Ohio | Industrial Commission

MEDICAL EXAMINATION MANUAL

Effective 09/10/19

MEDICAL EXAMINATION
MANUAL

Our mission is to serve the injured workers and the Ohio employers through expeditious and impartial resolution of issues arising from workers' compensation claims and through establishment of adjudication policy.

Mike DeWine
GOVERNOR

Jim Hughes
CHAIRMAN

Jodie M. Taylor
MEMBER

Karen L. Gillmor. Ph.D.
MEMBER

Table of Contents

GENERAL CONSIDERATIONS

Legal Considerations 4
- Injury
- Allowed Condition(s)
- Impairment
- Disability
- Independent Medical Examination
- Addenda
- Interrogatories
- Depositions
- File Reviews
- Medical Examinations

Independent Medical Examination Considerations 7
- Specialists
- Administrative Agents
- Acceptance of Allowed Condition(s)
- Causation
- Review of Pertinent Medical Records
- Clinical Findings
- Maximum Medical Improvement
- *AMA Guides*
- Whole Person Impairment
- Functional Limitations

Ethical Considerations 9
- Confidentiality
- Disclosure
- Maintenance of Medical Records

Administrative Policies 10
- Legal Status
- Examination Observers
- Recording Examinations
- Interpreter
- Chaperone
- Impartiality
- Ex Parte Communication
- Examination Requirements
- Timeliness Reporting

Examination Scheduling 12

Table of Contents

Billing Procedures 13

Independent Medical Examination & File Review Fees

Out-of-State

Cancel & No Show Fees

Fees for Addenda, Interrogatories, & Depostions

Allowed Diagnostic Testing

Submitting a Fee Bill

Directory of Commission Offices 16

EXAMINATIONS BY BODY SYSTEMS

Musculoskeletal, Cardiovascular, Respiratory, Central and Peripheral Nervous System

Multiple Claim Musculoskeletal/Neurological System

Examination Reporting Format Instructions 18

Report Example 22

One Claim Cardiovascular System

Report Example 27

Oral and Maxillofacial

Examination Reporting Format Instructions 36

Report Example 39

Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region, published by the American Association of Oral and Maxillofacial Surgeons, 2002 43

Mental and Behavioral

Examination Reporting Format Instructions 58

Methodology 62

Report Example 63

The Visual System

Examination Reporting Format Instructions 72

Methodology 75

Report Example 76

Ear, Nose, and Throat

Examination Reporting Format Instructions 82

Methodology 85

Report Example 86

APPENDIX

Medical Examination Referral Letter 92

Medical Exam Worksheet 94

Statement of Facts 95

Appropriate Assessment Forms 98

IC Provider Fee Bill 101

Permanent Total Disability Application 102

The Ohio Workers' Compensation System has provided Injured Workers with medical care and financial compensation for work-related injuries, diseases, and deaths since 1913. The Bureau of Workers' Compensation is the administrative branch of this system, managing claims, collecting employer premiums, and paying bills. The Ohio Industrial Commission (Commission) is the adjudicatory branch of this system. The Commission is responsible for providing a forum for fair and impartial claims resolution, conducting hearings on disputed claims and issues, adjudicating claims involving Employers' violations of specific safety requirements and determining eligibility for Permanent Total Disability benefits.

This Manual presents Commission policies for independent medical examinations and medical file reviews. The purpose of the independent medical examination is to determine the degree of functional impairment resulting from an allowed work injury. The Commission's Medical Examination Manual was developed as a source of information to assist specialists in writing reports that are fair, unbiased, objective, and credible. To meet Commission requirements, the reports must be medically sufficient and legally reliable.

To function effectively as a specialist performing Commission independent medical examinations, it is necessary to understand the medical and legal requirements. Key resources are Bureau of Workers' Compensation and Commission laws, rules, and statutes. Understanding these parameters is essential in adequately performing and appropriately responding to questions posed in Permanent Total Disability independent medical examinations and/or medical file reviews.

Most examinations are to assist the Commission in the consideration of Permanent Total Disability.
The specialist's role in the examination is to determine the Injured Worker's functional impairment from the allowed conditions and how it affects work activities. The Commission's role is to make a legal determination on disability based on Ohio law.

The first section of the manual explains administrative and examination policies common to all Commission independent medical examinations and medical file reviews. The remaining five (5) sections of the manual describe specific examination and report requirements for evaluating various body parts, regions, or organ systems affected by an industrial injury or disease, and specialty specific instructional sample reports.

We encourage specialists and other interested parties to share ideas they believe may improve the system. Contact Medical Services with any questions.

GENERAL CONSIDERATIONS

Legal Considerations

Independent Medical Examination Considerations

Ethical Considerations

Administration Policies

Examination Scheduling

Billing Procedures

Directory of Commission Offices

LEGAL CONSIDERATIONS

Injury

Ohio Workers' Compensation law states, for injuries occurring on or after August 25, 2006,

" 'Injury' includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. 'Injury' does not include:

1. Psychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate.

2. Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of a body.

3. Injury or disability incurred in voluntary participation in an employer sponsored recreation or fitness activity if The employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity.

4. A condition that pre-existed an injury unless that pre-existing condition is substantially aggravated by the injury. Such a substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. Subjective complaints may be evidence of such a substantial aggravation. However, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation."

For injuries occurring prior to August 25, 2006,

'Injury' includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. 'Injury' does not include:

1. Psychiatric conditions except where the conditions have arisen from an injury or an occupational disease.

2. Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of a body.

3. Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreational or fitness activity."

Allowed Condition(s)

Industrial injuries become allowed conditions in workers' compensation claims as follows: When an injury occurs, a first report of injury (FROI-1) is filed with the Bureau of Workers' Compensation. The Bureau of Workers' Compensation reviews accident reports from the Injured Worker and the Employer as well as the medical treatment information, and allows or denies the claim within 28 days. When approved, the allowed condition becomes the legal basis for the Injured Worker's claim for compensation.

There may be multiple allowed conditions in one claim and multiple claims for one worker.

Impairment

The Ohio Courts define impairment as, "the amount of the Injured Worker's anatomical and/or mental loss of function caused by the allowed condition." An impairment rating is a medical opinion given by the specialist to assist in the determination of disability. It is the responsibility of the specialist in Permanent Total Disability independent medical examinations and/or file reviews to provide an estimated percentage of whole person impairment arising from the allowed conditions in the claim, and to provide a discussion setting forth the physical or mental limitations resulting from the allowed conditions. All medical opinions must be supported by objective evidence to assist the adjudicator in the final legal determination.

Disability

The Ohio Courts define disability as "the effect the impairment has on the claimant's ability to work," based on the allowed conditions in the claim. Disability is a legal determination and is made only by the Ohio Courts or the Commission via the hearing process. The Commission considers impairment arising from the allowed conditions, and non-medical disability factors (age, education and work training/experience) in determining Permanent Total Disability. Non-medical disability factors are not to be considered by the specialist when formulating opinions regarding percentage of impairment or physical or mental limitations resulting from the allowed conditions. Considering non-medical disability factors and/or impairments resulting from non-allowed conditions will disqualify the report.

Independent Medical Examination

An independent medical examination is an impartial, fair, unbiased medical examination. An independent medical examination is based on objective evidence and should stand up to scrutiny at the hearing. The independent medical examination provides the Commission with expert medical opinions to assist with Permanent Total Disability and other adjudicator determinations. Specifically for the issue of Permanent Total Disability, the purpose of the independent medical examination is to evaluate whether the allowed condition(s) have reached a level of maximum medical improvement, as well as, to determine if and how much impairment has resulted from that condition(s). Commission independent medical examination referrals are on a one-time fee-for-service basis.

Addenda

In circumstances where additional information becomes available after the time of an examination, the specialist may be requested to provide an addendum to the original report. Specialists may charge for time spent preparing these addenda.

Reasons for addenda completion at no cost:

- The specialist submitted an incomplete report;
- There was illegible hand written documentation on the assessment form (PSR/OAA/RFA); or
- The specialist failed to adequately address all questions posed in the referral letter.

Interrogatories

Interrogatories are written questions submitted to specialists by Injured Worker and/or Employer legal representative(s) and must be answered. Interrogatories must be submitted to the Commission for approval. Specialists may charge for time spent preparing their response.

Depositions

Parties to the claim must request Commission approval to schedule a specialist deposition on the associated independent medical examination. The party requesting this administrative deposition must state the reason for the deposition and must pay all deposition costs, including a fee to the specialist who is to be deposed. The requesting party must also provide an estimate of the time period required for deposition. Commission policy prohibits pre-deposition conference between the specialist and any party to the claim.

A Commission Hearing Officer attends administrative depositions held in Ohio. This hearing officer controls the deposition by determining the appropriateness of questions and whether the specialist must answer. However, this hearing officer does not represent the specialist in the deposition.

When a claim is pending in court, administrative deposition rules no longer apply. In a court deposition, civil rules of procedure and of evidence apply.

File Reviews

The Ohio Supreme Court has held that "a physician who reviews the medical record, without conducting an examination of the Injured Worker, is required to expressly accept all allowed conditions and the clinical findings of the examining physicians, but not necessarily the opinion drawn therefrom." The Ohio Supreme Court also requires a reviewing specialist to consider and note all medical reports on record that may be considered relevant to the review issue. For these reasons, specialists must:

- indicate all examination reports considered in their review;
- expressly accept the findings reported by examiners; and
- review all available relevant medical records.

File reviews may be requested when an Injured Worker is incapable of travel, deceased, or has other special circumstances. Similar to the independent medical examination, specialists should provide an unbiased medical opinion on the allowed condition(s) in the claim only and the questions posed.

Commission file review referrals are on a one-time fee-for-service basis.

Medical Examinations

The Commission may require examinations on the following issues:

1. Original or additional allowance
2. Extent of disability – Temporary Total Disability and/or Permanent Total Disability
3. Amount of permanent partial disability due to amputation or loss of use as indicated in the referral letter
4. Determine permanent partial disability

Questions regarding cause of death and additional allowance requests sometimes require file reviews.

Due to the special nature of these examinations, reimbursement will be determined by Medical Services at the time of referral.

INDEPENDENT MEDICAL EXAMINATION CONSIDERATIONS

Specialists

A Commission approved specialist is well experienced in their field of practice. Specialists should have no bias in regards to the Injured Worker, Employer or the Bureau of Workers' Compensation.

Administrative Agents

Specialists can elect to designate an administrative agent to perform administrative functions on their behalf such as transcription, office space, scheduling, and attendants. The Commission has no contractual relationship with administrative agents.

Acceptance of Allowed Condition(s)

As previously mentioned, allowed condition(s) are the legal basis of each claim. It is essential to the legal integrity of an independent medical examination that specialists accept the allowed condition(s) in the claim. That is, the specialist should not question the validity of the allowed condition(s).

Specialists must base opinions solely on impairment arising from the allowed condition(s) underlined on the Commission - Medical Exam Worksheet. Specialists may not state there is no evidence of the allowed condition(s). This statement constitutes a denial of an allowed condition(s) and may disqualify the examination as "some evidence" at hearing or in court.

If current examination findings fail to confirm the presence of an allowed condition(s), specialists should state *there is no evidence of impairment from the allowed condition(s)* ***at the time of this examination.***

Causation

Do not express opinions on causation unless specifically asked to do so. Opinions implying or stating the industrial accident or exposure did not or could not cause the allowed condition(s) will disqualify the report as evidence at hearing.

Review of Pertinent Medical Records

The specialist is required to review pertinent medical records such as treatment(s), diagnostic testing, and examinations 36 months prior to the Injured Worker's application for Permanent Total Disability. In some cases, this review may not be adequate and additional records may be required. Contact Medical Services to provide any additional records.

It is possible the Injured Worker may hand carry documentation into the examination. Do not accept and/or review these documents.

Clinical Findings

Reports must present the objective clinical findings to support the specialist's opinion. These findings "shall be of sufficient quantity that they will hold true in fifty-one percent or more of similar cases."

Possibilities are not acceptable as clinical findings as they are true less than fifty percent of the time.

Maximum Medical Improvement

A Commission independent medical examination report may require a maximum medical improvement opinion as part of answers to the specific questions posed in the referral letter. Maximum medical improvement is a treatment plateau (static or well stabilized) where no fundamental or physiological change can be expected within reasonable probability,

in spite of continuing medical or rehabilitative procedures. An Injured Worker may require supportive treatment to maintain this level of function.

American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides)

Specialists performing Permanent Total Disability independent medical examinations must document references to the appropriate *AMA Guides* (see below), including citations to specific tables, figures and/or page numbers to assist reviewers in understanding the justification for the impairment rating. If conditions or associated body parts are identified that are NOT allowed within the claim, limit the impairment percentage to the best estimate of the allowed condition(s) only. State in the report if there are additional medical conditions or diagnoses that are not recognized as allowed in the claim and are NOT taken into consideration in the final opinion.

The following table summarizes the appropriate references for Commission independent medical examinations by specialty:

Specialty Description	*AMA Guides* Edition
Internal Medicine	Fifth
Neurology	Fifth
Occupational Medicine	Fifth
Orthopedics	Fifth
Physical Medicine & Rehab	Fifth
Psychiatry/Psychology	Fifth
Pulmonary Disease	Fifth
Neuropsychologist	Fifth
Cardiovascular Disease	Fifth
Dental Surgery	AAOMS*
Dermatology	Fifth
Otorhinolaryngology	Fifth
Gastroenterology	Fifth

Specialty Description	*AMA Guides* Edition
Ophthalmology	Fourth
Rheumatology	Fifth
Urology	Fifth
Allergy	Fifth
Endocrinology	Fifth
Maxillofacial Surgery	AAOMS*
Oncology	Fifth
Vascular Surgery	Fifth
Anesthesiology	Fifth
Gynecology	Fifth
Plastic Surgery	Fifth
General Surgery	Fifth

* *American Association of Oral and Maxillofacial Surgeons' Guidelines to the Evaluation of Impairment of the Oral and Maxillofascial Region*, 2002

Whole Person Impairment

A Commission independent medical examination report may require a whole person impairment opinion as part of answers to the specific questions posed in the referral letter. A whole person impairment is a percentage that estimates the impact of impairment on the Injured Worker's overall ability to perform activities of daily living, excluding work stemming from the allowed condition(s) associated with the claim(s). These impairments are standardized through the use of the *AMA Guides*.

Functional Limitations

A Commission independent medical examination report must present an opinion of the Injured Worker's functional limitations as part of answers to the specific questions posed in the referral letter. Functional limitations represent an Injured Worker's inability to completely perform a task due to the impairment associated with the allowed condition(s) in the claim(s). In some instances, functional limitations may be overcome through modification in the Injured Worker's personal or environmental accommodations.

ETHICAL CONSIDERATIONS

Confidentiality

The Commission defines confidential personal information (CPI) as personal information that is not a public record. Pursuant to R.C. 4123.88, records contained in a claim file and any information identifying the addresses or telephone numbers of Injured Workers are not public records. Improper use or invalid access is defined as access or use that is not for a valid business reason, which is any reason that reflects the execution of one's job duties for the Commission.

Specialists must adhere to the laws pertaining to confidentiality of medical information and professional standards of conduct. Any improper use or access of the Commission's information by a specialist, their administrative agent and/or designee will result in termination of the specialist's access.

The Commission has established prudent privacy practices to protect Injured Workers' CPI. Specialists should not send Injured Workers' names, Injured Workers' claim number(s) with their name, or sensitive medical information over the internet without additional security or encrypting. The Commission has adopted the use of ZixMail to make it possible for secure messaging. Please contact Medical Services for further guidance and/or written instructions.

Specialists may also use the Industrial Commission Online Network (ICON) as a secure method of uploading independent medical examination reports. Specialists will need to establish provider log-ins to ICON. For further questions about confidentiality information or log-in instructions, contact Medical Services or the Commission IT Help Desk.

Disclosure

Specialists or their designated agents shall protect the CPI of the Injured Worker. Specialists shall only disclose confidential claim information in the report to the Commission. The Commission shall distribute the report to all entitled parties to the claim in accordance with confidentiality provisions stated above.

Maintenance of Medical Records

The Commission holds specialists responsible for the methods in which they maintain and destroy Injured Workers' medical records. It is important that specialists adhere to the following:

- Specialists are responsible for their staff or other administrative agents including, but not limited to, secure handling, proper maintenance, utilization and destruction of all claim documents whether provided by the Commission or generated by the specialists' offices or agents;
- Specialists are responsible and liable for costs incurred by the Commission as a result of any loss, misuse, or improper destruction of such claim records by the specialists, their staff, or administrative agents;
- Specialists must maintain a copy of independent medical examination reports submitted to the Commission, as well as, associated documentation for a period of one (1) year following the approval of and payment for final reports. Records may be retained electronically or as a hardcopy, as long as, it is accessible and maintained in a safe, secure manner; and
- Specialists must properly dispose of documents in a safe, secure manner.

ADMINISTRATIVE POLICIES

Legal Status

Specialists are independent contractors. Referral for medical review or examination represents a single fee-for-service commitment for the Commission and the specialist. The Commission requires specialist maintain professional liability insurance with $1 million per incident and $1 million annual aggregate.

Examination Observers

Specialists may allow Injured Workers to have a relative present during the examination. The relative must quietly observe, avoid interference with the examination and cooperate with the specialist. The specialist may ask the relative for additional information if needed. Legal representatives may not be present at or during examinations.

Recording Examinations

Electronic recording equipment and cell phones are not permitted in the examination room.

Interpreter

The Commission shall provide interpreters on request when a hearing impairment or language barrier exists at no cost to the Injured Worker or the specialist. A family member is not considered a reliable interpreter. At the time of examination, the Injured Worker or the specialist shall request to reschedule in the absence of a necessary interpreter. Contact Medical Services for further information regarding interpreters.

Chaperone

Examinations should be conducted with a chaperone present when appropriate.

Impartiality

Examinations are to be performed by specialists with no bias or conflict of interest with respect to the Injured Worker, the Employer, or the workers' compensation system.

Specialists are excluded from performing independent medical examinations when they have examined the Injured Worker or reviewed the claim file for the Employer, the Injured Worker, the Bureau of Workers' Compensation or the Industrial Commission within three years of the filing date of an application for Permanent Total Disability. Specialists are also excluded from performing independent medical examinations when one of the following occurs:

- The specialist has a contractual relationship with the Injured Worker, Employer, and/or their representative(s);
- The specialist has been the physician of record for the Injured Worker; or
- The specialist routinely shares patients within the practice of the physician of record.

A specialist who does not meet the impartiality requirements shall decline to examine the Injured Worker. The Injured Worker will then be rescheduled with an impartial specialist. If the specialist has concerns regarding impartiality, contact Medical Services.

No authorization for treatment of the Injured Worker is implied or given in the Commission's request for examinations. The specialist may not accept the examined Injured Worker into treatment.

Ex Parte (Outside) Communication

Communication outside of the examination is not allowed. Specialists performing examinations for the Commission may not communicate with the Injured Worker other than during the examination. The specialist shall NOT respond to written or verbal communication prior to or following the examination with any of the following:

- The Employer(s) and/or their representative(s);
- The Bureau of Workers' Compensation; and/or
- The Injured Worker and/or their representative(s).

After the examination, please direct any written or verbal communication to Medical Services.

Examination Requirements

The Commission's expectation is that all independent medical examinations are conducted by the most appropriately qualified specialist. Medical Services has established a specialty selection process to direct this expectation. The specialist will receive documentation regarding the allowed condition(s) assigned to their specialty. If concerns regarding specialty selection arise, contact Medical Services immediately.

The examination location must be safe, clean, comfortable and permanent. It must be in compliance with ADA requirements. Unsatisfactory sites include, but are not limited to, mobile vehicles, hotels or motels. Medical Services reserves the right to do a facility site check.

Timeliness of Reporting

In consideration for all parties involved, reports are due within ten (10) business days of the examination. Statutory deadlines must be met by the Commission. If you are unable to meet this deadline, notify Medical Services immediately. Late reports may result in suspension or dismissal from the specialists' panel.

EXAMINATION SCHEDULING

Medical Services is responsible for all scheduling and rescheduling of independent medical examinations. Please direct questions to Medical Scheduling. The Injured Worker is given a two (2) weeks' notice of examination appointments. To allow specialists time to prepare for the examination, the Commission provides secure electronic access through ICON. All pertinent medical records will be available from the time of exam notice mailing until the final report is published. If you do not have electronic access or are having problems accessing the medical records in a claim, contact the Commission's IT HelpDesk for assistance.

The following information is sent to specialists prior to examination:

- **Medical Examination Referral Letter** states the examination issue and Commission requirements.
- **Medical Exam Worksheet** specifies the underlined allowed conditions in the claim to be addressed by the specialist. In addition, treating, examining, or reviewing physicians are listed, enabling the assigned specialist to determine whether impartiality conflicts exist.
- **Statement of Facts** provides a comprehensive summary of claim data.
- **Appropriate Assessment Form (Physical Strength Rating, Occupational Activity Assessment, Residual Function Assessment)** provides established Commission work categories. This form should correlate with the final opinion on functional limitation(s) stated in the report.
- **IC Provider Fee Bill** provides appropriate billing information for the service(s) provided.

Examples of the above mentioned Commission documents, as well as, the Permanent Total Disability Application are shown in the Appendix.

Additional evidence can be located on ICON. For access to this information, detailed instructions are found at www.ic.ohio.gov. Click "Medical Specialist Resources," then "Electronic Record Access." The Commission produced Specialist Packet is located on ICON and may also be mailed in special circumstances. Please contact the Industrial Commission Help Desk if assistance is needed.

BILLING PROCEDURES

Independent Medical Examination & File Review Fees

The **in-state** Permanent Total Disability independent medical examination fee schedule is set forth by Ohio Industrial Commission resolution.

Out-of-state examination fees are negotiated and based on usual, customary, and reasonable fees for that state depending on the availability, specialty, need, and distance of travel by the Injured Worker.

Evaluation fees include: examination, document review, and the completed final report.

Specialists must immediately notify Medical Services of any changes to enrollment status, billing or office locations to ensure proper payment of fees. Therefore, if any examinations are to be scheduled through an administrative agent, the Commission must be notified in advance or should be kept updated if the specialist's administrative agent changes.

Cancel & No Show Fees

When an Injured Worker fails to keep an appointment scheduled in the specialist's office, notify Medical Scheduling.

A fee may be billed when:

- the Injured Worker does not call to cancel or attend a scheduled independent medical examination (i.e. a "no show");
- the Injured Worker calls to cancel a scheduled independent medical examination within a 48 hour window prior to the time of the examination; or
- the Injured Worker cancels an appointment for an examination in a Commission office and no substitute examination is scheduled.

The cancel and no show fee schedule is set forth by Ohio Industrial Commission resolution. In order for specialists to be reimbursed for a cancellation or no show, specialists shall complete the bottom portion of the fee bill and forward it to Medical Services.

Fees for Addenda, Interrogatories, & Depositions

For **addenda**, specialists may charge a fee for time spent preparing the requested information.

For **interrogatories**, specialists may charge a fee for time spent preparing their responses.

For **depositions**, the requesting party must pay a fee to specialists one (1) week prior to deposition dates. If depositions are cancelled within two (2) business days, specialists will refund this fee. With less notice, specialists may keep this fee. Depositions requiring more than one (1) hour may be billed by specialists at a set fee.

The addendum, interrogatory, and deposition fee schedule is set forth by Ohio Industrial Commission resolution.

Allowed Diagnostic Testing

Commission independent medical examinations are performed to determine degree of impairment and functional limitations due to allowed condition(s), not to establish a diagnosis. Therefore, diagnostic testing requirements are minimal. CPT codes must be included on the fee bill for reimbursement. All fees are paid at the current Bureau of Workers' Compensation rate.

The *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition; Fourth Edition, and; the *Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region* (2002) clearly delineate necessary and appropriate testing for impairment rating of various body parts and systems. These studies, when necessary for application of the *Guides*, do not require pre-authorization and are billable at the time of report submission, along with the usual fee-for-service examination:

CPT Code	Diagnostic Procedure
72040	Cervical spine x-ray, 2 or 3 views
72052	Cervical spine x-ray, complete with flexion and extension
72070	Thoracic spine x-ray, 2 views
72100	Lumbar spine x-ray, 2 or 3 views
72114	Lumbar spine x-ray, complete with bending views
72200	Sacroiliac joint x-ray, < 3 views
73100	Wrist x-ray, 2 views
73500	Hip, unilateral x-ray, 1 view
73560	Knee x-ray, 1 or 2 views (AP +/- sunrise)
73600	Ankle x-ray, 2 views (include mortise)
73620	Foot x-ray, 2 views
70320	Teeth x-ray, complete, full mouth
70140	Facial Bones x-ray, < 3 views
70250	Skull x-ray, < 4 views
92083	Visual Fields/Refraction testing
92557	Comprehensive Audiometry
92567	Tympanometry (impedance testing)
94010	Spirometry
94060	Bronchodilation responsiveness (used with asthma and reactive airway disease only)
94720	CO diffusing capacity
NPT 1	1 hour neuropsychological testing
NPT 2	2 hours neuropsychological testing
NPT 3	3 hours neuropsychological testing
NPT 4	4 hours neuropsychological testing
80053	Comprehensive metabolic panel
81000	Urinalysis, non-automated with microscopic
81001	Urinalysis, automated with microscopic
85004	Blood count

Any other testing requires prior approval. If you feel that a specific diagnostic procedure is necessary to determine impairment or functional limitations due to the allowed conditions, please call Medical Services. The specialist will be put in contact with the Chief Medical Advisor for a physician-to-physician discussion for consideration of authorization.

It will be required that the fee bills include CPT code(s) for any testing. Payment will be denied for unauthorized testing. Reimbursement rates are according to the Bureau of Workers' Compensation fee schedule. Neuropsychological testing will be reimbursed at a rate of one hundred dollars ($100) per hour, with a maximum of four (4) hours.

Injured Workers are not required to submit to any diagnostic testing. If you feel additional testing is necessary for evaluation of impairment or functional limitations due to the allowed condition(s), and the Injured Worker declines, note the refusal and base opinions on the available diagnostic information.

Submitting a Fee Bill

An IC Provider Fee Bill is included in each referral packet (form located in Appendix). A Bureau of Workers' Compensation provider number is required for billing. Contact Medical Services for assistance in obtaining a provider number.

Verify the tax ID number, examination fee, and office mailing address. Sign and date the fee bill. Send the fee bill with the examination report and appropriate assessment form to Medical Services within ten (10) business days of the examination date.

If specialists have not received payment within three (3) months from the date of service or encounter billing problems, contact Medical Services. Have the Injured Worker's name and claim number(s) available when making inquiries. **Note that payment is withheld until the completed final report is published.**

SCHEDULING, BILLING & TESTING QUESTIONS

COLUMBUS OFFICE:
Medical Scheduling
30 West Spring Street, 10th Floor
Columbus, OH 43215-2233
Telephone: 614.466.4291
Toll Free: 1.800.574.6559
Fax No.: 614.752.4403

EXAMINATION FORMAT & *AMA GUIDES* QUESTIONS

COLUMBUS OFFICE:
Medical Services
30 West Spring Street, 10th Floor
Columbus, OH 43215-2233
Telephone: 614.387.3898
Toll Free: 1.800.574.6559
Fax No.: 614.752.4403

ICON QUESTIONS

COLUMBUS OFFICE:
Information Technology Help Desk
Telephone: 614.466.6595
Toll Free: 1.877.218.4810

COMMISSION EXAMINATION LOCATIONS

CLEVELAND REGIONAL OFFICE
615 Superior Avenue, N.W., 7th Floor
Cleveland, OH 44113-1898
Telephone: 216.787.3001

COLUMBUS REGIONAL OFFICE
30 West Spring Street, 1st Floor
Columbus, OH 43215-2233
Telephone: 614.995.5708

DAYTON DISTRICT OFFICE
3401 Park Center Drive, 3rd Floor
Dayton, OH 45414-2580
Telephone: 937.264.5116

YOUNGSTOWN DISTRICT OFFICE
242 Federal Plaza West, Suite 303, 3rd Floor
Youngstown, OH 44503-1206
Telephone: 330.792.1063

EXAMINATIONS BY BODY SYSTEMS

Musculoskeletal, Cardiovascular, Respiratory, Central and Peripheral Nervous System

Report Instructions

Multiple Claim Musculoskeletal/Neurological System Example

One Claim Cardiovascular System Example

One Claim Respiratory System Example

THE EXAMINATION REPORTING FORMAT INSTRUCTIONS

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided.
Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF REPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

OCCUPATIONAL HISTORY:

HISTORY OF THE PRESENT CONDITION:
(In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)

CURRENT SYMPTOMS: *(In this area include: pain location, character, intensity, aggravating and alleviating factors. Review systems pertinent to each allowed condition.)*

IMPACT ON ACTIVITIES: *(In this area include: walking, sitting, standing tolerance, housework, yard work, basic self-care [dressing, bathing, toileting], hobbies, sleep, driving; describe daily activities).*

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

HEALTH HABITS: *(Tobacco, alcohol, drugs, exercise)*

In each section, provide a summary with information from your exam and your review of the medical records provided.

When describing the Impact on Activities, it is important to compare/contrast the pre-injury and the post-injury activities.

1

Specrpt

Claim #:
Injured Worker Name:

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

PHYSICAL EXAMINATION: Height: Weight:
(Examine each body part and/or system for which there is a claim allowance, in the manner required by the AMA Guides, 5th Edition.)

This is your examination. Report all pertinent positive and negative findings. ROM should be well documented with the use of goniometers and inclinometers.

OPINION:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   - **Provide an answer regarding MMI status with supporting rationale.**
   - **Note: If NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed condition	Table/figure/page number	Comments	Whole Person Impairment %
Group your specialty assigned allowances by body part, and/or system being evaluated. List them exactly as on pg. 1.	Include the page number and the table or figure number for each table/figure used.	Provide comments that explain your table/percentage choice, such as: - DRE vs ROM rationale - Class ranking/ rationale for multi-class table/figure.	If there is no impairment for an allowance, indicate zero percent. WPI should always be expressed in a whole number percentage.
	Combined Values Chart, pgs. 604 - 606	Combined whole person impairment:	

2

Specrpt

Claim #:
Injured Worker Name:

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Physical Strength Rating.

- **Summarize objective findings from examination and record review that relate to the allowed condition(s) in the claim. Compare/contrast to Impact of Activities section.**
- **Relate these findings to functional deficits or capabilities.**
- **Cite the corresponding work capacity level as listed on the Physical Strength Rating form.**
- **If applicable, provide any further work place limitations additional to the established Department of Labor categories.**
- **Complete Physical Strength Rating form.**

______________________ __________
(Signature) (Date)

3

Specrpt

PHYSICAL STRENGTH RATING

INJURED WORKER: **CLAIM NUMBER(S):**

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the injured worker's age, education, or work training:

( ) This injured worker has no work limitations.

( ) This injured worker is incapable of work.

( ) This injured worker is capable of work as indicated below. } This box must be checked if indicating a work level listed below.

( ) "SEDENTARY WORK"
Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: ____________________

The work place limitations on this form must match what was stated in your report. If further limitations are indicated, you may write "see report" to ensure they are identical.

( ) "LIGHT WORK"
Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: ____________________

( ) "MEDIUM WORK"
Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"
Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"
Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

PHYSICIAN'S SIGNATURE ____________________

PHYSICIAN'S NAME (PRINT)____________________

DATE____________________

4

Specrpt

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

SAMPLE

Injured Worker Name: Robert Smith
Date of Birth: 01/01/1953
Claim Number(s): 97-00000, 99-00000
Date(s) of Injury: 05/22/1997, 01/06/1999
Claim Allowance(s): Lumbar Sprain; Herniated Disc At L5-S1; Bilateral Carpal Tunnel Syndrome

Place of Examination: 100 State St.
Columbus, Oh 41111

Date of Examination: 05/21/2013
Date of Report: 05/21/2013
Examiner Name: Michael Nowicki, M.D.

Purpose of Examination: Permanent Total Disability Impairment Evaluation.

History Of The Present Condition:
Mr. Smith reports while working in 1997, he tried to move out of the way of a forklift and he felt a twinge in his low back area. He was seen by the company doctor, placed on modified duty, had physical therapy, and returned to work.

Then, approximately 4 months later, he was lifting parts off of a skid when he experienced low back pain, with radiation into the right leg. He again underwent physical therapy while working modified duty, however experienced persistent symptoms. An MRI demonstrated a broad-based disc protrusion at L5-S1 to the right.

He underwent microdiskectomy surgery in 1998 at L5-S1. He indicates that he experienced persistent back pain and right leg pain after the surgery. He underwent additional physical therapy and epidural steroid injection without significant improvement. An EMG in 2000 demonstrated persistent chronic right L5 radiculopathy. Follow up MRI in 2000 showed post-operative cicatrix with no recurrent or residual disc herniation.

In 1999, he was required to work with impact wrenches, vibrating tools, and drills. He experienced the onset of numbness and tingling in both hands, and pain in the wrists. An EMG in 1999 revealed moderately severe bilateral carpal tunnel syndrome. He underwent bilateral carpal tunnel release in 1999. He reported some persistent paresthesia in his hands postoperatively, and went through Occupational Therapy. He experienced some improvement in his symptoms, and returned to work until retirement in 2003.

Current Symptoms:
He reports persistent low back pain, which he rates on a scale of 1 to 10 as 5/10 most of the time. It radiates to the anteriolateral calf. It is burning and stinging in nature. He reports worsening with long sitting, or bending and lifting. He reports his pain is alleviated if he gets into the semi-recumbent or fetal position with a pillow between his legs. He denies any associated dysfunctional bladder and bowel. He does report some associated paresthesia in the same distribution. He reports numbness in the great toe.

With regard to his hands, he reports tingling paresthesia, worse at night. He reports some stiffness and pain in his wrists. He reports that he drops things on occasion.

Impact On Activities:
He reports that he is able to walk approximately four blocks before having to rest because of back and leg pain. He reports a sitting tolerance of approximately 30 minutes before he has to get up and move around. He reports a standing tolerance of approximately 30 to 45 minutes before having to change position.

He is independent with his basic self-care, including dressing, bathing, and toileting. He does some light housework. He no longer does any heavy yard work. He continues to do some woodworking activities.

He indicates that his sleep is interrupted by numbness in his hands, and pain in his leg. He reports that he is able to drive, though only short distances, less than 30 minutes. He reports that his daily activities include getting up, taking the dog outside, occasionally going out to breakfast with his friends, working in his woodshop, watching TV, and doing some light housework.

Past Medical History:
Hypertension, osteoarthritis, and coronary artery disease.

Past Surgical History:
He has had kidney stones removed. He underwent open reduction and internal fixation of his left femur approximately six years ago.

Current Medications:
Gabapentin, 300 mg qid; hydrocodone, 5 mg qid; meloxicam, 15 mg qd; and lisinopril, 10 mg qd.

Allergies:
IVP dye.

Social History:
He is married, and lives with his wife. She continues to work outside of the home.

Health Habits:
He smokes a half pack of cigarettes a day, and does not drink alcohol. He denies any illicit drug use. He does not have a regular exercise program, though attempts to do some light low back stretching daily.

Review of Medical Records:
I reviewed all of the medical records provided to me by the Industrial Commission.

Physical Examination:
Height: 5’10”   Weight: 210 lbs.

This is a well developed, well nourished, male in no acute distress. Gait appears antalgic, favoring the right leg. He uses a cane in the right hand.

With the use of the dual inclinometer technique, true lumbar range of motion includes 80 degrees of forward flexion, 10 degrees of bilateral flexion, and 10 degrees of extension. There is a well healed surgical incision over the low back. He reports tenderness over tight muscles in the lumbar paraspinal region. Hip range of motion is full and pain-free. Reflexes are 2+ at the knees, and 2+ at the ankles. He has 4/5 left EHL weakness. Otherwise, strength is intact throughout the legs. Straight-leg raising appears non-radicular. Sensation is reported diminished to pinprick in a non-specific distribution in the right lower leg.

In the upper extremities, strength is intact throughout. There are well healed surgical incisions over the bilateral ventral wrists. He reports some tenderness over the ventral wrists. Tinel's and Phalen's signs are absent. Monofilament testing reveals decreased sensation to light touch reported throughout the palmar hands and fingers.

Opinion:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   In my opinion, Mr. Smith has reached maximum medical improvement for all of the allowed conditions in this claim. He has had preoperative conservative care, surgical treatment, and then postoperative conservative care of his bilateral carpal tunnel syndrome and lumbar allowances. He has reached a treatment plateau at which no significant change can be expected at this time.

2. **Based on the *AMA Guides, Fifth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Lumbar strain	Table 15-3, p. 384	Superseded by herniated disc at L5-S1	0%
Herniated disc at L5-S1	DRE method due to single level involvement - Table 15-3, p. 384	DRE Category III due to history of herniated disc	13%
Bilateral carpal tunnel syndrome	Tables 16-10, 16-11, & 16-15, pp. 482, 484, 492	Grade 4 sensory Grade 5 motor	1% right 1% left
	Combined Values Chart, pages 604-606	**Combined whole person impairment:**	**15%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in these claim(s) is: 15%.

Claim #: 97-00000, 99-00000
Injured Worker Name: Smith

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Physical Strength Rating.

In my opinion, based solely on the allowed conditions in this claim, Mr. Smith is capable of sedentary work. There is no significant residual deficit related to his allowed condition of bilateral carpal tunnel syndrome. However, the Injured Worker should avoid repetitive gripping. He also has persistent symptoms related to his disc herniation, with an associated neurologic gait deficit, and so his walking and standing would be limited to an occasional basis and lifting should be limited to 10 pounds occasionally as indicated in the sedentary work category.

In addition to the sedentary work limitations, he should be able to change positions from the seated to the standing position on an occasional basis.

Please contact me if I can provide any clarification on these matters.

Respectfully yours,

Michael Nowicki

Michael Nowicki, M.D.

PHYSICAL STRENGTH RATING

Injured Worker: Robert Smith

CLAIM NUMBER(S): 97-00000
99-00000

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the injured worker's age, education, or work training:

( ) This Injured Worker has no work limitations.
( ) This Injured Worker is incapable of work.
(X) This Injured Worker is capable of work as indicated below.

(X) "SEDENTARY WORK"
Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: Change position from seated to standing occasionally, no repetitive gripping

( ) "LIGHT WORK"
Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: ____________________

( ) "MEDIUM WORK"
Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"
Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"
Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: Michael Nowicki Date: 5/21/2013

Physician's Name (print): Michael Nowicki, M.D.

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

SAMPLE

Injured Worker Name: John Jones
Date of Birth: 07/19/1955
Claim Number(s): PEL00000
Date(s) of Injury: 12/06/2009
Claim Allowance(s): Aggravation of pre-existing coronary artery disease; cardiomyopathy; ventricular tachycardia

Place of Examination: 100 Ohio St.
Cleveland, OH 40000

Date of Examination: 05/23/2013
Date of Report: 05/29/2013
Examiner Name: Vighnesh Patel, M.D.

Purpose of Examination: Permanent Total Disability Impairment Evaluation.

Occupational History: Deputy sheriff, 1981-2009. Police officer, 1972-1981.

History of The Present Condition:
Mr. Jones was working as a deputy sheriff, in the process of an arrest, when a male suspect initially became combative, and then fled the scene. Mr. Jones reports having pursued the suspect, a brief altercation occurred, and he took the suspect into custody. Immediately after the event, Mr. Jones experienced the onset of severe crushing chest pain. He was taken to the emergency center at the local hospital, where he was found to have myocardial infarction. He was also noted to have ventricular tachycardia while in the emergency room. He required cardiac catheterization with stent placement. He also required implantation of a defibrillator device.

He underwent an echocardiogram, which demonstrated left ventricular hypokinesis, with an ejection fraction of 40%. He has not returned to work since the time of the injury.

Current Symptoms:
He reports intermittent chest pain with exertion. He tells me that this is relieved by rest, and he uses occasional nitroglycerin. He reports occasional swelling in his feet at the end of the day. He does report shortness of breath with exertion. He denies any palpitations.

Impact on Activities:
He reports a walking tolerance of four blocks. He tells me that his sitting and standing are unlimited. He does light housework, and is able to mow his lawn with a riding lawn mower. He is independent with dressing, bathing, and toileting. He builds model airplanes for a hobby. He reports no sleep disturbances. He reports no difficulty driving. He does stay involved in volunteer church activities, and goes out to meals with his wife and friends approximately twice a month.

Past Medical History:
Diabetes, hypertension, depression, coronary artery disease, peripheral vascular disease, anxiety, and hypercholesterolemia.

Past Surgical History:

Right shoulder surgery for rotator cuff impingement in 2002. Right carotid endarterectomy, 2011.

Current Medications:

Zoloft 50 mg qd; aspirin 325 mg qd; Actos 15 mg qd; Glucophage 600 mg bid; Coreg 26 mg bid; Gemfibrosil 600 mg qd; Wellbutrin 160 mg qd; Zestril 10 mg qd; Pepcid prn.

Allergies:

None.

Social History:

He is married, lives with his wife and an adult child.

Health Habits:

He reports that he has two beers per week. He does not smoke cigarettes, and quit at the time of his initial work injury. He denies any other drug use or abuse. He exercises by walking on a treadmill three days a week.

Review of Medical Records:

I reviewed all the medical records provided to me by the Industrial Commission.

Physical Examination:

Height: 6’2” Weight: 214 lbs.

Blood pressure: 120/62. Pulse: 68, regular. Respiration: 15, regular.

This is a well developed, well nourished male in no acute distress.

HEENT: Extraocular muscles are intact. Pupils are round, equal, and reactive to light. There is no scleral icterus. He wears dentures. His neck is supple, without masses or adenopathy. He has a left carotid bruit, and there is a well healed surgical scar from a previous right carotid endarterectomy.

Chest/Cardiac: Chest was clear to percussion and auscultation. Cardiovascular examination showed regular sinus rhythm without murmurs. The PMI was just to the right of the midclavicular line. An implanted defibrillator device was palpable in the left chest.

Abdomen: Abdomen was soft, non-tender, with no organomegaly or masses. Liver, spleen, and kidneys were not palpable. Bowel sounds were active, and there was no tenderness on palpation of the back.

Extremities: No edema. Pulses were 2+ at the dorsalis pedis, posterior tibialis, and radial locations. No abnormal movements were noted.

Opinion:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If “no”, describe the rationale for your opinion and disregard items #2 and #3. If “yes”, describe the rationale for your opinion and complete items #2 and #3.**

   Yes. He is medically stable, with no significant changes expected in his medical care with regard to the allowed conditions.

2. Based on the *AMA Guides, Fifth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Aggravation of pre-existing coronary artery disease; Cardiomyopathy; Ventricular tachycardia	Table 3-6a, p. 36	Class III	40%
	Combined Values Chart, pages 604-606	**Combined whole person impairment:**	**40%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in this claim is: 40%.

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Physical Strength Rating.

He can only tolerate occasional walking and should be limited to 10 pounds of force or less for lifting occasionally due to the exertional limitations caused by his allowed cardiac conditions. Thus, Mr. Jones would be capable of sedentary activities.

Please contact me if I can provide any further clarification on this matter.

Respectfully yours,

Vighnesh Patel, M.D.

Vighnesh Patel, M.D.

PHYSICAL STRENGTH RATING

Injured Worker: John Jones CLAIM NUMBER(S): PEL00000

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:

( ) This Injured Worker has no work limitations.
( ) This Injured Worker is incapable of work.
(X) This Injured Worker is capable of work as indicated below.

(X) "SEDENTARY WORK"
Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: ______________________

( ) "LIGHT WORK"
Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: ______________________

( ) "MEDIUM WORK"
Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"
Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"
Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: Vighnesh Patel Date: 5/29/2013

Physician's Name (print): Vighnesh Patel, M.D.

SAMPLE

OHIO INDUSTRIAL COMMISSION

SPECIALIST REPORT

Injured Worker Name: Jim White
Date Of Birth: 11/04/1946
Claim Number(s): OD2222-22
Date(s) of Injury: 06/13/1988
Claim Allowance(s): Asbestosis

Place of Examination: 100 State St.
Cincinnati, OH 40101

Date of Examination: 5/21/2013
Date of Report: 05/21/2013
Examiner Name: Michelle Ramirez, M.D.

Purpose of Examination: Permanent total disability impairment evaluation.

Occupational History: Laborer for the railroad.

History Of The Present Condition:
Mr. White reports that he was employed by the railroad as a laborer since age 18. He worked primarily in the yard, performing repair work. His work included placing insulation inside of cars. He indicated that he was diagnosed as having asbestosis in 1988. He continued to work until 1992.

Current Symptoms:
He currently complains of constant chest pain, which is located in the mid-anterior chest. He reports increased pain with taking deep breaths or heavy breathing. He reports a non-productive cough. He denies any swelling of his feet. He reports that he sleeps on two pillows because of shortness of breath. He reports shortness of breath with any type of activity, and uses oxygen. He receives biweekly respiratory therapy.

Impact on Activities:
He is capable of dressing himself, bathing, and toileting. He is able to drive. He reports that he spends most of his time watching TV, or sitting on his porch. He reports no hobbies.

Past Medical History:
Osteoarthritis.

Past Surgical History:
Bilateral total knee arthroplasty, and low back surgery.

Current Medications: Oxygen, Gauifenesin, Rescue Inhaler (prn), Arthrotec.

Allergies:
Aspirin.

Social History:
He is a widower and lives in a one-story house by himself.

Health Habits:
He does not drink alcohol or smoke. He reports he is unable to sustain any significant exercise.

Review of Medical Records:
I reviewed all the medical records provided to me by the Industrial Commission including but not limited to:

1. pulmonary function test from January 2012, which demonstrated an FVC of 35% and FEV-1 of 45%.
2. multiple CT scan reports of the chest, and chest X ray reports in the record, which are reported as showing findings consistent with asbestosis, including pleural plaques.

Physical Examination:
Height: 5’9” Weight: 154 lbs.

Blood pressure: 136/74. Respiration is 16 with pursed lips and effort, pulse 80.

Head, eyes, ears, nose, and throat evaluation is unremarkable, except for bilateral hearing aids. The chest is clear to auscultation. There are no rales or rhonci, rubs, or wheezes but does have diminished breath sounds. He has mild clubbing of the fingers, with no swelling in the feet. He reports no tenderness on palpation or percussion of the chest. Cardiac examination reveals normal rate and rhythm, with no murmurs.

Opinion:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If “no”, describe the rationale for your opinion and disregard items #2 and #3. If “yes”, describe the rationale for your opinion and complete items #2 and #3.**

   Yes. His pulmonary condition is at a plateau, and no change in his condition or treatment is anticipated. The natural course of asbestosis is gradual progression.

2. **Based on the *AMA Guides, Fifth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Asbestosis	Table 5-12, p. 107	Class 4	55%
	Combined Values Chart, pages 604-606	**Combined whole person impairment:**	**55%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in this claim is: 55%.

Claim #: OD2222-22
Injured Worker Name: White

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Physical Strength Rating.**

   This Injured Worker needs maintenance respiratory therapy and oxygen to maintain minimal ADLs. Due to his need to avoid respiratory irritants, participation in community activities are limited. Additionally, he does not have the exertional capabilities to move 10 lbs. of force occasionally or a negligible amount of force frequently. These respiratory deficits render this Injured Worker incapable of work. The Physical Strength Rating Form is completed and enclosed.

Respectfully yours,

Michelle Ramirez, M.D.

Michelle Ramirez, M.D.

PHYSICAL STRENGTH RATING

Injured Worker: Jim White CLAIM NUMBER(S): OD2222-22

Based solely on impairment due to the allowed conditions in the claim within my specialty and with no consideration of the Injured Worker's age, education, or work training:

( ) This Injured Worker has no work limitations.
(X) This Injured Worker is incapable of work.
( ) This Injured Worker is capable of work as indicated below.

( ) "SEDENTARY WORK"
Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated: ______________________________

( ) "LIGHT WORK"
Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling, or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated: ______________________________

( ) "MEDIUM WORK"
Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"
Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"
Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

Physician's Signature: Michelle Ramirez Date: 5/21/2013

Physician's Name (print): Michelle Ramirez, M.D.

EXAMINATIONS BY BODY SYSTEMS

Oral and Maxillofacial

Report Instructions

Oral and Maxillofacial System Example

Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region (AAOMS)

THE EXAMINATION REPORTING FORMAT INSTRUCTIONS

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided. Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF REPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

OCCUPATIONAL HISTORY:

HISTORY OF THE PRESENT CONDITION:
(*In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)*

CURRENT SYMPTOMS: *(In this area include: pain location, character, intensity, aggravating and alleviating factors)*

IMPACT ON ACTIVITIES: *(In this area include: dietary restrictions or intolerances, changes in voice or speaking abilities, impact on sleep).*

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

HEALTH HABITS: *(Tobacco, alcohol, drugs, exercise)*

In each section, provide a summary with information from your exam and your review of the medical records provided.

When describing the Impact on Activities, compare/contrast the pre-injury and the post-injury activities and abilities to fully convey the injury's effect on the functional capabilities.

Claim #:
IW Name:

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

PHYSICAL EXAMINATION:

MOUTH:

DETENTION:

TEMPOROMANDIBULAR JOINT:

CRANIAL NERVES:

FACE:

This is your examination, report all pertinent positive and negative findings.

OPINION:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**
   - **Provide your answer regarding MMI status with supporting rationale.**
   - **Note: If you opine NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Claim #:
IW Name:

Allowed conditions	Table/figure/page number	Comments	Whole Person Impairment %
Group your specialty assigned allowances by body part, and/or system being evaluated. List them exactly as on pg. 1.	**Include the page number and the table or figure number for each table/figure used.**	**Provide comments that explain your table/percentage choice such as: Class ranking/ rationale for multi-class table/figure.**	**If there is no impairment for an allowance, indicate zero percent. WPI should always be expressed in a whole number percentage.**
	Combined Values Chart, pages 604-606	Combined whole person impairment:	

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Function Assessment.**

- **Summarize objective findings from your examination and record review that are related to the allowed conditions in the claim.**
- **Relate these findings to functional deficits or capabilities.**
- **Cite the corresponding work capacity level.**
- **If applicable, provide any further work place limitations.**
- **Complete Residual Function Assessment form.**

____________________ __________
(Signature) (Date)

SAMPLE

OHIO INDUSTRIAL COMMISSION
DENTAL
SPECIALIST REPORT

Injured Worker Name: Khushwant Singh
Date of Birth: 06/04/1984
Claim Number(s): 09-000000
Date(s) of Injury: 04/06/2009
Claim Allowance(s): Traumatic brain injury; subdural hematoma; ***fracture mandible;*** fracture right orbit; fracture right clavicle; ***loss of teeth #8, #9, and #10.***

Disallowed Condition(s): None

Place of Examination: 100 State St.
Toledo, Ohio 41234

Date of Examination: 05/21/2013
Date of Report: 05/21/2013
Examiner Name: Isabella Russo, DDS

Purpose of Examination: Permanent Total Disability Impairment Evaluation.

Occupational History: Restaurant work

History of Present Condition:
Mr. Singh was on a delivery for his restaurant when he was attacked, robbed, and beaten. He sustained multiple injuries as detailed above. With regard to his dental conditions, he required surgical repair of his mandible, and has had dental implants placed for restoration of his teeth.

Current Symptoms:
He reports some persistent jaw pain, particularly when chewing solid foods. He denies any facial pain, numbness of the face, or headache. He reports no difficulty with mastication otherwise.

Impact On Activities:
He reports no dietary restrictions or intolerances due to his injuries. He reports no change in his voice or speaking abilities.

Past Medical History:
None. He reports that he was otherwise healthy.

Past Surgical History:
None.

Current Medications:
None.

Claim #: 09-000000
Injured Worker Name: Singh

Allergies:
None.

Social History:
He is single, and worked in a family-owned restaurant.

Health Habits:
He does not smoke cigarettes, drink alcohol, or use illicit drugs.

Review of Medical Records:
I reviewed all of the medical records provided to me by the Industrial Commission.

Panoramic X rays were obtained today, which demonstrate adequate healing of his mandible, and his dental implants are in place.

Physical Examination:
Mouth: Oral mucosa was pink and moist, with no palpable or visible lesions.

Dentition: Dental implants are in place for teeth #8, #9, and #10. All other dentition is intact, with good oral hygiene. Class I molar occlusion, 50% overbite, 3 mm of overjet and good midline.

Temporomandibular joint: Interincisal opening is 36 mm. Lateral excursive movement of his mandible is 2 mm in each direction. There is no palpable or auscultated crepitus of the joint.

Cranial nerves: Intact.

Face: No disfigurement.

Opinion:

1. **1.Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   Yes. He has had adequate surgical treatment and healing time for his mandible fracture. His lost teeth have been restored. He is no longer under active treatment for his dental condition. No significant change is expected.

2. **Based on the *Guidelines for Evaluation for Impairment of the Oral and Maxillofacial Region of the American Association of Oral and Maxillofacial Surgeons*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Claim #: 09-000000
Injured Worker Name: Singh

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Fracture of mandible	pp. 5 and 6	Decreased range of motion	7%
Loss of teeth #8, #9, and #10	p. 4	No impairment in mastication	0%
		Combined whole person impairment:	**7%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in this claim is 7%.

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Function Assessment.

Mr. Singh has no work limitations due to his dental injuries.

Respectfully submitted,

Isabella Russo, D.D.S.

Isabella Russo, D.D.S.

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: Khushwant Singh

Claim Number(s): 09-000000

Based solely on impairment resulting from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

(X) This Injured Worker has no work limitations.
(   ) This Injured Worker is incapable of work.
(   ) This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

Physician's Signature: *Isabella Russo, D.D.S* Date: 5/21/2013

Physician's Name (print): Isabella Russo, D.D.S.

GUIDELINES TO THE EVALUATION OF IMPAIRMENT OF THE ORAL AND MAXILLOFACIAL REGION

American Association of Oral and Maxillofacial Surgeons- 2002

1

The American Association of Oral and Maxillofacial Surgeons has recognized the need for the establishment of a specific method of evaluating permanent impairments of the maxillofacial region. The committee on Health Care Programs of the American Association of Oral and Maxillofacial Surgeons was given the responsibility of establishing the methodology of measurement, and assigning values for permanent impairment of this area. Using the methods described in this document, and the AMA Guides to the Evaluation of Permanent Impairment, the practitioner will be able to assign an impairment value to the individual for the maxillofacial region.

OBJECTIVES

- Provide a permanent Impairment Rating for the Maxillofacial Region
- Definition of terms
- Recognize that there are different purposes for providing an impairment rating, i.e. Workman's Compensation, Social Security Administration, Personal Injury Litigation and Medical Indemnity Insurance.
- Understand applicable state regulation for conducting such examinations.

ACKNOWLEDGEMENT

The Report of Medical Evaluation (Permanent Medical Impairment) on page 11, 12 & the combined injury ratings on page 3 are taken from the Guides to the Evaluation of Permanent Impairment, current edition 5th AMA Guides.

This document does not constitute endorsement by the American Medical Association of the methods and procedures described by the AAOMS in the Guidelines to the Evaluation of Impairment of the Oral and Maxillofacial Region.

I. HOW TO PERFORM AN IMPARIMENT EXAMINATION

1- History, physical examination, and review of pertinent medical records.

2- Review special studies.

3- Identify objective findings and compare with criteria (Injury Model vs. Range of Motion Model)

4- Consider permanency of Impairment
N.B. If impairment is resolving, changing, unstable or expected to change significantly within 12 months, do not do a rating. If condition is not fixed and stable, or if one is making a recommendation for curative (not palliative) treatment, do not give a rating

If range of motion model is used then combine the impairment ratings for injury model ratings

With neurologic impairment	p. 330, Table13-11, Ed. 5 VII, p332, Table13-12
With disfigurement impairment	p. 255, p. 272, p256, Table 11-5, Ed. 5.
With dietary impairment	p. 262, Table 11-7, Ed. 5
With pain	p 569, p 571, Table18-1, p573

If speech, airway, olfaction, ocular, auditory function is impaired, use ratings for injury model.

II DEFINTIONS

Clarification of the following terms is important in distinguishing between different terminology associated with impairments.

IMPAIRMENT
DISABILITY
HANDICAP

Impairment: is an alteration of an individual's health status that is assessed by medical means. Loss of or use of a body part, system of function.

***Disability*:** is an alteration of an individual's capacity to meet personal, social, or occupational demands or to meet statutory or regulatory requirement. It assumes a medical impairment exits.

For example: Impairment: Loss of index finger.

For a person who is a singer, this in fact would be impairment, but not a disability. For an individual who is a typist, this could represent significant disability in their work as a typist.

***Handicap*:** The Federal Rehabilitation Act of 1973 identifies a "handicapped" individual as one who has an impairment that substantially limits one or more life activities including work, has a record of such impairment, and this impairment can be overcome only by compensation. i.e. artificial limb, etc.

III EVALUATION OF THE ORAL AND MAXILLOFACIAL REGION FOR PERMANENT IMPAIRMENT

Injury model or range of motion model can be used to assess impairment in the maxillofacial region

A. **Masticatory Dysfunction**:

Eating involves the function of the teeth, jaws, muscles of mastication, muscles of deglutition, and temporomandibular joint. In addition, it requires the ability of a person through lip, tongue and muscle function to be able to swallow food. Loss or change in the functional relationship of any of these anatomic-physiologic components of the system will result in a functional change for the individual.

Loss of teeth and / or dentoalveolar structure (underlying osseous or soft tissue structure) may be due to trauma, developmental condition, or associated disease e.g. extractions indicated for radiation therapy.

There is a distinct and measurable variation between forces generated by natural dentition versus patients with prostheses (full removable dentures). Maximal bite forces appear to be five to six times less for complete denture wearers. In addition, many prosthetic patients select foods that require reduced masticatory capability.

Patients may also develop adverse sequelae with tooth loss including speech difficulties and associated psychosocial problem secondary to cosmetic changes.

The following recommendations are made for determining the impairment rating of the individual loss based on the contribution of each component to the masticatory system. However, reconstruction with prosthesis after a Loss of Dentition.

Patient restricted to liquid foods = 40 – 60% impairment of whole person if feeding tube is necessary

Loss of dentition with ability to wear dentures= 5 – 19% impairment of whole person if restricted to semi-solid and soft food, p 262, AMA Guides Ed 5.

Speech should not be evaluated by an Oral and Maxillofacial Surgeon, suggest referral to speech pathologist.

American Association of Oral and Maxillofacial Surgeons- 2002
4

Example of trauma or oral cancer patient:
Calculation of whole person impairment using the combined value chart with the following assignments:

1- 24% impairment of a person who is restricted to a liquid diet and

2- 10% for speech impairment (not rated by an Oral Surgeon) is a combined value equals 32% whole person impairment.

B. **Temporomandibular Joint**

Range of motion model used to assess impairment in the maxillofacial region involving the TMJ

The craniomandibular articulation is composed of the temporomandibular joints bilaterally and the masticatory musculature. These two joint function as a unit.

Total loss of motion or ankylosis renders the patient unable to chew or speak in a normal manner.

The following are not correlated to AMA Guide, but are suggestions of the Health Care Committee:

Summary of Steps in Evaluation Impairments of Craniomandibular Articulation

1- Identify the area of involvement.

2- Measure the voluntary, non-painful interincisal opening between maxillary and mandibular central incisors (Interincisal Range of Motion).
Measure the lateral excursive distance of the mandible, using the dental midlines from maximum dental intercuspation.

3- Add the impairment values for loss of interincisal opening and lateral excursive distance to obtain the craniomandibular articulation impairment value.

INTERINCISAL RANGE OF MOTION		% OF NORMAL WHOLE PERSON	% IMPAIRMENT WHOLE PERSON
Hypomobile	0-10 mm	20	10
Hypomobile	10-20 mm	40	8
Hypomobile	21-29 mm	50	5-7
Hypomobile	30-35 mm	70	3-4
Hypomobile	35- 39mm	95	3-5
Normal	40-50 mm	100	0

*35 mm is an acceptable range of jaw opening in the AAOMS Par Path Document.

LATERAL EXCURSION RANGE OF MOTION		% OF NORMAL	% IMPARIMENT OF WHOLE PERSON
Hypomobile	0-4mm	60	4
Hypomobile	4-7 mm	70	3
Hypomobile	8-10 mm	90	1
Normal	12 mm	100	0

Hypermobility generally does not impair function and is not ratable. If it appears to cause impairment, it should be treated as a muscle weakness.

Example: A patient has a noted disc derangement with an incisal opening of 25 mm. And lateral excursive movements of 6 mm.

Ratable Criteria:

Interincisal opening 6% impairment

Lateral excursive movement 3% impairment

The two range of motion values are added together:
6% + 3% = 9% impairment of whole person (see combined values chart p 604-5 AMA Guides Ed 5).

Example: A Patient has an ankylosis of the temporomandibular joint with a maximum opening of 5 mm. And lateral excursive movements of 2 mm. Diet is restricted to liquid foods.

Ratable Criteria:

Interincisal opening 10% impairment

Lateral excursive movement 4% impairment

Diet restriction (p. 262 Table11-7 AMA Guide Ed.5) 30% Impairment

First, add the range of motion values 10% + 4% +14%, then using the combined values chart (AMA Guides p604-5) add the 14% + 30% = 40% of the whole person.

Note impairments secondary to other derangement such as resection, implant arthroplasty, or musculoskeletal disorders are usually rated according to the above

criteria. It is left up to the individual examiner whether to consider these disorders separately. The evaluator must use judgment and avoid duplication of impairments.

C. **Skeletal Facial Deformities & Facial Disfigurement**
(p. 255-9 AMA Guide Ed5)

Skeletal-facial deformities of the maxilla and / or mandible can produce abnormal function and appearance. These deformities may arise from multiple genetic factors, environment influences, acquired defects, neoplastic processes, degenerative disease and trauma.

Documentation of a skeletal-facial deformity should include
- History to clearly indicate the source of the skeletal-facial deformity (congenital, developmental, or acquired);
- Imaging documentation when feasible of the deformity, e.g. post-traumatic defects and / or lateral skull and facial bone x-rays for cephalometric analysis;
- Clinical photographs and /or
- Facial moulage or dental models.

Impairment evaluation of an individual with a skeletal facial deformity should be based on a combined value score using AMA's combine value table based on the following ratable symptoms that are deviations from normal function.

The following conditions (impairments) should be separately rated. Then, using the combined value table, a whole person impairment can be calculated.

Masticatory Insufficiency: Premature loss of teeth not in functional occlusion as a result of the underlying skeletal deformity.

All teeth missing or not in functional occlusion could be assigned an impairment value of 5% of the dental system for molars and 3% of the dental system for incisors. If the whole person impairment value based on premature loss of teeth or teeth not in functional occlusion is less than that of a total restriction to liquid diet, the greater value of a whole person impairment assigning 20-30% loss of whole person impairment based on a liquid diet should be used.

A person missing 30 teeth with prosthesis is not usually on a liquid diet. Therefore, 0% - 8% for loss of teeth (injury model).

Abnormal Respiratory (Airway) Problem: (this usually would be rated by other examiners) – relating to the skeletal dental deformity which results in either obstruction, snoring, or sleep apnea. Needs referral for a laboratory sleep study.

Patient with facial skeletal deformities such as vertical maxillary excess and mandibular retrognathia may have upper airway impairment. A sequela of this deformity may be multiple episodes of cessation of breathing for at least 10 seconds during periods of sleep.

Some of the signs and symptoms of this syndrome are snoring, abnormal behavior during sleep and interrupted sleep patterns, and excessive daytime somnolence.

Facial Appearance (Disfigurement): Facial appearance is extremely important for identification and self image. Disturbances in facial appearance or function can also have major impact in social acceptance. Loss of structural integrity and soft tissue changes or injury can result in disfigurements that result not only in physical, but social and functional problems.

In those cases, where the skeletal facial defects, as a result of either congenital or developmental deformities, disease, trauma, or surgical intervention results in a permanent disfigurement, the following impairments may be assigned and used with the combined values scale in determining a total value for skeletal facial deformities.

The AMA Guides to the Evaluation of Permanent Impairment recommend the following classification s and rating of whole person impairment. P. 256 Table 11-5AMA Guide Ed5

Class 1 — Impairment of the Whole Person, 0-5%
A patient belongs in class 1 when the facial abnormality is limited to a disorder of the cutaneous structures, such as visible scars and abnormal pigmentation, or mild unilateral total facial paralysis, or nasal distortion that affects appearance

Class 2 — Impairment of the Whole Person, 6-10%
A patient belongs in class 2 when there is a loss of supporting structure of part of the face, with or without cutaneous disorder. Depressed cheek, nasal, or frontal bones.

Class 3 — Impairment of the Whole Person, 11-15%
A patient belongs in class 3 when there is an absence of a normal anatomical area of the face. Loss of an eye or loss of part of the nose with the resulting cosmetic deformity (if visual or respiratory loss, suggest other examiners), or severe unilateral total facial paralysis, or mild bilateral facial paralysis

Class 4 — Impairment of the Whole Person, 16-35%
A patient belongs in class 4 when facial disfigurement is so severe that it precludes social acceptance.
Massive distortion of normal facial anatomy, or severe bilateral total facial paralysis, or loss of major portion of nose

Disfigurement		Impairment of Whole Person
Unilateral Total Facial Paralysis	=	1-4% mild
	=	5-9% severe
Bilateral Total Facial Paralysis	=	5-18% mild

	=	20-45% severe
Loss of Deformity of Outer Ear	=	0-2% mild
Loss of the Entire Nose	=	25-50%
Nasal Distortions in Physical Appearance	=	0-5%

(p. 2332,Table 13-12 AMA Guide Ed.5)

***Cleft Palate Deformity*:** Example: Cleft palate deformity is a congenital deformity that is amenable to surgical correction and improvement from the time of birth through adolescent and adult year. It is a congenital deformity requiring multiple surgical procedures of the cleft. The cleft palate patient can be evaluated for impairment value based on skeletal deformity values of:

1- Mastication dysfunction / malocclusion
2- Articulation
3- Temporomandibular joint problems
4- Facial appearance
5- Psychosocial and / or behavioral problems
6- Sleep disorder

***Psychosocial*:** If indicated, impairment values can be assigned for behavioral or psychosocial problems that are the result of a facial deformity, but suggest rate by other examiners.

Pain*: This section has been totally revised from AMA Guides Ed4.A qualitative value for the evaluation of chronic pain and pain behaviors is now included in Edition 5. Although migraine, cluster and tension headache are now eliminated, pain disorders, somatoform disorder, psychogenic pain and malingering are discussed. A method for int*egrating impairment rating for pain with other impairments is now available.(see p. 580, Table 18-5, p584, Tables 18-6,18-7.

1- Headache: example, page 586.

2- Cranial Nerve Pain: example page 330, Table 13-11

a. *Trigeminal Nerve Pain*

Mild impairment due to uncontrolled Facial neuralgic pain	= 0-14% whole person
Moderate impairment	= 15-24%
Severe	= 25-35%

b. *Facial Nerve*

Complete loss of taste – anterior tongue =	1-4% whole person impairment
Mild unilateral facial weakness	= 1-4%
Mild bilateral facial weakness	= 5-19%

or

Severe unilateral facial paralysis with 75% or greater facial involvement

Severe bilateral facial paralysis with inability to control eyelid closure =20-45%

c. *Impairment of Cranial Nerve IX , X and XII, p 334, Table 13-14.*

Mild dysarthria, choke on liquid or semi-solid food = 1-14% whole person impairment

REPORT OF MEDICAL EVALUATION PERMANENT MEDICAL IMPAIRMENT

TO:

RE:

CASE #:

DATE OF LOSS:

1. PAST MEDICAL HISTORY **YES / NO**

A. MEDICAL OFFICE RECORDS REVIEWED ENCLOSED

B. HOSPITAL RECORD REVIEWED ENCLOSED

C. FROM PATIENT

D. FROM OTHER SOURCES (DESCRIBE)

2. CLINICAL EVALUATION **YES / NO**

A. PHYSICAL EXAMINATION REPORT ENCLOSED

B. LABORATORY TEST REPORT ENCLOSED

C. SPECIAL TESTS AND DIAGNOSTIC PROCEDURES REPORT ENCLOSED

D. SPECIALTY EVALUATIONS REPORT ENCLOSED

3. DIAGNOSES

A.

B.

American Association of Oral and Maxillofacial Surgeons- 2002
11

C. ____________________
D. ____________________

4. STABILITY OF MEDICAL CONDITION

A. THE CLINICAL CONDITION IS STABILIZED AND NOT LIKELY TO IMPROVE WITH SURGICAL INTERVENTION OR ACTIVE MEDICAL TREATMENT MEDICAL MAINTENANCE CARE IS WARRANTED.
YES / NO

B. THE DEGREE OF IMPAIRMENT IS NOT LIKELY TO CHANGE BY MORE THAN 3% WITHIN THE NEXT YEAR
YES / NO

C. EMPLOYMENT IS NOT LIKELY TO IMPROVE WITH SURGICAL INTERVENTION OR ACTIVE MEDICAL TREATMENT.
YES / NO

D. THE PATIENT IS NOT LIKELY TO SUFFER SUDDEN OR SUBTLE INCAPACITATION
YES / NO

5. OTHER ANALYSES

A. EXPLAIN BRIEFLY THE IMPACT (S) OF THE MEDICAL CONDITION (S) ON THE PATIENT'S ACTIVITIES OF DAILY LIVING (SEE APPENDIX A. P. 243)

____

____

B. IS THERE A MEDICAL REASON TO BELIEVE THE PATIENT IS LIKELY TO SUFFER INJURY, HARM, OR FURTHER MEDICAL IMPAIRMENT BY ENGAGING IN USUAL ACTIVITIES OF DAILY LIVING OR OTHER ACTIVITIES NECESSARY TO MEET PERSONAL, SOCIAL, OR OCCUPATIONAL DEMANDS? EXPLAIN BRIEFLY.

YES / NO

____

____

C. IS THERE A MEDICAL REASON TO BELIEVE OTHER RESTRICTIONS OR ACCOMMODATIONS ARE NECESSARY TO HELP THE PATIENT CARRY OUT USUAL ACTIVITIES OR MEET PERSONAL, SOCIAL AND OCCUPATIONAL

DEMANDS? IF SO, BRIEFLY EXPLAIN THEIR THERAPEUTIC, RISK-AVOIDANCE, OR OTHER KIND OF VALUE?

YES / NO

____

____

6. IMPORTANT EVALUATION ACCORDING TO AMA GUIDES – ATTACH A COMPLETE REPORT OF FINDINGS AND NARRATIVE COMMENTS FOR EACH BODY PART OR SYSTEM.

BODY PART OR SYSTEM CHAPTER # TABLE

A. ____
B. ____
C. ____
D. ____

- ❑ THIS PATIENT HAS BEEN UNDER MY CARE FROM _______TO________
- ❑ I HAVE NOT PROVIDED CARE FOR THIS PATIENT. I HAVE SEEN THIS PATIENT ______TIME (S) FOR THE PURPOSE OF EVALUATING MEDICAL IMPAIRMENT.

____
SIGNATURE

____
PLEASE PRINT NAME

American Association of Oral and Maxillofacial Surgeons- 2002

13

REFERENCES

Parameters and Pathways: Clinical Practice Guidelines for Oral & Maxillofacial Surgery (AAOMS Par Path 01)

Fundamentals of Impairment and Disability Evaluations Handbook, American College of Occupational and Environmental Medicine 1995.

Guides to the Evaluation of Permanent Impairment Fifth Edition. American Medical Association.

Statements by the American Association of Oral and Maxillofacial Surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures Temporomandibular Disorders.

Copyright © AAOMS 2002. Reprinted with permission from the American Association of Oral and Maxillofacial Surgeons.

EXAMINATIONS BY BODY SYSTEMS

Mental and Behavioral

Report Instructions

Mental and Behavioral System Example

THE EXAMINATION REPORTING FORMAT INSTRUCTIONS

OHIO INDUSTRIAL COMMISSION
MENTAL AND BEHAVIORAL HEALTH
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided.
Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF ERPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

HISTORIAN:

ALSO PRESENT DURING EXAMINATION:

DESCRIPTION OF INJURED WORKER:

HISTORY:

REVIEW OF RECORDS: I have reviewed all records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

CHIEF COMPLAINT:

HISTORY OF PRESENT CONDITION:
(*In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)*

REVIEW OF PAST TREATMENT:

CURRENT TREATMENT:

MEDICATIONS:

MENTAL HEALTH HISTORY:

In each section, provide a summary with information from your exam and your review of the medical records provided.

1

Specrpt

Claim #:
IW Name:

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

PAST MEDICAL HISTORY:

FAMILY OF ORIGIN AND PROCREATION:

EDUCATION:

WORK HISTORY:

LEGAL HISTORY:

MILITARY HISTORY:

SUBSTANCE USE AND ABUSE:

In each section, provide a summary with information from your exam and your review of the medical records provided.

MENTAL STATUS EXAMINATION:

APPEARANCE:

ATTITUDE:

BEHAVIOR:

MOOD AND AFFECT:

SPEECH:

PERCEPTUAL DISTURBANCES:

THOUGHT PROCESS: (*quantity, tempo and form*)

THOUGHT CONTENT: (*delusions, hallucinations, obsessions, and phobias*)

COGNITION: (*alertness, orientation, attention, memory, language, and executive function*)

INSIGHT:

JUDGMENT:

This is your examination, report all pertinent positive and negative findings

Specrpt

2

Claim #:
IW Name:

REVIEW OF FOUR FUNCTIONAL AREAS:

ADL/TYPICAL DAY:

SOCIAL FUNCTIONING:

CONCENTRATION, PERSISTENCE, AND PACE:

ADAPTATION:

It is important to compare/contrast the pre-injury and the post-injury activities and abilities to fully convey the injury's effect on the functional capabilities.

In each section, provide a percentage of impairment and the corresponding class level.

REVIEW OF TESTING: *(If applicable)*

MULTIAXIAL DIAGNOSIS:

GAF VALUE:

Provide complete DSM-IV multiaxial diagnosis and GAF value.

OPINIONS:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**
   - **Provide your answer regarding MMI status with supporting rationale.**
   - **Note: If you opine NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the class and percentage of impairment due to the allowed mental and behavioral condition(s) in each of the four functional areas, as well as, the percentage of whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

   ADL/TYPICAL DAY: %
   SOCIAL FUNCTIONING: %
   CONCENTRATION, PERSISTENCE, AND PACE: %
   ADAPTATION: %

   WHOLE PERSON IMPAIRMENT: %

Whole Person Impairment should always be expressed as a whole number.

3

Specrpt

Claim #:
IW Name:

3. **Summarize the Injured Worker's residual mental and behavioral capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Occupational Activity Assessment.**

- **Summarize objective findings from your examination and record review that are related to the allowed conditions in the claim.**
- **Relate these findings to functional deficits or capabilities.**
- **Cite the corresponding work capacity level.**
- **If applicable, provide any workplace limitations.**
- **Complete Occupational Activity Assessment form.**

____________________ (Signature)

__________ (Date)

4

Specrpt

METHODOLOGY

The *AMA Guides, Fifth Edition*, Chapter 14, (Mental and Behavior Disorders) discusses an approach to evaluate and classify mental and behavioral disorders. However, the *AMA Guides, Fifth Edition* does not provide impairment percentages.

Therefore, a table has been constructed for use by the examiners to assist them in classifying and estimating percent impairment, and in order to fulfill the Industrial Commission requirements. This table combines percentages of impairment with the classes of impairment taken from the *AMA Guides, Fifth Edition*, Chapter 14, Table 14.1. A checkpoint for consistency is also offered by the Global Assessment of Functioning (GAF) scale, as this value is inversely related to whole person percentage impairment. This table is included in this section of the *Industrial Commission Medical Examination Manual.*

Classes of Impairment	Class 1 No	Class 2 Mild	Class 3 Moderate	Class 4 Marked	Class 5 Extreme
Description of Impairment Severity	No Impairment is noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some, but not all, useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning
Area/Aspect of Functioning					
Activities of Daily Living					
Social Function					
Concentration					
Adaptation					
GAF Value	100-91	90-61	60-41	40-21	20-1
Whole Person Impairment %	0%	1-25%	26-50%	51-75%	>75%

OHIO INDUSTRIAL COMMISSION

MENTAL AND BEHAVIORAL HEALTH SPECIALIST REPORT

SAMPLE

Injured Worker Name: Sydney Jackson

Date of Birth: 12/04/1965

Claim Number(s): 06-000000

Date(s) of Injury: 08/01/2006

Claim Allowance(s): Lumbosacral strain; aggravation of pre-existing degenerative arthritis, lumbar spine; aggravation of pre-existing disc herniation L5-S1; ***depressive disorder.***

Disallowed Condition(s): None

Place of Examination: 100 State St.
Youngstown, OH 49999

Date of Examination: 05/21/13

Date of Report: 05/21/2013

Examiner Name: Darius Miller, Ph.D.

Purpose of Examination: Permanent Total Disability impairment evaluation.

The purpose of the examination was discussed with the Injured Worker prior to its initiation. I also explained that this would be a one-time evaluation at the request of the Industrial Commission in response to her application for permanent total disability, and that I would be providing a written report to the Industrial Commission, and that the results are not confidential. I explained that I would not be providing her with any type of treatment or advice.

Historian: Sydney Jackson.

Present During Examination: Sydney Jackson.

Description of Injured Worker:
Ms. Jackson is a mid-aged female with a reported height of 5'6" and weight of 280 lbs. She arrived on time for the examination, driven by her sister. She wore a "warm-up" suit, and a baseball cap. She used no walking aids. She moved slowly and guardedly, and grimaced when she sat down. There was no body odor. Her clothes were neat, clean, and appropriate for the weather. Her hair was cut short and was neat and clean. She did have some tears at times during the interview when discussing her injury and having to quit work. Her face looked sad and strained. She was cooperative with the interview and appeared to attempt to engage with the examiner.

Claim #: 06-000000
Injured Worker Name: Jackson

HISTORY:

Current Symptoms:

Low back and leg pain, depression, poor sleep, poor concentration, excessive worry, does not feel like a good wife, frequent crying, low self-esteem.

History of Present Condition:

Ms. Jackson reports while working as a dietary aide in a hospital, she began to experience progressively severe low back pain. Eventually, the pain radiated into her legs. She indicates that this was aggravated by pushing and pulling food trays. As her pain worsened, she requested that her supervisor have her see the occupational health doctor at the hospital. She was evaluated, and was started on physical therapy, and placed on modified duty. Her back pain continued to worsen, and she could no longer tolerate work. She had xrays and an MRI. She was told that "her back was shot" and she would be unable to return to her work. Surgery was not recommended. She underwent injections in her back. Pain medications were tried. She reports no relief from her pain.

She reports that, after leaving work, she became increasingly depressed. She reports feeling useless. "I missed the people at work." She reports more financial stress and stress in her marriage. "I couldn't do nothing to help my family or my husband. I couldn't pay my bills." She was referred for a psychological evaluation, and was diagnosed with depressive disorder.

She reports that she feels sad and lonely. She reports "I can't sleep, and I wake up worried." She reports crying spells five times per week. She reports that at times she has had suicidal thoughts, the last time being one month ago. She reports that she has never had any direct plans to kill herself. She reports no intent to harm anyone else. She reports a low energy level. She reports that she feels hopeless, helpless, and worthless. She reports that she can't do the things she wants to help support her husband financially, emotionally, and physically.

Review of Past Treatment:

With regard to her depression, she reports that she has been tried on various medications, and has undergone counseling on an approximately twice-per-month basis. She tells me that the counseling has helped her understand how to relax at times and cope with her emotional swings. "I don't take it out on everybody else as much."

Review of Records:

I have reviewed all records provided to me by the Industrial Commission including, but not limited to:

- A letter from Dr. Song, her treating psychologist, dated 12/04/12, indicating that "she is permanently and totally disabled due to her depression."
- A letter directed to the Bureau of Workers' Compensation dated 09-21-07, Dr. Chang, a psychiatrist states "it is my opinion that her diagnosis of depressive disorder is directly and causally related to her work injury of 08/01/06."
- An independent medical examination performed for the Industrial Commission on 06-05-10, Dr. Green, a psychologist states "In my opinion, the allowed condition of depression does not in and of itself preclude all work activities for Ms. Jackson. Solely due to her allowed psychological condition she would be capable of functioning in a low stress environment in which she would be able to work at her own pace and with little direct contact with the public."

Current Treatment:

She continues counseling with her psychologist on a twice-per-month basis.
She also sees a psychiatrist once every three months for medication. She has been on Lexapro tapering up to her current dose now for two years. She indicates "it's been the best one I've tried."

Medications:

Other medications include Prilosec, Ultram, Celebrex, and Ditropan. She takes Doxapin at night.

Mental Health History:

Ms. Jackson saw a counselor in the early 1990s for a short period of time following her divorce, and prior to her second marriage. "A couple of months. I felt betrayed." She did not require medication at that time. She reports no other psychiatric problems in the past.

Past Medical History:

She reports recurrent urinary tract infections with urgency and frequency, for which she uses Ditropan. She also has a history of right carpal tunnel syndrome, and has not had surgery. She reports osteoarthritis and joint pain, primarily in her hands and knees. Past surgical history is remarkable for a hysterectomy.

Family Of Origin And Procreation:

Ms. Jackson was born in Cleveland. "My mother and father had a fling." She reports that she never knew her father, and was raised by her mother and stepfather. She reports both physical and verbal abuse by her mother and stepfather. She reports sexual abuse by a friend of her stepfather when she was 15. She left home at age 17 and was married. She reports three siblings, and still keeps in touch with her older sister. "She is my best friend." She has very little contact with her brothers.

She reports that her first marriage lasted about three years, and produced two children. She then remarried several years later, and remains married to the same man, with no children from that marriage.

Education:

She quit school in the 11th grade. She reports that she was not in any special education classes. She achieved her GED approximately five years later.

Work History:

She initially worked as a waitress in a diner. She then worked for about seven years in a factory as a laborer, building automotive components. She then worked as a nursing assistant in a nursing home for about 10 years, and then as a dietary aide at a local hospital for about six years, until the time of her injury. She has not returned to work since 2006.

Legal History:

She reports no legal problems.

Military History:

None.

Substance Use and Abuse:

She reports that she never drank alcohol or smoked cigarettes. She denies the use of any illicit drugs, and tells me she does not misuse or abuse any prescription drugs.

Claim #: 06-000000
Injured Worker Name: Jackson

MENTAL STATUS EXAMINATION:

Attitude:
She was cooperative with the interview.

Behavior:
Mentation was slow, and she struggled to articulate each thought. She stated, "Some things come to me okay, other things I just can't focus on."

Mood and Affect:
She had dark circles under her eyes, and sad facial features. She fidgeted in her chair at times. She would wring her hands at times. She had tears when saying "I just want my life, my work back." She reported no substantial change in appetite over several years, but indicated that she did gain 40 pounds in the first year after she left work. She reports that she typically sleeps four or five hours and then wakes up and has trouble getting back to sleep. She reports forgetting appointments. She reports decreased sex drive.

Speech and Language:
Her speech was of low tone, slow pace, and normal rhythm. She was relevant and coherent. There was no tangential speech or circumlocution.

Perceptual Disturbances:
She denied any hallucinations. She denied any feelings that people are "out to get her."

Thought Process (Quantity, Tempo and Form):
There is no tangential or circumstantial conversation, and she appears to maintain the flow of conversation in a goal-directed fashion.

Thought Content (Delusions, Hallucinations, Obsessions and Phobias):
She denies any suicidal or homicidal ideation. She reports suicidal thoughts about once a month. "I've thought about it, but I couldn't leave my sister or kids." She denies any obsessions or delusions.

Cognition (Alertness, Orientation, Attention, Memory, Language and Executive Function):
She is alert and oriented to person, place, time, and situation. She states the place as Youngstown, Ohio, the year as 2013, the month as May, and the situation as "Workers' Comp." She demonstrated recall of her past information regarding her work injury history, which was consistent with the medical record. She stated the current President as Obama, and former President as Bush. When asked, "Who was Thomas Edison?" she stated "light bulbs." When asked, "Who was Martin Luther King, Jr.?" she stated "civil rights leader." When asked, "What is Genesis?" she stated, "A book of the Bible." When asked, "What did you have for dinner the night before?" she stated, "Creamed corn, beans and meatloaf." When asked, "What did you watch on TV the day before?" she stated, "Dancing with the Stars." She could not recall the winner. She did not recall my name. She did recall two of three objects at five minutes. She was able to recall six digits forward and three digits backward. She was able to spell the word house backwards without errors. She was not able to spell the word world backwards without errors. She was able to complete serial sevens backwards from 100 to 93, and then said "87."

Insight:
When asked, "What is causing your problems?" she stated, "I was hurt at work. I have pain. It took away my life. I am not the person I used to be. I feel bad about myself, and how I have to live now."

Judgment:

When asked, "What do you do if you're the first person in a movie theater to see smoke and fire?" she stated, "Look for the fire alarm and tell people to get out." When asked, "What would you do if you found on the street of a city an envelope that was sealed, addressed, and stamped?" she stated, "Mail it." When asked, "Why shouldn't people smoke in bed?" she stated, "They'll catch on fire."

REVIEW OF FOUR FUNCTIONAL AREAS:

ADLs/Typical Day:

Ms. Jackson reports that she is physically limited by back pain. She reports that she can only stand at the sink for 5 minutes at a time, and walks about a half block before having to sit down. I asked her to try to separate her physical limitations from what she can do based on her depression. She is able to perform her own hygiene activities, "but it takes me twice as long." She reports that she and her husband argue over that a lot, especially about preparing meals. She stated that she does not have the "push" to cook every night, or to complete all of her housework in a day. She will go to the store with her sister, who helps her. She rides an electric cart. She states that she does make phone calls and talks to her sister and friends most days. She spends much of her time reading magazines or watching TV, or sitting on the porch if the weather is nice. She indicates that when they recently moved, she felt like a burden because she was not able to help with any of the lifting or boxing. She reports that her desire for sex is markedly decreased "I feel like I have to force myself." Class II, mild, 20%.

Social Functioning:

She reports that she does go to church with her husband on a weekly basis. She does not participate in any volunteer activities. She says, "I feel like I'm just not worth anything to anybody." She talks on the phone with her sister and friends several times a week. She and her husband do not go out to eat, unless there is some special occasion with the family. She does not belong to any clubs or organizations. Class II, mild, 15%.

Concentration, Persistence, And Pace:

She tells me that she has forgotten appointments, and her husband makes a point to write things on the calendar for her. She was able to pay attention and persist in goal-directed conversation during the interview. She tells me she reads about a half an hour at a time "then things get fuzzy. I can't remember what I read the day before." Class II, mild, 20%.

Adaptation:

She tells me that several times a week, she becomes frustrated with her situation, and breaks down and cries. This often happens when her husband asks her to complete a task. She tells me that when this happens, she "shuts down," and is not motivated to pursue anything more the rest of the day. Class II, mild, 25%.

Multiaxial Diagnosis:

AXIS I: Depressive disorder
AXIS II: Diagnosis deferred
AXIS III: Diagnosis deferred
AXIS IV: Occupational stress and physical pain
AXIS V: GAF = 70

Claim #: 06-000000
Injured Worker Name: Jackson

OPINIONS:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no, describe the rationale for your opinion and disregard items #2 and #3. If "yes," describe the rationale for your opinion and complete items #2 and #3..**

   Yes. Her depressive symptoms appear stable over time. She continues on medication and counseling, which have not changed now for several years, and are not expected to change in the foreseeable future.

2. **Based on the *AMA Guides, Fifth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the class and percentage of impairment due to the allowed mental and behavior condition(s) in each of the four functional areas, as well as, the percentage of whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

   ADL/TYPICAL DAY: 20%, Class II, mild
   SOCIAL FUNCTIONING: 15%, Class II, mild
   CONCENTRATION, PERSISTENCE, AND PACE: 20%, Class II, mild
   ADAPTATION: 25%, Class II, mild
   WHOLE PERSON IMPAIRMENT: 20%, Class II, mild

3. **Summarize the Injured Worker's residual mental and behavioral capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Occupational Activity Assessment.**

   Considering only her psychological impairment due to the allowed condition of depressive disorder, it is my opinion that Ms. Jackson would be capable of work with the following further limitations:
   1. One to two step tasks only to address her concentration deficits, and;
   2. Ability to have a flexible break schedule to address her adaption needs and avoid frustration.

Darius Miller, Ph.D.

Darius Miller, Ph.D.

OCCUPATIONAL ACTIVITY ASSESSMENT

Mental & Behavioral Examination

Injured Worker: Sydney Jackson   Claim Number(s): 06-000000

Based solely on impairment resulting from the allowed mental and behavioral condition(s) in this claim within my specialty, and with no consideration of the Injured Worker's age, education, or work training:

( ) This Injured Worker has no work limitations.
( ) This Injured Worker is incapable of work.
(X) This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

See report.

Physician's Signature: Darius Miller, Ph.D. Date: 5/21/2013

Physician's Name (print): Darius Miller, Ph.D.

EXAMINATIONS BY BODY SYSTEMS

Visual System

Report Instructions

Visual System Example

THE EXAMINATION REPORTING FORMAT INSTRUCTIONS

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided. Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF REPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

OCCUPATIONAL HISTORY:

HISTORY OF THE PRESENT CONDITION:
(In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)

CURRENT SYMPTOMS: *(In this area include: pain location, character, intensity, aggravating and alleviating factors)*

IMPACT ON ACTIVITIES: *In this area include: visual impact on mobility, reading ability, driving ability, hobbies, describe daily activities)*

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

HEALTH HABITS: *(Tobacco, alcohol, drugs, exercise)*

In each section, provide a summary with information from your exam and your review of the medical records provided.

When describing the Impact on Activities, compare/contrast the pre-injury and the post-injury activities and abilities to fully convey the injury's effect on the functional capabilities.

Claim #: Provide a claim identifier (claim #, Injured Worker's name) and page
IW Name: number on every page to ensure we have received your complete report.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records provided to me by the Ohio Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

PHYSICAL EXAMINATION:

This is your examination, report all pertinent positive and negative findings

OPINION:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**
   - Provide your answer regarding MMI status with supporting rationale.
   - Note: If you opine NOT at MMI, please provide proper rationale according to State of Ohio definitions.

2. **Based on the AMA Guides, Fourth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed conditions	Table/figure/page number	Comments	Whole Person Impairment %
Group your specialty assigned allowances by body part, and/or system being evaluated. List them exactly as on pg. 1.	Include the page number and the table or figure number for each table/figure used.	Provide comments that explain your table/percentage choice such as: Class ranking/ rationale for multi-class table/figure.	If there is no impairment for an allowance, indicate zero percent. WPI should always be expressed in a whole number percentage.
	Combined Values Chart, pgs 322-324	Combined whole person impairment:	

Claim #:
IW Name:

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Function Assessment.**

- **Summarize objective findings from your examination and record review that are related to the allowed conditions in the claim.**
- **Relate these findings to functional deficits or capabilities.**
- **Cite the corresponding work capacity level.**
- **If applicable, provide any further work place limitations.**
- **Complete Residual Function Assessment form.**

________________________ ____________
(Signature) (Date)

METHODOLOGY

The Commission will continue to use *AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition*, in determining whole person percentage impairment, since *AMA Guides, Fifth Edition*, procedures do not meet Ohio's legal requirements.

Please note that corrected vision should be used for rating impairment in the case of application for Permanent Total Disability, including if the correction is by surgical or other (e.g., contact lens or glasses) means.

However, in the rare case of evaluation for loss of use of an eye in the case of application for a scheduled loss award, then the specialist must use uncorrected vision, without consideration of correction to vision due to surgical or other (e.g., contact lens or glasses) means.

AMA Guides, Fourth Edition, permanent impairment percentages consider near and far central visual acuity, visual field perception, abnormal ocular motility and binocular diplopia. Specialists may combine an additional five to ten percent impairment for ocular or adnexal conditions that interfere with visual function not reflected in the visual acuity, visual field, or ocular motility impairment. These conditions might include media opacities, corneal or lens opacities, and abnormalities that cause symptoms such as epiphora, photophobia, or metamorphopsia. Up to ten percent additional impairment may also be considered for scars or cosmetic defects.

Table 3 "Loss (in %) of Central Vision in a Single Eye" provides the percent loss of central vision in a single eye using the measured Snellen rating for distant and near vision. The table also provides values for each combination of near and distant vision with and without allowance for monocular aphakia and pseudophakia.

Table 5 "Loss of Monocular Visual Field" provides percent loss based on the number of degrees of visual field loss due to the allowed condition. Figure 3 "Percentage Loss of Ocular Motility of One Eye in Diplopia Fields" is used to determine the loss due to ocular motility when appropriate.

To determine visual loss for "an eye," loss of central and near vision, loss due to visual fields, and loss due to diplopia are combined using the *AMA Guides* Combined Values Chart (pages 322-324).

An example of an Ophthalmologic Independent Medical Examination follows.

SAMPLE

OHIO INDUSTRIAL COMMISSION
OPHTHALMOLOGY SPECIALIST REPORT

Injured Worker Name: Daniel Brown
Date of Birth: 07/15/1964
Claim Number(s): 10-000000
Date(s) of Injury: 05/05/2010
Claim Allowance(s): ***Retinal edema, left eye; optic atrophy, left eye;*** traumatic brain injury; subdural hematoma; fracture right humerus; pneumothorax; hearing loss, left ear; tinnitus.

Disallowed Condition(s): None
Place of Examination: 100 State Street, Dayton, OH 45454
Date of Examination: 05/01/2013
Date of Report: 05/01/2013
Examiner Name: Alexis Hill, M.D.

Purpose of Examination: Permanent Total Disability Impairment Evaluation

Occupational History: Mr. Brown was working as a construction laborer/carpenter doing house framing, window, door, and dry wall installations.

History of the Present Condition:
Mr. Brown was working on a roof trying to throw an extension cord from the second floor when he slipped and fell downward from the roof rafters for about 20 feet. He fell face down in the dirt, as well as on his chest and arm. He had multiple injuries as outlined in the allowed conditions. He did obtain some stitches above his left eyebrow.

Current Symptoms:
He says his vision is fuzzy all the time. The closer the object gets, the fuzzier the image. He feels he has some type of pimple or foreign body in his eyes and he uses tears for relief. He reports frequent headaches and the light bothers him especially when he moves his eyes. He has a lot of pain in the front of his eyes. When he moves his eyes it feels like his whole forehead is moving.

Impact on Activities:
The Injured Worker reports modest visual impact as a result of his injuries. He is able to read fine print with reading glasses that are appropriate for his age. He was able to obtain a standard driver's license.

Past Medical History:
Headaches, depression, and anxiety.

Past Surgical History:
Cholecystectomy, 2009.

Current Medications:
Ultram, Neurontin, Cymbalta

Allergies:
Penicillin

Social History:
He is divorced and has two grown children.

Health Habits:
He denies alcohol or tobacco use.

Review of Medical Records:
I reviewed all of the medical records provided to me by the Industrial Commission.

Physical Examination:
Uncorrected distance vision OD is 20/20. Best corrected distance vision OD is 20/20. Uncorrected near vision OD is J-7. Best corrected near vision OD is J-1. Uncorrected distance vision OS is 20/25. Best corrected distance vision OS is 20/25. Uncorrected near vision OS is CF. Best corrected near vision OS is J-1.

Pupil OD is normal. Pupil OS is normal but there is faint evidence of an afferent pupillary defect. Motility OU is normal. Adnexa OU is normal with exception of a lateral horizontal scar above left eyebrow. Eyelids are normal OU. Sclera is normal OU. Conjunctiva is normal OD. Conjunctiva OS has a pterygium which is well onto the cornea nasally. Iris is normal OU. Media is clear OU. IOP is 18 mm Hg OU. Fundus is normal OD (optic nerve, macula, vessels and periphery). Fundus is normal OS with exception of temporal optic nerve atrophy (macula, vessels and periphery).

Goldmann visual field OD is normal. Goldmann visual field OS shows nasal hemianopsia but otherwise normal. Confrontation field OD is normal. Confrontation field OS tested normal with only minimal nasal field depression.

Opinion:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   Yes. His allowed conditions related to the left eye have had adequate time to return to baseline and are not expected to change.

2. **Based on the *AMA Guides, Fourth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Claim #: 10-000000
Injured Worker Name: Brown

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Retinal edema, left eye		Receded.	0%
Optic atrophy, left eye	Tables 3 and 6, pp. 212 and 218.		3%
	Combined Values Chart, pages 604-606	**Combined whole person impairment:**	**3%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in this claim is: 3%.

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Functional Assessment.

Solely with regard to his allowed visual conditions, there are no work limitations. He should be able to safely work at heights or around moving equipment as his central visual reduction and his peripheral vision reduction should not be limiting. Corrected reading and distant vision are not significantly affected.

Alexis Hill, M.D.

Alexis Hill, M.D.

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: Daniel Brown ______________ Claim Number(s): 10-000000 ______

____

____

____

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

(X) This Injured Worker has no work limitations.
(   ) This Injured Worker is incapable of work.
(   ) This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

____

____

____

____

____

Physician's Signature: *Alexis Hill, M.D.* __________ Date: 5/21/2013 ___

Physician's Name (print): Alexis Hill, M.D. ______________________

EXAMINATIONS BY BODY SYSTEMS

Ear, Nose, and Throat

Report Instructions

Ear, Nose, and Throat System Example

THE EXAMINATION REPORTING FORMAT INSTRUCTIONS

OHIO INDUSTRIAL COMMISSION
SPECIALIST REPORT

INJURED WORKER NAME:
DATE OF BIRTH:
CLAIM NUMBER(S):
DATE(S) OF INJURY:
CLAIM ALLOWANCE(S):
DISALLOWED CONDITION(S):

This information can be found on the Medical Scheduling Worksheet and/or the Statement of Facts and must be listed exactly as provided.
Do NOT include Social Security number.

PLACE OF EXAMINATION:
DATE OF EXAMINATION:
DATE OF REPORT:
EXAMINER NAME:

Your examiner information.

PURPOSE OF EXAMINATION: The purpose of the examination was discussed at the request of the Ohio Industrial Commission in response to the Injured Worker's application for permanent total disability, that I would be providing a written report to the Ohio Industrial Commission and that the results of this examination are not confidential. I explained that I would not be providing the Injured Worker with any type treatment or advice.

OCCUPATIONAL HISTORY:

HISTORY OF THE PRESENT CONDITION:
(In this area include: description of injury, job duties at the time, treatment, response to treatment, current treatment, treatment plan)

CURRENT SYMPTOMS: *(In this area include: pain location, character, intensity, aggravating and alleviating factors. Review systems pertinent to each allowed condition.)*

IMPACT ON ACTIVITIES: *(In this area include: walking, sitting, standing tolerance, housework, yard work, basic self-care [dressing, bathing, toileting], hobbies, sleep, driving; describe daily activities).*

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

HEALTH HABITS: *(Tobacco, alcohol, drugs, exercise)*

In each section, provide a summary with information from your exam and your review of the medical records provided.

When describing the Impact on Activities, it is important to compare/contrast the pre-injury and the post-injury activities.

1

Specrpt

Claim #:
Injured Worker Name:

Provide a claim identifier (claim #, Injured Worker's name) and page number on every page to ensure we have received your complete report.

REVIEW OF MEDICAL RECORDS: I reviewed all of the medical records provided to me by the Industrial Commission.

This statement encompasses the Medical Scheduling Worksheet, Statement of Facts, Referral letter, and the Specialist Packet.

PHYSICAL EXAMINATION: Height: Weight:
(Examine each body part and/or system for which there is a claim allowance, in the manner required by the AMA Guides, 5th Edition.)

This is your examination. Report all pertinent positive and negative findings. ROM should be well documented with the use of goniometers and inclinometers.

OPINION:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**
   - **Provide an answer regarding MMI status with supporting rationale.**
   - **Note: If NOT at MMI, please provide proper rationale according to State of Ohio definitions.**

2. **Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed condition	Table/figure/page number	Comments	Whole Person Impairment %
Group your specialty assigned allowances by body part, and/or system being evaluated. List them exactly as on pg. 1.	Include the page number and the table or figure number for each table/figure used.	Provide comments that explain your table/percentage choice, such as: - DRE vs ROM rationale - Class ranking/ rationale for multi-class table/figure.	If there is no impairment for an allowance, indicate zero percent. WPI should always be expressed in a whole number percentage.
	Combined Values Chart, pgs. 604 - 606	Combined whole person impairment:	

2

Specrpt

Claim #:
Injured Worker Name:

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Function Assessement.**

   - **Summarize objective findings from examination and record review that relate to the allowed condition(s) in the claim. Compare/contrast to Impact of Activities section.**
   - **Relate these findings to functional deficits or capabilities.**
   - **Cite the corresponding work capacity level as listed on the Residual Function Assessment form.**
   - **If applicable, provide any further work place limitations additional to the established Department of Labor categories.**
   - **Complete Residual Function Assessment form.**

____________________ (Signature)

__________ (Date)

3

Specrpt

METHODOLOGY FOR RATING HEARING IMPAIRMENT

As stated in *AMA Guides, Fifth Edition*, hearing should be measured and reported with and without the Injured Worker's assistive device, if applicable. Impairment rating is to be determined without the assistive device. Assisted hearing is to be considered when determining residual functional capacity due to the allowed conditions when the Injured Worker has an assistive device.

OHIO INDUSTRIAL COMMISSION
ENT
SPECIALIST REPORT

SAMPLE

Injured Worker Name: Daniel Brown
Date of Birth: 07/15/1964
Claim Number(s): 10-000000
Date(s) of Injury: 05/05/2010
Claim Allowance(s): Retinal edema, left eye; optic atrophy, left eye; traumatic brain injury; subdural hematoma; fracture right humerus; pneumothorax; ***hearing loss, left ear; tinnitus***.

Disallowed Conditions: None
Place of Examination: 100 State Street,
Dayton, OH 45454

Date of Examination: 05/01/2013
Date of Report: 05/21/2013
Examiner Name: Kelly Sullivan, M.D.

Purpose of Examination: Permanent Total Disability Impairment Evaluation

Occupational History: Construction laborer/carpenter

HISTORY OF THE PRESENT CONDITION:

Complaint: Hearing loss.
Location: Left ear.
Quality: Ringing.
Severity: Trouble following conversations with background noise.
Timing: Constant.
Setting in which it first occurred: Work injury fell 20 feet with head injury.
Aggravating factors: None
Relieving factors: None
Associated manifestations: None
Previous tests/evaluations: Prior audiometry on record December 2010 reported moderate neural hearing loss.
Previous treatment: None

Impact on Activities:
He reports trouble hearing in crowds or when there is background noise. Injured Worker does not wear a hearing aide in either ear.

Past Medical History:
Headaches, depression, and anxiety.

Past Surgical History:
Cholecystectomy, 2009.

CURRENT MEDICATIONS:
Ultram, Neurontin, Cymbalta

ALLERGIES:
Penicillin

SOCIAL HISTORY:
He is divorced and has two grown children.

HEALTH HABITS:
He denies alcohol or tobacco use.

REVIEW OF MEDICAL RECORDS:
I reviewed all of the medical records provided to me by the Industrial Commission.

PHYSICAL EXAMINATION:

Inspection of the Head and Face: Face and head symmetry and contour normal. No skin lesions noted.
Percussion and palpitation of the Face: No tenderness to percussion or pressure.
Palpation of Parotid and Submaxillary glands: Right parotid normal. Left parotid normal. Right submaxillary gland normal. Left submaxillary gland normal.
Facial Mobility: Normal
Temporomandibular Joints: Hypomobile.
Pinnas and External Nose: Normal.
Otoscopic exam:
*Right ear – External canal – normal size; skin normal; cerumen absent. Tympanic membrane translucent, normal light reflex; normal mobility to pneumatic otoscopy.
*Left ear – same as the right. External auditory canal normal. Tympanic membrane translucent, normal light reflex; normal mobility to pneumatic otoscopy.
Hearing: Normal to conversational and whispered speech and to tuning fork tests.
Nasal Interior: Normal nasal septum.
Turbinates and middle meatus –
*Right – inferior turbinate normal.
*Left – inferior turbinate normal.
Normal mucosa with no swelling, polyps, active bleeding or evidence of bleeding.
Lips, Teeth and Gums: Lips normal. Teeth in good repair. Gums normal.
Oral Cavity and Oropharynx: Tonsils and soft palate normal. Posterior pharynx normal. Oral mucosa with normal color and moisture. No oral or oropharyngeal mucosal lesions. Anterior 2/3rds of tongue nrmal. Hard palate normal.
Base of tongue, Pharyngeal walls, Vallecula and Pyriform Sinuses: The hypopharyngeal walls normal. Pyriform sinuses normal.
Larynx: Epiglottis – normal. False vocal cords – normal. True vocal cords – normal mobility, no lesions. Voice quality – normal.
Nasopharynx examination: Could not visualize with the mirror due to gag. Nasopharyngeal mucosa normal. Adenoids normal. Posterior choanae normal. Eustachian tubes orifices normal.
Neck: Normal symmetry; trachea midline; normal laryngeal crepitation; no adenopathy; no neck masses.

Claim #: 10-000000
Injured Worker Name: Brown

Thyroid: Normal size; no masses or tenderness
Lymph nodes neck: Normal

92557 Comprehensive Audiometry:
Tympanograms: Type Ad for the right ear, Type A for the left ear. Acoustic Immitance revealed normal external auditory canal volumes for both ears. Speech discrimination
Scores: R: 100%, L:92%. Pure tone audiometry testing indicated hearing WNL from 250-4000 Hz sloping to a mild hearing loss at 8 kHz in the right ear, and a moderately-severe SNHL for the left ear. The impairment calculated from this audiogram is based on the DSHL. The DSHL for the left ear is 30 (5+5+5+15) and 0% for the right.

Opinion:

1. **Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.**

   Yes. His allowed conditions related to hearing are stable compared to previous audiometric examination on the record. No further change is expected with or without treatment.

2. **Based on the *AMA Guides, Fifth Edition*, and with reference to the *Industrial Commission Medical Examination Manual*, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.**

Allowed Condition	Table/Figure/Page Number	Comments	Whole Person Impairment %
Hearing loss, left ear	Tables 11-1, 11-2, and 11-3, pp. 247-249	There is 34% hearing loss, left ear, with tinnitus, stable	2%
Tinnitus	Page 246		3%
	Combined Values Chart, pages 604-606	**Combined whole person impairment:**	**5%**

It is my opinion that the combined whole person impairment for the allowed condition(s) in this claim is: 5%.

3. **Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Residual Functional Assessment.**

   The Injured Worker would require standard occupational hearing protection.

Kelly Sullivan, M.D.

Kelly Sullivan, M.D

RESIDUAL FUNCTION ASSESSMENT

Injured Worker: Daniel Brown Claim Number(s): 10-00000

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education and work experience:

( ) This Injured Worker has no work limitations.
( ) This Injured Worker is incapable of work.
(X) This Injured Worker is capable of work with the limitation(s)/modification(s) noted below:

The Injured Worker would require standard occupational hearing protection.

Physician's Signature: Kelly Sullivan, M.D. Date: 5/21/2013

Physician's Name (print): Kelly Sullivan, M.D.

APPENDIX

Medical Examination Referral Letter

Medical Exam Worksheet

Statement of Facts

Appropriate Assessment Forms

IC Provider Fee Bill

Permanent Total Disability Application

MEDICAL EXAMINATION REFERRAL LETTER

STATE OF OHIO
THE OHIO INDUSTRIAL COMMISSION

MEDICAL EXAMINATION REFERRAL

DOCTOR: SPECIALTY: Occupational Medicine

DATE & TIME OF EXAM:

INJURED WORKER: CLAIM NUMBER(S):

The above Injured Worker has been referred to you for an independent medical examination to assist the Ohio Industrial Commission in its consideration of the Injured Worker's application for a determination of Permanent Total Disability. Pertinent medical documents are enclosed. Based solely on the allowed condition(s) within your specialty, which are identified on the enclosed Medical Examination Worksheet, provide opinions on the following issues:

1. Has the Injured Worker reached maximum medical improvement with regard to the allowed condition(s)? If "no", describe the rationale for your opinion and disregard items #2 and #3. If "yes", describe the rationale for your opinion and complete items #2 and #3.

2. Based on the AMA Guides, Fifth Edition, and with reference to the Industrial Commission Medical Examination Manual, provide the estimated percentage of whole person impairment arising from each allowed condition. Then, provide a combined whole person impairment. If there is no impairment for an allowed condition, indicate 0%.

3. Summarize the Injured Worker's residual functional capacity resulting from the impairment associated with the allowed condition(s). Then, complete the enclosed Physical Strength Rating.

Use the standard format and follow the policies presented in the Industrial Commission Medical Examination Manual (www.ic.ohio.gov) when reporting your findings and opinions. If you have questions regarding examination issues, fee bills, or the report format, please contact Medical Services at 614-466-4291.

As an Industrial Commission independent examiner, you may have no contact with any party to the claim except the Injured Worker. Contact with the Injured Worker must be limited to the examination only. You may not accept the examined Injured Worker into treatment, as this action disqualifies you as an independent medical examiner.

Within ten (10) business days from the date of examination, forward your report, the Physical Strength Rating, and fee bill to Medical Services.

If the Injured Worker fails to keep the appointment, or if you have other questions, please call 614-387-4501 or 1-800-574-6559.

Page 1

DRLTR

STATE OF OHIO
THE OHIO INDUSTRIAL COMMISSION

MEDICAL EXAMINATION REFERRAL

INJURED WORKER: CLAIM NUMBER(S):

Medical Services (Columbus Office)
30 W. Spring St., Level 10
Columbus OH 43215-2233

DATE MAILED:

Page 2

DRLTR

MEDICAL EXAM WORKSHEET

MSCRME03 I C - M E D I C A L E X A M W O R K S H E E T Page 1

COL : Medical Territory Location
POR : 1st Level Hearing Location

Claim Number:

Injured Worker:

****
* PLEASE EXAMINE *
* IDENTIFIED *
* CONDITIONS ONLY *
****

Employer:

Date Of Birth: Sex: SSN:
Date Of Injury/Diagnosis/Disability: Date of Death:

Claim Allowance(s):
1/16/2017 PARALYSIS VOCAL CORDS AND LARYNX, UNILATERAL; CONTUSION/LACERATION RIGHT CEREBRUM WITH LOSS OF CONSCIOUSNESS 30 MINUTES/LESS; TRAUMATIC SUBDURAL HEMORRHAGE WITH LOSS OF CONSCIOUSNESS 30 MINUTES/LESS; WEDGE COMPRESSION FRACTURE FIRST LUMBAR VERTEBRA; TRAUMATIC SUBARACHNOID HEMORRHAGE WITH LOSS OF CONSCIOUSNESS 30 MINUTES/LESS; OTHER FRACTURE OCCIPITAL RIGHT SIDE; CONTUSION/LACERATION LEFT CEREBRUM WITH LOSS 30 MINUTES/LESS; OTHER FRACTURE OCCIPITAL LEFT SIDE; STRAIN UNSPECIFIED MUSCLE/FASCIA/TENDON RIGHT SHOULDER; WINGED SCAPULA RIGHT SHOULDER; RIGHT ACROMIOCLAVICULAR JOINT SEPARATION; SUBSTANTIAL AGGRAVATION OF PRE-EXISTING DERANGEMENT TEMPOROMANDIBULAR JOINT RIGHT SIDE; BILATERAL INGUINAL HERNIAS; MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD; GENERALIZED ANXIETY DISORDER; GLIOSIS WITHIN INFERIOR FRONTAL LOBE AND ENCEPHALOMALACIA; TRAUMATIC BRAIN INJURY AND CONCUSSION WITH LOSS OF CONSCIOUSNESS; POST CONCUSSION SYNDROME. DISALLOWED: ANOSMIA AND AGEUSIA.

Clt County: Scioto

Previous Physician(s):

Number of Specialists: 04
Type(s): PMR OCCMD ENT NEURP

Examination Issue: ME5

Other Questions:

Created By: LC Revised By: SC

MEDWRKSHT

STATEMENT OF FACTS

STATEMENT OF FACTS

INJURED WORKER CLAIM NUMBER(S)

ISSUE: APPLICATION FOR PERMANENT TOTAL DISABILITY, FILED 06/12/2019

CLAIM NUMBER: EMPLOYER:

ALLOWED CONDITION(S): SPRAIN NECK; SPRAIN LUMBAR REGION; FOREHEAD ABRASION, FACE; CONTUSION LEFT ELBOW; CONTUSION LEFT SHOULDER REGION; CONTUSION SCALP (HEAD); L4-5 DISC PROTRUSION; POST-TRAUMATIC STRESS DISORDER; LEFT ROTATOR CUFF TENDINOSIS; PARTIAL LEFT ROTATOR CUFF TEAR; SUBSTANTIAL AGGRAVATION OF PRE-EXISTING DEGENERATIVE JOINT DISEASE C3-C4, C4-5, C5-6, C6-7; LEFT SHOULDER LABRAL TEAR; LUMBAR POST LAMINECTOMY SYNDROME; CONCUSSION WITHOUT LOSS OF CONSCIOUSNESS; POST-CONCUSSIVE SYNDROME; SUBSTANTIAL AGGRAVATION OF PRE-EXISTING CHRONIC MIGRAINES.

DISALLOWED CONDITION(S): None.

DATE OF INJURY: 05/10/2012

OCCUPATION AT THE TIME OF INJURY: Truck Driver

DESCRIPTION OF INJURY AS PROVIDED: Per Order: Injured Worker was driving West on 303 coming up to 57, car started slow and then speed up through stop sign. T-boned ended in ditch.

DIAGNOSTIC TESTS:

1. (ECM document date: 5/15/2012) Medina Hospital - Brain, 05/10/2012, CT SCAN*
2. (ECM document date: 5/15/2012) Medina Hospital - cervical/thoracic/lumbar spine, 05/10/2012, X-RAY*
3. (ECM document date: 5/15/2012) Medina Hospital - left elbow/left knee/left shoulder, 05/10/2012, X-RAY*
4. (ECM document date: 5/22/2012) Medina Hospital - Left Elbow, 05/21/2012, X-RAY*
5. (ECM document date: 6/7/2012) Medina Hospital - Left Elbow, 06/04/2012, MRI*
6. (ECM document date: 6/16/2012) Medina Radiology - Cervical Spine, 06/04/2012, MRI*
7. (ECM document date: 6/28/2012) Medina Radiology - lumbar spine, 06/15/2012, MRI*

8. (ECM document date: 6/28/2012) Medina Radiology - left shoulder, 06/15/2012, MRI*
9. (ECM document date: 9/19/2013) St. Vincent Charity - Lumbar Spine, 08/14/2013, X-RAY*
10. (ECM document date: 11/7/2017) University Hospitals - Cervical spine/Lumbar spine, 10/25/2017, MRI*
11. (ECM document date: 6/4/2018) Rockside Physician Center - cervical spine, 08/30/2017, X-RAY*

SURGERIES:

1. (ECM document date: 9/11/2013) 8/14/2013, Lumbar discectomy with partial medial facetectomy and laminectomy.
2. (ECM document date: 1/31/2014) 10/30/2013, Left shoulder arthroscopy with arthroscopic repair of superior labrum.
3. (ECM document date: 5/24/2017) 5/18/2017, 1. Left C4-5 facet joint radiofrequency denervation.
   2. Left C5-6 facet joint radiofrequency denervation.

PAID:	Total Indemnity	$210,395.98
	Total Medical	$95,807.03
	Last date of Temporary Total Compensation	8/14/2019

INJURED WORKER'S EVIDENCE:

1. (ECM document date: 6/12/2019) Application for Permanent Total Disability

EMPLOYER'S MEDICAL EVIDENCE: None.

DISABILITY FACTORS (Not to be considered by specialist when answering questions 1, 2, & 3):

1. Age: 48 Date of Birth: 06/13/1971 Date Last Worked: 5/10/2012
2. Education: North Royalton High School
   Graduated, 6/1990

   Injured Worker can read, write and do basic math. Injured Worker does not have basic computer skills.
3. Previous Occupations and Work Experience: 1) Truck Driver, 2005 to 5/10/2012. Load steel on trailer, secure steel to trailer, deliver and unload steel. Read/wrote log books.

   2) , Machine Operator/Warehouse Worker, 2002 to 2004. Ran machines, shipping and receiving in warehouse.

3) Machine Operator, 1996 to 2001. Ran grinding machine. Used grinding machines. Read blueprints for sizes.

4) Warehouse Shipping & Receiving, 1990 to 1995. Drove tow motor, used pallet jacks to move deliveries. Used tow motor and pallet jack.

4. Special Training and/or Special Vocational Skills/Certifications: Truck Driving School in 2003

OTHER RELEVANT FACTORS:

Tens unit
Cane
Cervical traction unit
Right hand dominant

Mental MMI 4/29/2019, DD: 6/13/2019.

Stacey Viar, 09/06/2018, FUNC CAPACITY EVAL

Physical - ongoing tt

SOL: All MV'S, All 94's, 10-307470; 04-377118

Injured Worker filed for Social Security Disability benefits.

REHABILITATION INVOLVEMENT:

1. (ECM document date: 11/1/2012) Opening/Closing Date: 11/1/2012: Vocational Rehabilitation Closure Report
2. (ECM document date: 6/1/2018) Opening/Closing Date: 6/1/2018: Vocational Rehabilitation Closure Report
3. (ECM document date: 10/3/2018) Opening/Closing Date: 9/19/2018: Vocational Rehabilitation Closure Report

Statement Prepared By:	Created:	Current Date:
Medical Services	Modified:	Current Time:

SOFSHO1

APPROPRIATE ASSESSMENT FORM: PHYSICAL STRENGTH RATING

PHYSICAL STRENGTH RATING

INJURED WORKER: CLAIM NUMBER(S):

Based solely on impairment due to the allowed condition(s) in the claim within my specialty, and with no consideration of the injured worker's age, education, or work training:

( ) This injured worker has no work limitations.

( ) This injured worker is incapable of work.

( ) This injured worker is capable of work as indicated below.

( ) "SEDENTARY WORK"

Sedentary work means exerting up to ten pounds of force occasionally (occasionally: activity or condition exists up to one-third of the time) and/or a negligible amount of force frequently (frequently: activity or condition exists from one-third to two-thirds of the time) to lift, carry, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

Further limitations, if indicated:
____
____

( ) "LIGHT WORK"

Light work means exerting up to twenty pounds of force occasionally, and/or up to ten pounds of force frequently, and/or a negligible amount of force constantly (constantly: activity or condition exists two-thirds or more of the time) to move objects. Physical demand may be only a negligible amount, a job should be rated light work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling or arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

Further limitations, if indicated:
____
____

( ) "MEDIUM WORK"

Medium work means exerting twenty to fifty pounds of force occasionally, and/or ten to twenty-five pounds of force frequently, and/or greater than negligible up to ten pounds of force constantly to move objects. Physical demand requirements are in excess of those for light work.

( ) "HEAVY WORK"

Heavy work means exerting fifty to one hundred pounds of force occasionally, and/or twenty to fifty pounds of force frequently, and/or ten to twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for medium work.

( ) "VERY HEAVY WORK"

Very heavy work means exerting in excess of one hundred pounds of force occasionally, and/or in excess of fifty pounds of force frequently, and/or in excess of twenty pounds of force constantly to move objects. Physical demand requirements are in excess of those for heavy work.

PHYSICIAN'S SIGNATURE ______________________________ DATE _____________
PHYSICIAN'S NAME (PRINT) ___________________________________

SPECRPT

APPROPRIATE ASSESSMENT FORM: OCCUPATIONAL ACTIVITY ASSESSMENT

OCCUPATIONAL ACTIVITY ASSESSMENT
Mental & Behavioral Examination

INJURED WORKER : CLAIM NUMBER(S):

___

Based solely on impairment resulting from the allowed mental and behavioral condition(s) in this claim within my specialty, and with no consideration of the injured worker's age, education, or work training:

( ) This injured worker has no work limitations.

( ) This injured worker is incapable of work.

( ) This injured worker is capable of work with the limitation(s)/modification(s) noted below:

___

Psychiatrist/Psychologist Signature:____________________________

Psychiatrist/Psychologist Name (Print):
Date:____________________________

APPROPRIATE ASSESSMENT FORM: RESIDUAL FUNCTION ASSESSMENT

RESIDUAL FUNCTION ASSESSSMENT

INJURED WORKER ______________________________

CLAIM NUMBER(S): ____________________
____
____
____

____

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the injured worker's age, education, and work experience:

( ) This injured worker has no work limitations.

( ) This injured worker is incapable of work.

( ) This injured worker is capable of work with the limitation(s)/modification(s) noted below:

____
____
____
____
____
____
____
____
____
____

Physician Signature:______________________________

Physician Name (Print):______________________________

Date:______________________________

IC PROVIDER FEE BILL

STATE OF OHIO
THE INDUSTRIAL COMMISSION OF OHIO

P R O V I D E R F E E B I L L

Claim Number(s): **Claim Type:**

Injured Worker's Name:

Provider Number: ______________________

Tax ID Number: ______________________

Type of Service	Date of Service	Charges
( ) Exam by Ohio Provider	____________	____________
( ) Exam by Out of State Provider	____________	____________
( ) File Review by Ohio Provider	____________	____________
( ) File Review by Out of State Provider	____________	____________
( ) Vocational File Review	____________	____________
( ) Interpretive Services	____________	____________
( ) Injured Worker "No Show" for Exam	____________	____________
( ) Cancellation of Exam (IC approved)	____________	____________
( ) Diagnostic Test(s) CPT CODE # ____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
	Total:	____________

I hereby certify that the information contained on this form is true and correct to the best of my knowledge and belief.

____
Provider Signature Date (Use Stamp Below)

Provider Name:
Street Address
City, State, Zip
Phone No.:

For I.C. Use Only I.C. Verification

____________________ ____________________
Initial here for SURPLUS payment

PERMANENT TOTAL DISABILITY (PTD) APPLICATION

Ohio | Industrial Commission

Claim Number:

(Use the claim #with the most recent date of injury or diagnosis)

APPLICATION FOR COMPENSATION FOR PERMANENT TOTAL DISABILITY

1. Each application for permanent total disability shall identify, if already on file, or be accompanied by medical evidence supporting the application. If documents are already on file, there is no need to resubmit them.
   a. The medical examination upon which the report is based must have been **performed within twenty-four months prior to the date of filing of the application for permanent total disability compensation (document information below).**
   b. If an application for permanent total disability compensation is filed that does not meet the filing requirements of Ohio Adm.Code **4121-3-34**, or if proper medical evidence is not filed or identified within the claim file, the application **shall be dismissed** without hearing.

2. The completed application should be filed at an Industrial Commission office.

3. **If permanent total disability is granted, the injured worker is not permitted to return to work in any capacity.**

Injured Worker's Information	
Name	Date of Birth
Address	
City, State, Zip	
Telephone	Fax

Injured Worker's Representative Information	
Rep ID#	
Name	
Telephone	Fax

☐ Consider All Claims

☐ Consider only the injured worker's claim numbers listed below when processing this application (claims with similar body parts will be considered):

Claims not listed here will not be considered and cannot be added at the time of your hearing.

By not listing a claim, you cannot then argue that the allowed conditions in that claim prevent you from working. This does not preclude future benefits and/or medical treatment for the named conditions in the claim.

If you have not checked the "Consider All Claims" box, the Industrial Commission will include all claims containing similar body parts to those conditions in the claims that have been identified.

☐ I have attached the required medical documentation to support this application for permanent total disability.

Date of Exam ______ (mm/dd/yyyy) Physician Name ______

Date of Exam ______ (mm/dd/yyyy) Physician Name ______

☐ Medical documentation listed below has been previously filed and supports this application for permanent total disability.

Claim ______ Date of Exam ______ (mm/dd/yyyy) Physician Name ______

Claim ______ Date of Exam ______ (mm/dd/yyyy) Physician Name ______

Claim ______ Date of Exam ______ (mm/dd/yyyy) Physician Name ______

Medical documentation listed above must opine only on the allowed conditions in the claims you have identified above or the application for permanent total disability will be dismissed.
If necessary, please attach additional information.

Claim Number:

MEDICAL HISTORY

List all of the physicians you have seen in the last five years, their addresses, and for what condition(s) you have seen them:

Physician's Name	Physician's Address	Condition(s)

List all of the surgeries and procedures you have had, beginning with the most recent:

Surgery/Procedure	Physician's Name	Date (mm/dd/yyyy)

Do you use any medical equipment such as a cane, brace, walker, wheelchair, oxygen or TENS unit? ☐ Yes ☐ No

If yes, please specify: ____________________

____

Do you have any other medical conditions that impact your ability to work? ____________________

____

____

DAILY ACTIVITIES

Has your treating doctor told you to restrict or limit your activities due to your injuries? ☐ Yes ☐ No

If yes, please specify: ____________________

____

Do you drive a vehicle? ☐ Yes ☐ No How far can you drive at one time? __________

How far can you walk at one time? __________ How long can you stand at one time? __________

How long can you sit at one time? __________ How long do you sleep each night? __________

Claim Number:

DAILY ACTIVITIES CONTINUED

Are you involved in any organizations, clubs, charities or associations of any kind, either as a volunteer or member? ☐ Yes ☐ No

If yes, please provide name of organization and nature of association: ______

Do you have hobbies or engage in recreational or social activities? ☐ Yes ☐ No

If yes, please specify: ______

Do you dress yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you shower or bathe yourself? ☐ Yes ☐ No ☐ Need Assistance

Do you prepare any meals? ☐ Yes ☐ No

Do you do any housework/yardwork (laundry, repairs, grocery shopping, grass cutting etc.)? ☐ Yes ☐ No

If yes, please specify: ______

What is the most weight you lift on a daily basis? ______

Describe any other limitations or changes in your lifestyle, if any, resulting from the allowed condition(s) in your claim(s): ______

OTHER DISABILITY BENEFITS

Have you ever filed for Social Security Disability benefits? ☐ Yes ☐ No

If you are now, or have ever, received Social Security Disability payments, complete the following section. This **does not** apply to Social Security Retirement.

Starting Date ______ (mm/dd/yyyy) Termination Date ______ (mm/dd/yyyy)

What was the reason for termination? ______

Do you receive disability benefits other than Social Security? (i.e.: VA, Fireman & Police Officer Disability, etc.)? ☐ Yes ☐ No

Claim Number:

VOCATIONAL REHABILITATION HISTORY

Have you sought or been offered vocational rehabilitation services? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

____

EDUCATION

What is the highest grade of school you completed? [ ] When? [ ] (mm/dd/yyyy)

Where? [ ] (School, City)

Did you graduate from high school? ☐ Yes ☐ No

If yes, which curriculum? ☐ Special Education ☐ Standard ☐ College Preparatory

If no, did you receive a certificate for passing the General Educational Development test (GED)? ☐ Yes ☐ No

Why did you end your schooling? ______________________________

Have you gone to trade or vocational school or had any type of training? ☐ Yes ☐ No

If yes, what type of trade school, vocational schooling or special training have you received and when?

____

How has this schooling or training been used in any of the work you have done? ______________________________

____

Can you read? ☐ Yes ☐ No If yes, what language(s)? ______________________________

Can you write? ☐ Yes ☐ No If yes, what language(s)? ______________________________

What languages can you speak? ______________________________

Can you do basic math? ☐ Yes ☐ Not Well ☐ No

Do you have basic computer skills (keyboarding; business office software applications such as Microsoft Office; using and creating spreadsheets)? List all software with which you are proficient. ______________________________

____

____

____

WORK HISTORY

What is the last date you worked in any capacity, including contractor work or self-employment: [ ] (mm/dd/yyyy)

Do you have military experience? ☐ Yes ☐ No

If yes, provide your last date of service: [ ] (mm/dd/yyyy)

Include your military service information in the work history list starting on the next page.

Claim Number:

When completing the following sections of the application, please be specific and as detailed as possible. **A thorough work history is very important when processing an application for permanent total disability.** Attach additional pages as needed providing the same information as listed below for past positions held. Include all military service and past positions.

Title of Most Recent Job

Name of Employer

Dates Worked From: (mm/dd/yyyy) To: (mm/dd/yyyy) Hours per Week

Describe your basic duties:

List machines, tools, and equipment, including computer equipment, you used:

Describe technical knowledge and skills you used:

Describe reading and writing you did:

Did you supervise people? ☐ Yes ☐ No If yes, how many?

Describe the kind and amount of physical activity this job involved during a typical day:

Walking	(circle the number of hours a day spent walking)	0	1	2	3	4	5	6	7	8
Standing	(circle the number of hours a day spent standing)	0	1	2	3	4	5	6	7	8
Sitting	(circle the number of hours a day spent sitting)	0	1	2	3	4	5	6	7	8
Bending	(circle how often a day you had to bend)	Never	Occasionally		Frequently		Constantly			

Check the heaviest weight lifted occasionally: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

Check the weight frequently lifted/carried: ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Up to 50 lbs. ☐ Up to 100 lbs. ☐ Over 100 lbs.

Claim Number:

SPECIAL FACTORS

Please use this space for comments, explanations or special factors (social, economic, psychological) you wish to add to support your application.

____

____

____

____

____

____

ATTENTION

This application will be dismissed if not signed by the injured worker or if the medical evidence supporting the request for Permanent Total Disability is not attached or identified as previously filed.

I, ______________________________ (Injured Worker's Name), certify that the information on this page and the preceding pages is true to the best of my knowledge. By signing this application, I expressly waive all provisions of law which forbid any person, persons or medical facility who has medically attended, treated, or examined me, or who may have medical information of any kind which may be used to render a decision in my claim, from disclosing such knowledge or information to the Industrial Commission or employer(s) in my claim(s).

Help Us, Help You!

Please take a minute to give us your correct address in the space provided on the first page of this application.

Injured Worker's Name:	Date:	Person Completing this Form:	Date:
Signature		Signature	