) disturbance** restricts the worker from doing regular work, describe the restriction using one of the following:
 - Reaction is a nuisance
 - Prevents some work-related activities
 - Prevents most work-related activities
4. Indicate if the findings are valid for the purposes of rating impairment. If any findings are considered invalid, provide your detailed and specific reasoning in accordance with Bulletin 239 and the Disability Rating Standards.
5. State if exam findings are due to the compensable injury (refer to the section titled “Compensable injury” [on page 3](#)) or to unrelated factors. If exam findings are due, in part, to factors other than the compensable injury, address apportionment and pre-existing conditions as described in the case-specific questions posed by ARU (refer to the sections titled “Apportionment” and “Pre-existing conditions” [on page 8](#)). Provide detailed and specific reasoning for your apportionment determinations.

Sample Forms

Arbiter report format example

Please use the format below to organize your arbiter report. It can also serve as a checklist for the arbiter physician to use while the examination is in progress to ensure none of the pertinent data has been overlooked.

[Date]

Workers' Compensation Division
Resolution Section
Appellate Review Unit
350 Winter St. NE
P.O. Box 14880
Salem, OR 97309-0405

Medical Arbiter Report

RE: Worker:

WCD No:

Date of Injury:

Claim No:

Dear [name of appellate review specialist from the appointment notice],

The worker referenced above was referred by the Workers' Compensation Division for an impartial medical arbiter examination. The examination performed on [date] by [name of physician(s)] focused on impairment findings. Dr. [name] dictated this report. The medical records provided by the Appellate Review Unit were reviewed before this examination. No patient/doctor relationship was sought or established.

Accepted conditions: Noted at the top of the medical arbiter questions document.

Denied conditions: Noted at the top of the medical arbiter questions document.

Current medical status: Include any intervening incident since claim closure.

History of the compensable injury: Briefly address the history of the injury, diagnosis, treatment, outcome, etc.

Past medical history: Summarize the medical history, prior to the compensable injury, that has an effect on the examination findings.

Work status: Working or not, job-at-injury or modified, etc.

Description of clinical exam: List all examination tests performed and their results.

Examination findings: Answer all questions from the ARU and include any findings that in your medical opinion are due to the compensable injury.

Direct medical sequela: Per the medical record, identify and clearly describe sequela due to accepted conditions. Describe relationship to accepted condition.

Impression/discussion: Clearly describe impairment due to the compensable injury. Opinions, validity, etc. If a finding is invalid, specifically outline your medical reasoning.

[Signature]

cc: [Worker or worker's attorney (if applicable) and address]
[Insurer and insurer's attorney (if applicable) and address]

Conflict of Interest Disclosure Statement

Worker:
Claim No:
Date of Exam:

WCD No:
Date of Injury:
Time of Exam:

Prior to commencing the exam, please read and complete the following statement to the best of your knowledge. If you are aware of any conflict of interest that would preclude you from conducting an impartial examination of this worker, do not proceed with the examination. If you do not proceed with the examination, call the Appellate Service Team at 503-947-7816, for rescheduling of the examination with another physician. If you do proceed with the examination, please complete the statement below and return with your medical arbiter report. Thank you for your close attention to this matter.

I hereby affirm the following:

I have reviewed the medical record and other material provided by the Oregon Workers' Compensation Division regarding the worker referred to me for an impartial medical arbiter examination.

To the best of my knowledge, I am not acquainted with nor have I examined or treated this worker.

To the best of my knowledge, I am not aware of any conflict of interest, financial or otherwise, that would preclude me from conducting an impartial arbiter examination of this worker.

_____ Date: _____
(Physician Signature)

cc:

Medical Arbiter Examination Appointment Notice**WCD No:****Ins. Claim No:**

The Workers' Compensation Division, Appellate Review Unit, has scheduled a Medical Arbiter Examination for you with Dr. on:

Date:
Time:
Place:

Phone No: (for directions only)

For travel expenses, contact directly.

This examination has been requested as part of the reconsideration of your claim closure. We have chosen an impartial physician to examine you and describe any permanent disability due to your compensable injury. The arbiter's opinion will be considered in the review process.

It is very important that you keep this appointment and that you be on time. If you have previously seen this doctor, can't keep this appointment or have any other questions about the appointment, contact immediately at the number listed below. Failure to attend this examination or to cooperate with the physician will result in suspension of all disability benefits unless a "good cause" reason for missing the examination is established. You must contact within 24 hours if you don't attend the scheduled arbiter examination.

For appointment questions call .

For questions about your reconsideration call .

cc:

Billing Instructions

RE: Worker:
Claim No:
Date of Exam:

WCD No:
Date of Injury:
Time of Exam:

Fill out the CMS-1500 form using the appropriate Oregon Specific Codes and fees specific to this claim including the ICD-10-CM code Z02.9, pursuant to OAR 436-009-0010(3):

Exam Fee:	Code:
Report Fee:	Code:
Review of File:	Code:

Within 5 working days send the original arbiter report to:

Department of Consumer & Business Services
 Workers' Compensation Division, Resolution Section
 PO Box 14480, Salem, OR 97309-0405
 Attn: Appellate Service Team

At the same time, send copies of the arbiter report to the worker, worker's representative, insurer and the insurer's representative pursuant to OAR 436-030-0165. See addresses listed below. Additional copies of the physician's report are to be billed under Oregon specific code R0001. The charge is \$10.00 for the first page and \$.50 for each page thereafter. Send your bill directly to .

If the worker does not show for the examination please call me immediately. When the worker fails to appear for a medical arbiter examination, or if the appointment is canceled without providing at least 48 hours notice, each selected physician shall receive 50% of the examination fee.

If additional diagnostic tests are required, the costs of these test(s) shall be reimbursed in accordance with the fee schedule.

Contact information: Fax 503-947-7555

cc: