

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 9416 TEMPORARY

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 12-28
DATE FOR REVIEW
DATE DUE 1-5

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved ____ Disapproved ____ Returned to Agency ____

Resubmitted ____ Due ____
Approved ____ Disapproved ____ Returned to Agency ____

Date filed w/Secretary of State ____ Revisor approved ____ disapproved ____

✓ Rule as Adopted

✓ Rule as Proposed (A) - 9.21.83 (B) " " " - 11.18.83.

✓ Order Adopting 12.28.83 Date

✓ Notice of Intent to Solicit Outside Opinion SR. 6.20.83.

✓ Orders for rulemaking
(A) 11.4.83 date of Hearing
(B)

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
(A) Hearing ✓ Sufficiency } See my comment.
(B) Reference previous notice

✓ Affidavit of Mailing Notice or rulemaking
(A) 10.4.83 At least 30 days prior to hearing/adoption
(B) 12.1.83 28

✓ Mailing list Certificates
(A) 10.4.83 (B) 12.1.83

✓ Publications in State Register
(A) 10.3.83 At least 30/20 days prior to hearing/adoption
(B) 12.5.83

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
____ Approving H.E.'s Report
____ Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

✓ Certificate of Board's Resolution Adopting Rules

✓ Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

OPPERMAN & PAQUIN
ATTORNEYS AT LAW
2200 WASHINGTON SQUARE
100 WASHINGTON AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55401
TELEPHONE (612) 339-6900
TELECOPIER (612) 339-0981

VANCE K. OPPERMAN
ROBERT J. SCHMIT
JOSEPH R. KERNAN, JR.
JAMES E. SCHATZ
JEROME F. PAQUIN
RICHARD G. BRAMAN
AUDREY L. ESTEBO
MARY AMBLER LANY
CHARLES N. NAUEN
MEAGHAN E. HARPER
H. THEODORE GRINDAL

OF COUNSEL
JAY B. KELLY

December 28, 1983

Mr. Larry Starns
Special Assistant Attorney General
204 Administration Building
50 Sherburne Avenue
St. Paul, Minnesota 55155

Re: Workers' Compensation
Permanent Partial Disability
Schedule Rules

Dear Larry:

This cover letter is unusually long, but will hopefully provide you with essential background information during your review of the above-captioned rules. Any questions you may have during your review should be directed to either Joan Volz at 297-4795; Leslie Altman at 297-2972; or Ted Grindal at 339-6900.

This letter will discuss the following topics concerning the rules as proposed and amendments to those rules:

I. Procedural compliance by the agency;

II. Background concerning the drafting of this rule;

III. Statutory authority and requirements for this rulemaking;

IV. Amendments to rules as proposed;

V. Overview of public comment on rule;

VI. Timing of rule review and action by Attorney General.

Please forgive the overly detailed discussion of this rule. You will soon realize, however, the vital importance of this rule and its approval.

I. Procedural compliance by the agency.

The Department of Labor and Industry has complied with all procedural requirements set forth in Minn. Stat. § 14.29-.36 (1983) concerning temporary rulemaking. The procedural requirements are summarized below:

* A Notice of Intent to Solicit Outside Opinion Regarding Proposed Temporary Rules Governing Workers' Compensation Disability Schedules was published in the State Register June 20, 1983. At least 30 days was allowed for public comment. All comments received as a result of that Notice are part of the record.

* Commissioner Steve Keefe executed an Order September 21, 1983, for a notice to be published in the State Register regarding the rule and the public hearing required by Minn. Stat. § 176.105, subd. 4 (1983).

* Commissioner Steve Keefe gave Notice of Hearing and of Intent to Adopt Temporary Rules in a document signed September 21, 1983.

* The Department certified on October 4, 1983, that it possessed an accurate and complete list of persons, groups and associations requesting that their names be placed on file pursuant to Minn. Stat. § 14.14, subd. 1 (1983).

* An Affidavit of Mailing was executed and the appropriate Notice of Intent to Adopt Temporary Rules and Notice of Hearing was mailed October 4, 1983, to the list earlier certified by the Department.

* The Notice of Hearing and of Intent to Adopt Temporary Rules and the Temporary Rules as Proposed was published in the October 3, 1983, issue of the State Register.

* The Temporary Rules as Proposed were approved as to form, including incorporation by reference by the Revisor of Statutes on September 21, 1983.

* The Department prepared a Statement of Need and Reasonableness and made it available to the public 25 days prior to the public hearing, although not required by temporary rulemaking.

* Commissioner Steve Keefe signed an Order for Publication of Proposed Amendments to the Temporary Rules as Proposed on November 18, 1983.

* The Department certified on December 1, 1983, that it possessed an accurate and complete list of persons, groups and associations requesting that their names be placed on file pursuant to Minn. Stat. § 14.14, subd. 1 (1983).

* An Affidavit of Mailing the appropriate Notice of Intent to Adopt Temporary Rules and Notice of Hearing was mailed December 1, 1983 to the list earlier certified by the Department.

* The Proposed Amendments to the Temporary Rules as Proposed were Approved as to Form by the Revisor of Statutes on November 18, 1983.

* The Notice of Intent to Adopt Amendments to Proposed Temporary Rules was published in the State Register on December 5, 1983.

* Commissioner Steve Keefe issued a Findings of Fact and Conclusions concerning the Proposed Amendments and the Rules as Proposed on December 28, 1983.

* Commissioner Steve Keefe issued an Order Adopting the Temporary Rules as Proposed and the Amendments to the Rules as Proposed on December 28, 1983.

* H. Theodore Grindal, Special Counsel to the Department of Labor and Industry, signed a Certificate of Compliance with Rulemaking Procedures on December 28, 1983.

* The Department has sent Notification of Submittal to the Attorney General to all those in attendance at the November 4, 1983 public hearing although not required by the statute or Attorney General's rules.

* The Department of Labor and Industry has complied with all requirements of Minn. Stat. § 14.29-.36 (1983) and 1 MCAR § 1.204 for temporary rulemaking.

II. Background concerning the drafting of this rule.

The Adopted Rule is an integral part of the new workers' compensation law passed by the 1983 Legislature. One of the main objectives of the new law is to reduce litigation wherever possible. This Disability Schedule rule will hopefully help accomplish this. However, to understand the effect of the new law and this rule, you first need to know a bit about the old law and Disability Schedule.

Until January 1, 1984, a injured worker will be compensated for permanent partial disabilities under the old law Disability Schedule. The old law Disability Schedule was applicable to only the loss of one's most obvious members. Internal organs had no set percentages at all. Essentially, the old Disability Schedule allowed great discretion to the Compensation Judge and physicians to determine what was an appropriate percentage of permanent partial disability. This broad discretion created an incentive to litigate in search of higher recoveries.

The new Disability Schedule removes much of the discretion from the physician and sets specific percentages for specific disabilities. The hope is that attorneys and physicians will have less incentive to litigate because of the specific categories and percentages of recovery. Therefore, the schedule has no ranges of recovery (i.e., 10-25%). For both actuarial and rulemaking purposes, the schedule had to select one percentage for a particular type of disability.

The Minnesota Medical Association created an Ad Hoc Committee on Workers' Compensation consisting of specialists which was largely responsible for assisting the Department in drafting the rule. At least 38 physicians were involved in over 900 hours of meetings alone in developing the rules. The Ad Hoc Committee and its Task Forces considered the most current problems facing a physician in rating an injured workers' permanent partial disability. The list of participating physicians and their credentials is included as part of the record.

The Adopted Rule represents the best possible combination of medical knowledge and practical knowledge of workers' compensation injuries. The new Disability Schedule takes the best of what other states have done and goes further. It deals with disabilities other states have not. It is a unique

and progressive attempt at bringing certainty and fairness to an extremely complicated and litigated area. If it is successful, it will lower costs to insurers and speed recoveries to injured workers.

III. Statutory authority and requirements for this rulemaking.

The statute authorizing the rulemaking is found at Minn. Stat. § 176.105, subd. 4 (1983). The statute created an unusual type of temporary rulemaking. It provided, in part:

> Temporary rules shall be adopted for this purpose not later than January 1, 1984. Prior to the adoption of these rules, at least one public hearing shall be held by the Commissioner, in addition to the requirements of sections 14.29 to 14.36. Notwithstanding sections 14.29 to 14.36, the temporary rules adopted under this subdivision shall be effective until superseded by permanent rules.

Minnesota Laws 1983, Chapter 290, Section 86, subd. 4(b).

The statute mandated one public hearing (not required under 14.29 to 14.36), yet put no expiration date on the rules (contrary to 14.35).

The Department complied with the public hearing requirement. On November 4, 1983, a public hearing was held at Room 83 of the State Office Building, St. Paul, Minnesota. Notice of this public hearing was published in the State Register October 3, 1983, a full 30 days before the hearing. Also, Deputy Chief Hearing Examiner Myron Greenberg of the Office of Administrative Hearings presided over the hearing. The public hearing commenced at 8:30 a.m. and continued until all in attendance were provided an opportunity to comment on the proposed rules.

The authorizing statute also specifically required two other steps to complete this rulemaking process. These other requirements were, in relevant part, as follows:

1. "The schedule shall be determined by sound actuarial evaluation and shall be based on the benefit level which exists on January 1, 1983." and

2. "Prior to adoption of temporary rules, the commissioner shall conduct an analysis of the current permanent partial disability schedule for the purpose of determining the number and distribution of permanent partial disabilities and the coverage compensation for various permanent partial disabilities."

Minnesota Laws 1983, chapter 290, section 86, subd. 4(a) and (b).

Both of these mandated steps have been complied with by the Department. Exhibit J was introduced at the public hearing showing compliance with both the requirement for an actuarial evaluation and the requirement for a distribution analysis and compensation. Exhibit J includes the National Council on Compensation Insurance Actuarial Analysis of the Rules as Proposed dated November 1, 1983. The same group has provided another certification of the Disability Schedule as amended.

The authorizing statute provided several other discretionary steps the Commissioner could take in drafting the eventual Disability Schedule. The Commissioner, to one degree or another, took all of these other factors into consideration. Nevertheless, the Attorney General should realize that all of the other factors listed in the statute are discretionary. Therefore, any argument that the Commissioner did not comply with the authorizing statute must be examined critically in light of the mandated requirements set forth in the plain language of the statute.

IV. Amendments to rules as proposed.

The Rules as Proposed published in the October 3, 1983 State Register received many comments. A number of these comments came from members of the Minnesota Medical Association Ad Hoc Committee on Workers Compensation (hereinafter "MMA Committee"). Many of the comments received by the Department were incorporated into Proposed Amendments to the Rules as Proposed. Almost all of these Amendments, including the new sections on burns and apportionment, were distributed to attendees at the November 4, 1983 public hearing.

Some of the Amendments (specifically the sections on Burns and Apportionment of Pre-Existing Impairments) were totally

new material. Because of the possibility of rejection of these portions of the rules under the doctrine of "substantial change," the Amendments were published in the December 5, 1983 State Register. Furthermore, to avoid any challenge under the "substantial change" doctrine, all of the Amendments to the Rules as Proposed were included in the December 5, 1983 State Register. Therefore, the public has had specific notice of all modifications the Commissioner has included in the Adopted Rule.

Arguably, the Department could have submitted the entire Rule as Proposed and Amendments to the Attorney General for approval without re-publication. However, because of the unique posture and deadline for approval of the rules, re-publication was the safest procedure. In effect, the publication of the Amendments to the Rules as Proposed could have the same result as complying with the entire rulemaking process. Nevertheless, the statute, Minn. Stat. §14.29 to 14.36 (1983), is silent on a procedure to amend temporary rules. All of the procedures followed by the Department were taken to insure maximum public participation in the rulemaking process.

The Commission has issued a Findings of Fact and Conclusion regarding the Amendments to the Rules as Proposed. This document sets forth the Department's rationale for the Amendments. Many of these Amendments were the result of public comment or corrections of typographical errors and format changes. Some helpful changes were based upon comments from the MMA Committee which reviewed the precise language of the rule again. Undoubtably these Amendments make the Adopted Rule more comprehensive and accurate.

V. Overview of public comment on the rule.

The Department has truly tried to fashion a rule that is usable by those in the workers' compensation field. Interestingly the Department received only five negative comments on the rules. These consisted of two speakers at the public hearing and three letters. Conversely, diverse groups such as the Minnesota Medical Association, the Minnesota Chiropractic Association, the Minnesota Association of Commerce and Industry and the Minnesota Insurance Association support the rules. This degree of supported is unprecedented in the stormy world of workers' compensation.

The exhaustive work by Department staff to meet with members of the public and associations wishing to comment on the

rule should be commended. No person or group can say they have been foreclosed from comment or ignored by the Department. The result is a better, more comprehensive and balanced rule.

VI. Timing of rule review and action by Attorney General.

As quoted earlier in this letter, the Adopted Rule shall be effective no later than January 1, 1984. The reason for this effective date is found in the new workers' compensation law. The major portions of the law are all keyed to become effective January 1, 1984. The new Disability Schedule is a major building block of the new law.

More importantly, the old Disability Schedule expires January 1, 1984. If these Adopted Rules were not approved on January 1, 1984, an injured worker who suffered a permanent partial disability on or after January 1, 1984, would not be able to recover a major portion of his or her just award. Consequently, the Governor would be forced to call a special session of the legislature to remedy the lack of a Disability Schedule. If the Adopted Rules were approved earlier than January 1, 1984, a person could attempt recovery under either or both Disability Schedule. Unfortunately, poor drafting of this law has forced us to seek approval of the Adopted Rule on January 1, 1984.

The Adopted Rule and all procedural and jurisdictional documents will be submitted to the Attorney General's office on Wednesday, December 28, 1983. The Department would respectfully request any defects be brought to our attention by Thursday, December 29, 1983. If a minor change is necessary, the Department will gladly do everything in its power to comply with the requests of the Attorney General's office. The Department, in turn, would be prepared to cure the defect and submit the necessary documents to the Attorney General's office the following day December 30, 1983.

The Department would also respectfully request that the Attorney General approve the Adopted Rule (if all requirements are fulfilled) on January 1, 1984. Although this may present an inconvenience to the attorney reviewing the Adopted Rule, it is critical to the Department and the State of Minnesota that approval occur on January 1, 1984. If it is not possible to grant this request, please contact the Department immediately to discuss this matter.

I thank you for all your cooperation in reviewing this unique set of rules. I truly hope the significance of these rules will justify your patience in considering our special requests. Again, thank you for your assistance and courtesy in this matter.

Sincerely,

OPPERMAN & PAQUIN

H. Theodore Grindal

HTG/sm

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : Steve Keefe, Commissioner of Labor and Industry

DATE: 1/1/84

Attn: H. THEODORE GRINDAL, Special Attorney

FROM : MARTHA J. CASSERLY
Special Assistant
Attorney General

MJC

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry, Governing Workers' Compensation Permanent Partial Disability Schedule

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.
MJC/ls
cc: Ms. Kathy Burek
Mr. Duane Harves

AG copy?

Department of Labor and Industry

Workers' Compensation Division

Adopted Amendments to Temporary Rules of the State Department of Labor and Industry Governing Workers' Compensation Permanent Partial Disability Schedule

Temporary Rules as Adopted

8 MCAR S 1.9001 [Temporary] Workers' compensation permanent partial disability schedule rules.

A. Purpose of schedules. Laws of Minnesota 1983, chapter 290, section 86, requires the commissioner of labor and industry to promulgate temporary rules assigning specific percentages of disability of the whole body for specific permanent partial disabilities. Rules 8 MCAR SS 1.9001-1.9025 [Temporary] assign percentages of disability of the whole body for permanent partial disabilities.

B. Interpretation of schedules. Only the categories set forth in the schedules in 8 MCAR SS 1.9001-1.9025 [Temporary] may be used when rating the extent of a disability. Where a category represents the disabling condition, the disability determination shall not be based on the cumulation of lesser included categories. If more than one category may apply to a condition, the category most closely representing the condition shall be selected. Where more than one category is necessary to represent the disabling condition, categories shall be selected to avoid double compensation for any part of a condition. The percentages of disability to the whole body as set forth in two or more categories shall not be averaged, prorated, or otherwise deviated from, unless specifically provided in the schedule. Unless provided otherwise, where an impairment must be rated under more than one category, the ratings must be combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c). With respect to the musculo-skeletal schedule, the percent of whole body disability for motor or sensory loss of a member shall not exceed the percent of whole body disability for

amputation of that member.

C. Disabilities not part of schedules. A category not found within 8 MCAR SS 1.9001-1.9025 [Temporary] shall not be used to determine permanent partial disability.

D. Rules of construction. The technical terms in 8 MCAR SS 1.9001-1.9025 [Temporary] are defined in either 8 MCAR S 1.9002 [Temporary], or by the documents incorporated by reference in this rule. Documents are incorporated by reference only to the extent necessary for definition or to the extent specifically referenced in a schedule. These documents are as follows:

1. Guides to the Evaluation of Permanent Impairment, published by the American Medical Association, Committee on Rating of Mental and Physical Impairment, 1976 edition. This document is also known as the A.M.A. Guides.

2. Snellen Charts, published by American Medical Association Committee for Eye Injuries and designated Industrial Vision Test Charts. These charts are also known and referred to as A.M.A. charts;

3. American Medical Association Rating Reading Card of 1932, published by the American Medical Association Committee for Eye Injuries. This document is also known as the A.M.A. Card.

4. American National Standard Institutes, Inc., S3.1-1977 Criteria for Permissible Ambient Noise during Audiometric Testing and S3.6-1969 (R1973) Specification for Audiometers;

5. Metropolitan Life Insurance Company Height and Weight Tables, published by the Metropolitan Life Insurance Company, 1983;

6. The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, Sister Kenny Institute, 1973;

7. Dorland's Illustrated Medical Dictionary, 25th edition, 1974. This document is also known as Dorland's;

8. D.S.M. III, Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1980. This document is also known as D.S.M. III;

9. Fractures, Charles A. Rockwood and David Green, 1975;

10. Textbook on Anatomy, William Henry Hollinshead, 1974; and

11. "The Estimation of Areas of Burns," in Surgery, Gynecology and Obstetrics, by Lund and Browder, pages 352-358, volume 79, 1944. This document is referred to as Lund and Browder.

E. Severability. If any provision of these rules is held to conflict with a governing statute, applicable provisions of the Minnesota Administrative Procedure Act, or other relevant law; to exceed the statutory authority conferred; to lack a reasonable relationship to statutory purposes or to be unconstitutional, arbitrary, or unreasonable; or to be invalid for any other reason; the validity and enforceability of the remaining provisions of the rule shall in no manner be affected.

8 MCAR S 1.9002 [Temporary] Definitions.

A. Scope. For the purpose of 8 MCAR SS 1.9001-1.9025 [Temporary] the terms defined in this rule have the meanings given them unless the context clearly indicates otherwise. Terms not defined in this rule are defined in Dorland's or other documents incorporated by reference. If the definition in a document incorporated by reference conflicts with or differs from the definition set forth in 8 MCAR S 1.9001-1.9025 [Temporary], the specific definitions set forth in these rules shall govern.

B. Acromio-clavicular grade 1. "Acromio-clavicular grade 1" means an undisplaced acromio-clavicular joint.

C. Acromio-clavicular grade 2. "Acromio-clavicular grade 2" means a 50 percent displacement of the clavicle in relationship to the acromion at the acromio-clavicular joint.

D. Acromio-clavicular grade 3. "Acromio-clavicular grade 3" means a completely disrupted acromio-clavicular joint.

E. Activities of daily living. "Activities of daily living" means the ability to perform self cares, to perform housework and related tasks, to ride in or operate a motor vehicle, and to perform vocational tasks not requiring physical labor.

F. Ankylosis. "Ankylosis" means the stiffening or fixation of a joint.

G. ANSI. "ANSI" means the American National Standards Institute.

H. Banding. "Banding" means a thick, rope-like cord of hypertrophic scarring resulting from burns.

I. Category. "Category" means a permanent partial disability as described in these rules and the corresponding percent of disability to the whole body for that permanent partial disability.

J. Chronic. "Chronic" means the repeated or continuous occurrence of a specific condition or symptom.

K. Demonstrable degenerative changes. "Demonstrable degenerative changes" means radiographic findings demonstrating the presence of degeneration of intervertebral disc or facet joints. Examples of demonstrable degenerative changes are disc space narrowing, small osteophytes, and facet joint hypertrophic changes.

L. Desirable level of weight. "Desirable level of weight" means preferred weights set forth in tables created by the Metropolitan Life Insurance Company.

M. Disarticulation. "Disarticulation" means an amputation occurring through a joint.

N. Distance vision. "Distance vision" means the ability to distinguish letters at a distance of 20 feet according to the Snellen and A.M.A. Charts.

O. Family member. "Family member" means cohabitants and is not limited to those related by blood or marriage. In cases of institutionalization or similar nonhome environment, family member may include staff members who care for the individual on a regular basis.

P. Fore-quarter. "Fore-quarter" means the amputation of the upper extremity involving the scapula, clavicle, and muscles that attach to the chest.

Q. Fusion. "Fusion" means the surgical uniting of one vertebral segment to an adjoining vertebral segment.

R. Gastrostomy. "Gastrostomy" means a surgical creation of a gastric fistula through the abdominal wall for the purpose of introducing food into the stomach.

S. Glossopharyngeal. "Glossopharyngeal" means the ninth cranial nerve with sensory fibers to the tongue and pharynx. It affects taste and swallowing.

T. Gross motor weakness. "Gross motor weakness" means total or partial loss as described at 8 MCAR S 1.9016 A. and B.

U. Hypertrophic scar. "Hypertrophic scar" means an elevated irregularly shaped mass of scar tissue.

V. Hypoglossal. "Hypoglossal" means the motor nerve to the tongue. It is the 12th cranial nerve and carries impulses from the brain to the tongue, including movement of muscles and secretion of glands and motor movement.

W. Kenny scale. "Kenny scale" means the Kenny self-care evaluation system as set forth in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence of Activities of Daily Living.

X. Laminectomy. "Laminectomy" means the removal of part or all of the lamina of one vertebral segment, usually with associated disc excision.

Y. Lethargy. "Lethargy" means, in relation to a nervous system injury to the brain, that an individual is drowsy, but can be aroused.

Z. Moderate referred shoulder and arm pain. "Moderate referred shoulder and arm pain" means pain of an intensity necessitating decreased activity in order to avoid the pain. This pain is demonstrated in a dermatomal distribution into the shoulder and upper extremity.

AA. Moderate partial dislocation. "Moderate partial dislocation" means a loss of normal vertebral alignment of up to 50 percent of the vertebral body on the adjacent vertebral body associated with vertebral fractures.

BB. Near vision. "Near vision" means clearness of vision at the distance of 14 inches.

CC. Nonpreferred extremity. "Nonpreferred extremity" means

the arm or leg not used dominantly, as for example, the left hand of a right-handed writer.

DD. Objective clinical findings. "Objective clinical findings" as used in 8 MCAR S 1.9007 [Temporary] means examination results which are reproducible and consistent. Examples of objective clinical findings are involuntary muscle spasms, consistent postural abnormalities, and changes in deep tendon reflexes.

EE. Postural abnormality. "Postural abnormality" means a deviation from normal posture, as found on anterior/posterior or lateral X-rays, that involves the spine and pelvis or segments of the spine or pelvis, such as kyphosis, lordosis, or scoliosis.

FF. Preferred extremity. "Preferred extremity" means the dominant leg or arm, as for example, the right arm of a right-handed person.

GG. Presbycusis. "Presbycusis" means a decline in hearing acuity that occurs with the aging process.

HH. Pseudophakia. "Pseudophakia" means that the crystalline lens of the eye has been replaced with a surgically implanted lens.

II. Self cares. "Self cares" means bed activities, transfers, locomotion, dressing, personal hygiene, bowel and bladder, and feeding as described in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, pages 10-24.

JJ. Spinal stenosis. "Spinal stenosis" means the narrowing of the spinal canal.

KK. Spondylolisthesis. "Spondylolisthesis" means the forward movement of one vertebral body of one of the lower lumbar vertebrae on the vertebrae below it or upon the sacrum.

LL. Spondylolisthesis grade 1. "Spondylolisthesis grade 1" means forward movement from zero to 25 percent of the vertebral body.

MM. Spondylolisthesis grade 2. "Spondylolisthesis grade 2" means forward movement from 25 to 50 percent of the vertebral body.

NN. Spondylolisthesis grade 3. "Spondylolisthesis grade 3" means movement from 50 to 75 percent of the vertebral body.

OO. Spondylolisthesis grade 4. "Spondylolisthesis grade 4" means forward movement from 75 to 100 percent of the vertebral body.

PP. Stupor. "Stupor" means, in relation to a nervous system injury to the brain, that a strong stimulus or pain is needed to arouse consciousness or response.

QQ. Tinnitus. "Tinnitus" means a subjective sense of noises in the head or ringing in the ear for which there is no observable external cause.

RR. Trigeminal. "Trigeminal" means the mixed nerve with sensory fibers to the face, cornea, anterior scalp, nasal and oral cavities, tongue and supertentorial dura matter. It also has motor fibers to the muscles of mastication. It is the fifth cranial nerve.

SS. Vertigo. "Vertigo" means a sensation of moving around in space or having objects move about the person. It is the result of a disturbance of the equilibratory apparatus.

TT. Vestibular. "Vestibular" means the main division of the auditory nerve. It is the eighth cranial nerve and deals with equilibrium.

UU. Wrinkling. "Wrinkling" means small ridges on the skin formed by shrinking or contraction as a result of burns.

VV. 14/14. "14/14" is a term used in the measurement of near vision. It is the clearness of vision at a distance of 14 inches. The numerator is the test distance in inches. The denominator is the distance at which the smallest letter on the A.M.A. card can be seen.

WW. 20/20 Snellen or A.M.A. Chart. "20/20 Snellen or A.M.A. Chart" refers to a chart imprinted with block letters or numbers in gradually decreasing sizes, identified according to distances at which they are ordinarily visible. It is used in testing visual acuity. The numerator is the test distance in feet. The denominator is the distance at which the smallest letter discriminated by a patient would subtend five minutes of arc.

8 MCAR S 1.9003 [Temporary] Eye schedule.

A. Complete loss of vision. For complete loss of vision in both eyes, disability of the whole body is 85 percent. For complete loss of vision in one eye, disability of the whole body is 24 percent. In determining the degree of vision impairment and of whole body disability, B.-F. shall be used.

B. Examination. Disability shall not be determined until all medically acceptable attempts to correct the defect have been made. Prior to the final examination on which disability is to be determined, at least six months shall elapse after all visible inflammation has disappeared. In cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, injury of the retina, sympathetic ophthalmia, and traumatic cataract, at least 12 months shall elapse before the final examination is made. Testing shall be conducted with corrective lenses applied, unless indicated otherwise in this rule.

C. Maximum and minimum limits of primary coordinate factors of vision. The primary coordinate factors of vision are central visual acuity, visual field efficiency, and ocular motility. The determination of maximum and minimum limits for each of the coordinate functions is established below.

1. Maximum limit.

a. The maximum limit of central visual acuity is the ability to recognize letters or characters which subtend an angle of five minutes, each unit part of which subtends a one-minute angle at the distance viewed. A 20/20 Snellen or A.M.A. chart is 100 percent (maximum) central visual acuity for distance vision. 14/14 A.M.A. card is 100 percent (maximum) central visual acuity for near vision.

b. The maximum visual field is defined as 500 degrees. It is the sum of the degrees in the eight principal meridians from the point of fixation to the outermost limits of visual perception and defines the area in which a three millimeter white target is visible at 33 centimeters. One hundred percent visual field efficiency is that visual field which extends from the point of fixation outward 85 degrees, down 65 degrees, down

and in 50 degrees, inward 60 degrees, in and up 55 degrees, upward 45 degrees, and up and out 55 degrees.

c. Maximum ocular motility is present if there is absence of diplopia in all parts of the field of binocular fixation, and if normal binocular motor coordination is present.

2. Minimum limit.

a. The minimum limit of central visual acuity is

(1) for distance vision, 20/800 Snellen or A.M.A. chart;

(2) for near vision, 14/560 A.M.A. card.

b. The minimum limit for field vision is established as a concentric central contraction of the visual field to five degrees. Five degrees of contraction of the visual field reduces the visual efficiency of the eye to zero.

c. The minimum limit for ocular motility is established by the presence of diplopia in all parts of the field of binocular fixation or by absence of binocular motor coordination. The minimum limit is 50 percent ocular motility efficiency.

D. Measurement of coordinate factors of vision and the computation of their partial loss.

1. Central visual acuity efficiency. Central visual acuity shall be measured both for distance vision and for near vision, each eye being measured separately, both with and without correction. A Snellen or A.M.A. chart shall be used for distance vision and an A.M.A. card shall be used for near vision. Illumination shall be at least five footcandles.

a. Table 1 shows the percentage of visual efficency corresponding to the notations for distance vision and for near vision. For test readings between those listed on the chart, round up from the midpoint to the nearest reading, and round down from below the midpoint.

Where distance vision is less than 20/200 and the A.M.A. chart is used, readings are at ten feet. The test reading is translated to the corresponding distance reading in Table 1 by multiplying both the numerator and the denominator of the test

reading by two.

TABLE 1

Central Visual Acuity

A.M.A. Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Central Visual Acuity Efficiency
20/20	14/14	100.00
20/25	14/17.5	95.7
20/25.7	.....	95.0
20/30	14/21	91.5
20/32.1	.....	90.0
20/35	14/24.5	87.5
20/38.4	.....	85.0
20/40	14/28	83.6
20/44.9	14/31.5	80.0
20/50	14/35	76.5
20/52.1	....	75.0
20/60	14/42	69.9
20/60.2	.....	70.0
20/68.2	.....	65.0
20/70	14/49	64.0
20/77.5	.....	60.0
20/80	14/56	58.5
20/86.8	.....	55.0
20/90	14/63	53.4
20/97.5	.....	50.0

1	20/100	14/70	48.9
2			
3	20/109.4	.....	45.0
4	20/120	14/84	40.9
5	.....	14/89	38.4
6			
7	20/122.5	.....	40.0
8	20/137.3	.....	35.0
9	20/140	14/98	34.2
10			
11	20/155	.....	30.0
12	20/160	14/112	28.6
13	20/175	.....	25.0
14			
15	20/180	14/126	23.9
16	20/200	14/140	20.0
17	20/220	14/154	16.7
18			
19	20/240	14/168	14.0
20			
21	....	14/178	12.3
22	20/260	14/182	11.7
23			
24	20/280	14/196	9.7
25	20/300	14/210	8.2
26	20/320	14/224	6.8
27	20/340	14/238	5.7
28	20/360	14/252	4.8
29	20/380	14/266	4.0
30			
31	20/400	14/280	3.3
32	20/450	14/315	2.1
33	20/500	14/350	1.4
34			
35	20/600	14/420	0.6
36	20/700	14/490	0.3

20/800 14/560 0.1

b. The percentage of central visual acuity efficiency of the eye for distance vision is that percentage in Table 1 which corresponds to the test reading for distance vision for that eye.

c. The percentage of central visual acuity efficiency of the eye for near vision is that percentage in Table 1 which corresponds to the test reading for near vision for that eye.

d. The percentage of central visual acuity efficiency of the eye in question is determined as follows:

(1) Multiply by two the value determined for corrected near vision in c.

(2) Add the product obtained in step 1 to the value determined for corrected distance vision in b.

(3) Divide the sum obtained in step 2 by three.

The following is an example of this calculation. If the central visual acuity efficiency for distance is 70 percent, and that for near is 25 percent, the percentage of central visual acuity efficiency for the eye is:

$$\frac{70\% + (2 \times 25)}{3} = 40\% \text{ central visual acuity efficiency}$$

e. For traumatic aphakia, the corrected central visual acuity efficiency of the eye is 50 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

f. For traumatic pseudophakia, the corrected central visual acuity efficiency of the eye is 80 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

2. Visual field efficiency. For each eye, the extent of the field of vision shall be determined by perimetric test methods. A three millimeter white disk which subtends a

0.5-degree angle under illumination of not less than seven footcandles shall be used. For aphakia, a six millimeter white disk shall be used. The result shall be plotted on the visual field chart as illustrated in the A.M.A. Guides, page 94.

a. The amount of radial contraction in the eight principal meridians shall be determined. The sum of the degrees of field vision remaining on these meridians, divided by 500, is the visual field efficiency of one eye, expressed as a percentage. If the eye has a concentric central contraction of the field to a diameter of five degrees, the visual efficiency is zero.

b. When the impairment of field is irregular and not fairly disclosed by the eight radii, the determination shall be based on a number of radii greater than eight and the divisor in a. shall be changed accordingly.

c. Where there is a loss of a quadrant or a half-field, the degrees of field vision remaining in each meridian are added to one-half the sum of the two boundary meridians.

3. Ocular motility. Ocular motility shall be measured in all parts of the motor field with any useful correction applied.

a. All directions of gaze shall be tested with use of a test light and without the addition of colored lenses or correcting prisms. The extent of diplopia is determined on the perimeter at 330 millimeters or on a tangent screen at a distance of one meter from the eye.

b. Plot the test results on a motility chart as illustrated in the A.M.A. Guides, page 97.

c. Determine the percentage loss of ocular motility from the motility chart. This percentage is assigned to the injured eye or, if both eyes are injured, to the eye with the greatest impairment of central visual acuity and field vision. The eye with the greatest impairment means the eye for which the product of central visual acuity efficiency and visual field efficiency is the least. For the purpose of calculation, a value of zero percent is deemed to be one percent. For the

other eye, the percentage loss of ocular motility is zero.

d. The percentage loss of ocular motility is subtracted from 100 percent to obtain the ocular motility efficiency. The minimum ocular motility efficiency of one eye is 50 percent.

E. Visual efficiency. The visual efficiency of one eye is the product of the efficiency values of central visual acuity, of visual field, and of ocular motility. For the purpose of this calculation, these values shall be expressed as decimals and not as percentages; a value of zero percent is deemed to be one percent.

1. For example, if central visual acuity efficiency is 50 percent, visual field efficiency is 80 percent, and ocular motility efficiency is 100 percent, the visual efficiency of the eye is .50 times .80 times 1.00, equals 40 percent. If ocular motility efficiency is changed to 50 percent, the visual efficiency is .50 times .80 times .50, equals 20 percent.

2. Visual efficiency shall be adjusted as set in this clause. Visual efficiency may not be less than zero percent. No adjustment for glasses or contacts shall be made in cases of aphakia or pseudophakia where the central visual efficiency was adjusted pursuant to D.1.e. or f.

a. Visual efficiency shall be decreased by subtracting two percent for any of the following conditions which are present due to the injury: loss of color vision; loss of adaptation to light and dark; metamorphosis; entropion or ectropion uncorrected by surgery; lagophthalmos; epiphora; and muscle disturbances such as ocular ticks not included under diplopia.

b. If glasses are required as a result of the injury, or if as a result of the injury the refractive error increases by at least one diopeter of sphere or of cylinder or of both, subtract five percent from the visual efficiency. Where the glasses contain prisms, subtract six percent.

c. If a noncosmetic contact lens is required in one or both eyes as a result of the injury, subtract seven percent from

the visual efficiency.

F. Procedure for determining whole body disability due to vision loss. For each eye, subtract the percentage of visual efficiency as determined in E. from 100 percent. The difference is the percentage impairment of each eye. The better eye has the lower percentage impairment. The poorer eye has the greater percentage impairment.

1. Multiply the percentage impairment of the better eye by three.

2. Add the percentage impairment of the poorer eye to the product obtained in step 1.

3. Divide the sum obtained in step 2 by four.

4. The quotient obtained in step 3 is the percentage impairment of the visual system. Fractions shall be rounded to the nearest whole number percentage as provided in D.1.a.

5. The percentage impairment of the visual system is translated to the percentage disability of the whole body by Table 2.

Table 2

Eye Schedule

Impairment of Visual System, %	Disability of Whole Man, %	Impairment of Visual System, %	Disability of Whole Man, %
0	0	45	42
1	1	46	43
2	2	47	44
3	3	48	45
4	4	49	46
5	5	50	47
6	6	51	48
7	7	52	49
8	8	53	50
9	8	54	51
10	9	55	52
11	10	56	53
12	11	57	54
13	12	58	55
14	13	59	56
15	14	60	57
16	15	61	58
17	16	62	59
18	17	63	59
19	18	64	60
20	19	65	61
21	20	66	62
22	21	67	63
23	22	68	64
24	23	69	65
25	24	70	66
26	25	71	67
27	25	72	68

28	26	73	69
29	27	74	70
30	28	75	71
31	29	76	72
32	30	77	73
33	31	78	74
34	32	79	75
35	33	80	76
36	34	81	76
37	35	82	77
38	36	83	78
39	37	84	79
40	38	85	80
41	39	86	81
42	40	87	82
43	41	88	83
44	42	89	84
		90 - 100	85

8 MCAR S 1.9004 [Temporary] Ear schedule.

A. General. For hearing loss, the maximum disability of the whole body is 35 percent. The procedures in B.-G. shall be used to determine the extent of binaural hearing loss and of whole body disability.

B. Medical diagnosis. Otological evaluation shall be the method for determining the degree of permanent partial hearing loss. The medical diagnosis shall include the following:

1. A complete history of occupational, military, and recreational noise exposure. This medical history shall include documentation of any previous hearing loss, if that information is available;

2. A complete physical examination of the ear; and

3. An audiological evaluation which shall include pure tone air conduction and bone conduction testing.

C. Standards for audiometric calibration and test environment. To ensure accurate measurement of hearing loss, the following standards shall be observed in conducting the tests required in B.:

1. The audiometer used to measure hearing loss shall be calibrated to meet the specifications of ANSI S3.6-1969 (R1973), Specifications for Audiometers. The following are also required:

a. Biological or electroacoustical calibration checks of the audiometer shall be performed monthly;

b. Electroacoustical calibration shall be performed annually to certify the audiometer to the ANSI standard in 1;

and

c. The calibration records shall be preserved and shall be provided upon request; and

2. Audiometric test rooms or booths shall meet the specifications of ANSI S3.1-1977, Criteria for Permissible Ambient Noise during Audiometric Testing.

D. Waiting period for final evaluation of hearing loss. A waiting period of at least three months shall elapse between the date of the occurrence of the noise injury and the final evaluation of the permanent partial hearing loss.

E. Procedure for determining disability of whole body due to hearing loss.

1. The binaural hearing loss is determined. The calculation for the percent of binaural hearing loss consists of the following steps:

a. For each ear, test the hearing threshold levels at the four frequences of 500, 1,000, 2,000, and 3,000 Hertz;

b. For each ear, determine the average four-frequency hearing level. The average four-frequency hearing level is one-fourth of the sum of the threshold levels at each of the four tested frequencies. The average four-frequency hearing level is expressed in decibels;

c. For each ear, subtract 25 decibels from the average four-frequency hearing level for that ear. The remainder, expressed in decibels, is the adjusted average four-frequency hearing level;

d. For each ear, multiply the adjusted average four-frequency hearing level by 1.5 percent. The product is the monaural hearing loss, expressed as a percentage. A product less than zero percent is deemed to be zero. A product greater than 100 percent is deemed to be 100 percent;

e. Considering both ears, compare the monaural hearing losses as determined in d. The ear with the smaller monaural hearing loss is the better ear. The ear with the larger monaural hearing loss is the poorer ear; and

f. Multiply the monaural hearing loss of the better

ear by five, add this product to the monaural hearing loss of the poorer ear, and divide the sum by six. The quotient is the binaural hearing loss, expressed as a percentage. The formula is:

$$\frac{(5 \times \text{monaural hearing loss of better ear}) + (\text{monaural hearing loss of poorer ear})}{6} = \text{percent binaural hearing loss}$$

2. The calculation of the percent of binaural hearing loss is illustrated by the following examples.

Example 1

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	15	25	45	55
Left ear	30	45	60	85

a. Calculation of the average four-frequency hearing level:

$$\text{Right ear} = \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = \frac{220}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level:

Right ear = 35 decibels - 25 decibels = 10 decibels;
Left ear = 55 decibels - 25 decibels = 30 decibels;

c. Calculation of monaural hearing loss:

Right ear = 10 x 1.5% = 15%
Left ear = 30 x 1.5% = 45%

d. Calculation of binaural hearing loss:

$$\frac{(15\% \times 5) + 45\%}{6} = 20 \text{ percent binaural hearing loss}$$

Example 2

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	20	25	30	35
Left ear	30	45	60	85

a. Calculation of average four-frequency hearing level.

$$\text{Right ear} = \frac{20 + 25 + 30 + 35}{4} = 25 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level.

Right ear = 25 decibels - 25 decibels = 0 decibels
Left ear = 55 decibels - 25 decibels = 30 decibels

c. Calculation of monaural hearing loss:

Right ear = 0 x 1.5 percent = 0
Left ear = 30 x 1.5 percent = 45 percent

d. Calculation of binaural hearing loss:

$$\frac{(0\% \times 5) + 45\%}{6} = 7.5 \text{ percent binaural hearing loss}$$

3. The binaural hearing loss is translated to a percentage of disability of the whole body by the ear schedule set forth below:

EAR SCHEDULE

Binaural Hearing Loss, Percent	Disability of Whole Body Percent
0 - 1.7	0
1.8 - 4.2	1
4.3 - 7.4	2
7.5 - 9.9	3
10.0 - 13.1	4
13.2 - 15.9	5
16.0 - 18.8	6
18.9 - 21.4	7
21.5 - 24.5	8
24.6 - 27.1	9
27.2 - 30.0	10
30.1 - 32.8	11
32.9 - 35.9	12
36.0 - 38.5	13
38.6 - 41.7	14
41.8 - 44.2	15
44.3 - 47.4	16
47.5 - 49.9	17
50.0 - 53.1	18
53.2 - 55.7	19
55.8 - 58.8	20
58.9 - 61.4	21
61.5 - 64.5	22
64.6 - 67.1	23
67.2 - 70.0	24
70.1 - 72.8	25
72.9 - 75.9	26
76.0 - 78.5	27
78.6 - 81.7	28
81.8 - 84.2	29
84.3 - 87.4	30
87.5 - 89.9	31
90.0 - 93.1	32
93.2 - 95.7	33
95.8 - 98.8	34

98.9 -100.0 35

F. Presbycusis. The calculation of the binaural hearing loss shall not include an additional adjustment for presbycusis.

G. Tinnitus. No additional percentage of permanent partial disability for hearing loss shall be allowed for tinnitus.

8 MCAR S 1.9005 [Temporary] Skull defects.

A. Skull depressions. For skull defects the percent of disability of the whole body is provided by the following schedule:

	Unfilled defect Percent	Filled defect Percent
0 - 1-1/2 square inches	0	0
1-1/2 - 2-1/2 square inches	5	0
2-1/2 - 4 square inches	10	2
4 - 6-1/2 square inches	15	3
6-1/2 or more square inches	20	5

B. Skull fractures.

1. Basilar skull fracture with persistent spinal fluid leak, 20 percent.

2. Basilar skull fracture without cerebrospinal fluid leak, 0 percent.

8 MCAR S 1.9006 [Temporary] Central nervous system.

A. General. For permanent partial disability of the central nervous system the percentage of disability of the whole body is as provided in B.-I.

B. Trigeminal nerve. Permanent partial disability of the trigeminal nerve is a disability of the whole body as set forth below:

1. Partial unilateral sensory loss, 3 percent;

2. Complete unilateral sensory loss, 5 percent;

3. Partial bilateral sensory loss, 10 percent;

4. Complete bilateral sensory loss, 25 percent;

5. Intractable trigeminal neuralgia, 20 percent;

6. Atypical facial pain, 5 percent;

7. Partial unilateral motor loss, 2 percent;

8. Complete unilateral motor loss, 5 percent;

9. Partial bilateral motor loss, 10 percent; or

10. Complete bilateral motor loss, 30 percent.

C. Facial nerve. Permanent partial disability of the facial nerve is a disability of the whole body as set forth below:

1. Total loss of taste, 3 percent;

2. Partial unilateral motor loss, 25 to 75 percent of function lost, 3 percent;

3. Unilateral motor loss, more than 75 percent of function lost, 10 percent;

4. Partial bilateral motor loss, 25 to 75 percent of function lost, 10 percent;

5. Bilateral motor loss, more than 75 percent of function lost, 20 percent.

D. Vestibular loss with vertigo or disequilibrium is a disability of the whole body as set forth below:

1. A score of 24 to 28 on the Kenny scale, and restricted in activities involving personal or public safety, such as operating a motor vehicle or riding a bicycle, 10 percent;

2. A score of 16 to 28 on the Kenny scale, and ambulation impaired due to equilibrium disturbance, 30 percent;

3. A score of 10 to 16 on the Kenny scale, 40 percent;

4. A score of 0 to 10 on the Kenny scale, 70 percent.

E. Glossopharyngeal, vagus and spinal accessory nerves. Permanent partial disability to glossopharyngeal, vagus and spinal accessory nerves is a disability of the whole body as set forth below:

1. Swallowing impairment caused by disability to any one or more of these nerves:

a. diet restricted to semi-solids, 10 percent;

b. diet restricted to liquids, 25 percent; or

c. diet by tube feeding or gastrostomy, 50 percent.

2. Mechanical disturbances of articulation due to disability to any one or more of these nerves:

a. 95 percent or more of words are understood by those who are not family members and others outside the immediate

family, but speech is distorted, 5 percent;

b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by those who are not family members, 10 percent;

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent;

d. more than 50 percent of words are understood by family members, 20 percent;

e. less than 50 percent of words are understood by family members, 25 percent;

f. 10 percent or less of words are understood by family members, 30 percent.

G. Hypoglossal nerve. Permanent partial disability of hypoglossal nerve is a disability of the whole body as listed below:

1. Bilateral paralysis; swallowing impairment:

a. diet restricted to semi-solids, 10 percent;

b. diet restricted to liquids, 25 percent; and

c. diet by tube feeding or gastrostomy, 50 percent.

2. Mechanical disturbances of articulation:

a. 95 percent or more of words are understood by family members and others outside the immediate family, but speech is distorted, 5 percent;

b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by nonfamily members, 10 percent;

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent;

d. more than 50 percent of words are understood by family members, 20 percent;

e. less than 50 percent of words are understood by family members, 25 percent;

f. 10 percent or less of words are understood by family members, 30 percent.

H. Spinal cord. To rate under this section, determine the disability to the lower extremities, upper extremities,

respiration, urinary bladder, anorectal, and sexual functions as set forth below. The percentage of whole body disability under this section is determined by combining the disabilities under 1.-6. in the manner described at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

1. Lower extremities. A permanent partial disability in the use of lower extremities is a disability of the whole body as set forth below:

a. can rise to a standing position and can walk, but has difficulty walking onto elevations, grades, steps, and distances, 15 percent;

b. can stand but can walk only on a level surface, 30 percent;

c. can stand but cannot walk, 45 percent; and

d. can neither stand nor walk, 65 percent.

2. Upper extremities. Permanent partial disability in the use of upper extremities is a disability of the whole body as set forth below:

Whole Body Disability, Percentages

	Preferred extremity	Nonpreferred extremity	Both
score of 24 to 28 on Kenny scale, but some difficulty with digital dexterity	10	5	15
score of 16 to 28 on Kenny scale, but no digital dexterity	20	10	30
score of 10 to 16 on Kenny scale	40	40	50
score of 0 to 10 on Kenny scale	70	70	85

3. Respiration. Permanent partial disability of the respiratory function is a disability of the whole body as set forth below:

a. difficulty only where extra exertion is required,

such as running, climbing stairs, heavy lifting, or carrying loads, 10 percent;

b. restricted to limited walking, confined to one's own home, 35 percent;

c. restricted to bed, 75 percent; and

d. has no spontaneous respiration, 95 percent.

4. Urinary bladder function. Permanent partial disability of the bladder is a disability of the whole body as set forth below. Evaluative procedures to be followed are set forth in 8 MCAR S 1.9022 [Temporary] B.

a. Impaired voluntary control evidenced by urgency or hesitancy, but continent without collecting devices, 10 percent.

b. Impaired voluntary control, incontinent requiring external collecting devices, 20 percent.

c. Impaired voluntary control, incontinent requiring internal collecting or continence devices, 30 percent.

5. Anorectal function. The permanent partial disability of the anorectal function is a disability of the whole body as set forth below:

a. impaired voluntary control with urgency, 10 percent;

b. impaired voluntary control without reflex regulation, 20 percent;

c. impaired voluntary control, incontinent without diversion, 30 percent.

6. Sexual function. Permanent partial disability of sexual function is a disability of the whole body as set forth below.

a. Male:

(1) impaired sexual function, but vaginal penetration possible, 10 percent;

(2) impaired sexual function, and vaginal penetration not possible, 20 percent.

b. Female:

(1) impaired sexual function, but penile containment possible, 10 percent;

(2) impaired sexual function, and penile containment

not possible, 20 percent.

I. Brain injury. Supporting objective evidence of structural injury, neurological deficit, or psychomotor findings is required to substantiate the permanent partial disability. Permanent partial disability of the brain is a disability of the whole body as set forth below.

1. Communications disturbances, expressive:

a. mild disturbance of expressive language ability not significantly impairing ability to be understood, such as mild word-finding difficulties, mild degree of paraphasias, or mild dysarthria, 10 percent;

b. severe impairment of expressive language ability, but still capable of functional communication with the use of additional methods such as gestures, facial expression, writing, word board, or alphabet board, 35 percent;

c. unable to produce any functional expressive language, 70 percent.

2. Communication disturbances, receptive:

a. mild impairment of comprehension of aural speech, but comprehension functional with the addition of visual cues such as gestures, facial expressions, or written material, 40 percent;

b. some ability to comprehend language is present, but significant impairment even with use of visual cues such as gestures, facial expressions, and written material, 60 percent;

c. no evidence of functional comprehension of language, 90 percent.

3. Complex integrated cerebral function disturbances must be determined by medical observation and organic dysfunctions supported by psychometric testing. Functional overlay or primary psychiatric disturbances shall not be rated under this rule. The permanent partial disabilities are as follows:

a. mild impairment of higher level cognitive function or memory, but able to live independently and function in the community as evidenced by independence in activities such as shopping and taking a bus, 20 percent;

b. same as a., and also requires supporting devices and direction to carry out limited vocational tasks, 30 percent;

c. moderate impairment of memory, judgment, or other higher level cognitive abilities, can live alone with some supervision such as for money management, some limitation in ability to function independently outside the home in activities such as shopping and traveling, 50 percent;

d. moderately severe impairment of memory, judgment, or other higher cognitive abilities, unable to live alone and some supervision required at all times, but able to perform self cares independently, 70 percent;

e. severe impairment of memory, judgment, or other higher cognitive abilities such that constant supervision and assistance in self cares are required, 95 percent.

4. Emotional disturbances and personality changes must be substantiated by medical observation and by organic dysfunction supported by psychometric testing. Permanent partial disability is a disability of the whole body as set forth below:

a. only present under stressful situation such as losing one's job, getting a divorce, or a death in the family, 10 percent;

b. present at all times but not significantly impairing ability to relate to others, to live with others, or to perform self cares, 30 percent;

c. present at all times in moderate to severe degree, minimal ability to live with others, some supervision required, 65 percent;

d. severe degree of emotional disturbance which, because of danger to self and others, requires continuous supervision, 95 percent.

5. Psychotic disorders, as described in D.S.M. III, not caused by organic dysfunction and substantiated by medical observation:

a. only present under stressful situation, such as losing one's job, getting divorced, a death in the family, 10 percent;

b. present at all times but not significantly impairing ability to relate to others, live with others, or perform self cares, 30 percent;

c. present at all times in moderate to severe degree significantly affecting ability to live with others, and requiring some supervision, 65 percent;

d. severe degree of emotional disturbance which, because of danger to self or others, requires continuous supervision, 95 percent.

6. Consciousness disturbances; permanent partial disability of the whole body is as set forth below:

a. mild or intermittent decreased level of consciousness manifested by periodic mild confusion or lethargy, a score of 16 to 28 on the Kenny scale, 40 percent;

b. moderate intermittent or continuous decreased level of consciousness manifested by a moderate level of confusion or lethargy, and a score of 10 to 16 on the Kenny scale, 70 percent;

c. severe decreased level of consciousness manifested as stupor with inability to function independently, and a score of 0 to 10 on the Kenny scale, 95 percent;

d. comatose or persistent vegetative state, 99 percent.

7. Motor dysfunction, movement disorder, paralysis, spasticity, sensory loss, or neglect. Where these impairments are due to brain or brain stem injury, rate as provided in H.1. and 2.

8. Other impairments; impairments of respiration, urinary bladder function, anorectal function, or sexual function due to brain or brain stem injury are rated as provided in H.3.-6.

9. Epilepsy; permanent partial disability due to epilepsy is a disability of the whole body as set forth below:

a. well controlled, on medication for one year or more, able to enter work force but with restrictions preventing operation of motor vehicles or dangerous machinery and climbing above six feet in height, 10 percent;

b. seizures occurring at least once a year, but not severely limiting ability to live independently, 20 percent;

c. seizures occurring at least six times per year, some supervision required, 40 percent;

d. seizures poorly controlled with at least 15 seizures per year, supervision required, protective care required with activities restricted, 75 percent;

e. frequency of seizures requires continuous supervision and protective care, activities restricted, unable to perform self cares, 95 percent.

10. Headaches; permanent partial disability due to vascular headaches with nausea or vomiting is a five percent disability of the whole body.

8 MCAR S 1.9007 [Temporary] Musculo-skeletal schedule; back.

A. Lumbar spine. The spine rating is inclusive of leg symptoms except for gross motor weakness, bladder or bowel dysfunction, or sexual dysfunction. Permanent partial disability of the lumbar spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

d. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical

findings.

(1) Spondylolisthesis grade I, no surgery, 7 percent.

(2) Spondylolisthesis grade II, no surgery, 14 percent.

(3) Spondylolisthesis grade III or IV, without fusion, 24.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. back and specific radicular pain present with objective neurologic findings; and X-ray or computerized axial tomography or myelogram specifically positive for herniated disc; and no surgery is performed for treatment, 14 percent;

b. condition treated by surgery:

(1) surgery or chemonucleolysis with excellent results such as mild low back pain, no leg pain, and no neurologic deficit, 9 percent;

(2) surgery or chemonucleolysis with average results such as mild increase in symptoms with bending or lifting, and mild to moderate restriction of activities related to back and leg pain, 11 percent;

(3) surgery or chemonucleolysis with poor surgical results such as persistent or increased symptoms with bending or lifting, and major restriction of activities because of back and leg pain, 13 percent;

(4) multiple operations on low back with poor surgical results such as persisting or increased symptoms of back and leg pain, 15 percent;

c. recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery or chemonucleolysis, add five percent to b.(1)-(4);

d. herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

3. Spinal stenosis, central or lateral, proven by computerized axial tomography or myelogram:

a. mild symptoms such as occasional back pain with athletic activities or repetitive bending or lifting, leg pain

with radicular symptoms, one vertebral level and no surgery, 14 percent;

b. severe spinal stenosis with bilateral leg pain requiring decompressive laminectomy, single vertebral level, with or without surgery (if multiple vertebral levels, add five percent per vertebral level), 18 percent.

4. Fusion surgery. Spinal fusion surgery for single vertebral level with or without laminectomy, 17.5 percent. Add five percent for each additional vertebral level.

5. Fractures:

a. vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 10.5 percent;

b. vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 15 percent;

c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent radicular pain, 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

d. severe dislocation:

(1) normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular pain, 17.5 percent;

B. Cervical spine. The spine rating is inclusive of arm symptoms except for gross motor weakness; sensory loss; and bladder, bowel, or sexual dysfunction. Bladder, bowel, or sexual dysfunction must be rated as provided in 8 MCAR S 1.9006 H. Permanent partial disability of the cervical spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. Neck and specific radicular pain present with objective neurologic findings; and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc; and no surgery is performed for treatment, 14 percent.

b. Condition treated by surgery:

(1) Surgery with excellent results such as mild neck pain, no arm pain, and no neurologic deficit, 9 percent.

(2) Surgery with average results such as mild increase in symptoms with neck motion or lifting, and mild to moderate restriction of activities related to neck and arm pain, 11 percent.

(3) Surgery with poor surgical results such as persistent or increased symptoms with neck motion or lifting, and major restriction of activities because of neck and arm pain, 13 percent.

(4) Multiple operations on neck with poor surgical results such as persisting or increased symptoms of neck and arm pain, 15 percent.

c. Recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery, add

five percent to b.(1)-(4).

d. Herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

3. Spinal stenosis, proven by computerized axial tomography or myelogram.

a. With myelopathy verified by objective neurologic findings, no loss of function, 14 percent.

b. Loss of function. Rate as provided in 8 MCAR S 1.9006 H.

4. Fusion surgery. Anterior or posterior. Fusion of a single vertebral level with or without a laminectomy, 11.5 percent. Add five percent for each additional vertebral level.

5. Fracture:

a. vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 14 percent;

b. vertebral compression with a decrease of more than 25 percent of vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 19 percent;

c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent pain, 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

d. severe dislocation:

(1) normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular

pain, 17.5 percent.

C. Thoracic spine. The spine rating is inclusive of all symptoms including radicular gross motor weakness and sensory loss, but excluding spinal cord injury. Permanent partial disability of the thoracic spine is a disabilty of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with chronic muscle spasm. The chronic muscle spasm is substantiated by objective clinical findings and is associated with demonstrable degenerative changes, single or multiple level, 3.5 percent.

2. Herniated intervertebral disc, symptomatic:

a. Specific radicular pain present with objective neurologic findings, and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc, and no surgery is performed for treatment, 5 percent.

b. Condition treated by surgery:

(1) Surgery with excellent results such as mild thoracic pain, no radicular pain, and no neurological deficit, 5 percent;

(2) Surgery with poor surgical results such as persistence of increased symptoms with lifting, and major restriction of activities, 10 percent.

3. Fractures:

a. Vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 10.5 percent.

b. Vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 15 percent.

c. Vertebral fracture with involvement of posterior

elements with x-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent pain, with mild motor and sensory manifestations, 17.5 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent.

d. Severe dislocation, normal reduction with surgical fusion:

(1) No residual motor or sensory changes, 12 percent;

(2) Poor reduction with fusion, persistent radicular pain, motor involvement, 17.5 percent;

8 MCAR S 1.9008 [Temporary] Musculo-skeletal schedule; amputations of upper extremity.

A. Permanent partial disability due to amputation of upper extremities is a disability of the whole body as set forth below:

1. forequarter amputation, 70 percent;

2. disarticulation at shoulder joint, 60 percent;

3. amputation of arm above deltoid insertion, 60 percent;

4. amputation of arm between deltoid insertion and elbow joint, 57 percent;

5. disarticulation at elbow joint, 57 percent;

6. amputation of forearm below elbow joint proximal to insertion of biceps tendon, 57 percent;

7. amputation of forearm below elbow joint distal to insertion of biceps tendon, 54 percent;

8. disarticulation at wrist joint, 54 percent;

9. midcarpal or midmetacarpal amputation of hand, 54 percent;

10. amputation of all fingers except thumb at metacarpophalangeal joints, 32.5 percent;

11. amputation of thumb:

a. at metacarpophalangeal joint or with resection of metacarpal bone, 21.5 percent;

b. at interphalangeal joint or through proximal phalynx, 16 percent;

c. from interphalangeal joint to midportion distal

phalynx, 13 percent;

12. amputation of index finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 13.5 percent;

b. at proximal interphalangeal joint or through middle phalynx, 11 percent;

c. at distal interphalangeal joint to middistal phalynx, 5 percent;

d. from middistal phalynx, distal, 2.5 percent;

13. amputation of middle finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 11 percent;

b. at proximal interphalangeal joint or through middle phalynx, 9 percent;

c. at distal interphalangeal joint to middistal phalynx, 5 percent;

d. from middistal phalynx, distal, 2.5 percent;

14. amputation of ring finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 5.5 percent;

b. at proximal interphalangeal joint or through middle phalynx, 4 percent;

c. at distal interphalangeal joint to middistal phalynx, 3 percent;

d. from middistal phalynx, distal, 1.5 percent;

15. amputation of little finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 3 percent;

b. at proximal interphalangeal joint or through middle phalynx, 2 percent;

c. at distal interphalangeal joint to middistal phalanx, 1 percent;

d. from middistal phalynx, distal, 0.5 percent.

8 MCAR S 1.9009 [Temporary] Musculo-skeletal schedule; sensory loss, upper extremities.

A. General. For sensory loss to the upper extremities

resulting from nerve injury, the disability of the whole body is set forth in B.-D. For the portion of the body described in B., there must be a total loss of the sensory function.

B. Sensory loss, complete:

1. median function at wrist, 22.5 percent;

2. ulnar function at wrist, 11 percent;

3. radial function at wrist, 5.5 percent;

4. medial antebrachial cutaneous, 3 percent;

5. medial brachial cutaneous, 3 percent;

6. loss of thumb, whole, 11 percent;

a. radial digital nerve, 4 percent;

b. ulnar digital nerve, 6.5 percent;

7. index finger, whole, 5.5 percent;

a. radial digital nerve, whole, 3.5 percent;

b. ulnar digital nerve, 2 percent;

8. long finger, whole, 5.5 percent;

a. radial digital nerve, 3.5 percent;

b. ulnar digital nerve, 2 percent;

9. ring finger, whole, 3 percent;

a. radial digital nerve, 2 percent;

b. ulnar digital nerve, 1 percent;

10. little finger, whole, 3 percent;

a. radial digital nerve, 1 percent;

b. ulnar digital nerve, 2 percent;

11. sensory loss distal to proximal interphalangeal joint, 50 percent of the value of entire digital nerve as set forth in B., either radial or ulnar as applicable;

12. sensory loss distal to one-half distal phalanx, 25 percent of entire digital nerve as set forth in B.

C. Quality of sensory loss in the hand. The levels of sensory loss and the corresponding disabilities of the whole body are measured as follows:

1. minimal, 2-point discrimination at 6 millimeters or less, 0 percent;

2. moderate, 2-point discrimination greater than 6 millimeters, 1/2 of value in B.;

3. severe, 2-point discrimination at greater than 10 millimeters, 3/4 of value in B.;

4. total, 2-point discrimination at greater than 15 millimeters, same value as in B.

D. Causalgia. When objective medical evidence shows persistent causalgia despite treatment, there is loss of sensory and motor function, loss of joint function, and inability to use the extremity in any useful manner. The permanent partial disability to the member, rating from the most proximal joint involved, and the percentage disability of the whole body is 50 percent of that set forth in 8 MCAR S 1.9008 [Temporary] A.1.-15.

8 MCAR S 1.9010 [Temporary] Musculo-skeletal schedule; motor loss or motor and sensory loss, upper extremities.

A. Total or complete loss. Total or complete loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is:

1. Motor loss, complete:

a. median nerve above mid forearm, 30 percent;

b. median nerve below mid forearm, 19 percent;

c. radial nerve, 19 percent;

d. ulnar nerve above mid forearm, 19 percent;

e. ulnar nerve below mid forearm, 13.5 percent.

2. Complete motor and sensory loss:

a. median nerve above mid forearm, 40.5 percent;

b. median nerve below mid forearm, 35 percent;

c. radial nerve, 27 percent;

d. ulnar nerve above mid forearm, 21.5 percent;

e. ulnar nerve below mid forearm, 16 percent.

3. Complete loss of motor function:

a. brachial plexus complete, 60 percent:

(1) upper trunk C5-6, 47 percent;

(2) mid trunk C7, 23 percent;

(3) lower trunk C8-T1, 46 percent;

b. anterior thoracic, 3 percent;

c. axillary nerve, 23 percent;

d. dorsal scapular, 3 percent;

e. long thoracic, 9 percent;

f. musculo cutaneous, 17.5 percent;

g. subscapular, 3 percent;

h. suprascapular, 11.5 percent;

i. thoraco dorsal, 6 percent.

4. Complete loss of function, motor and sensory:

a. C-5 root, 11 percent;

b. C-6 root, 12 percent;

c. C-7 root, 11 percent;

d. C-8 root, 13 percent.

B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity, and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-4.

8 MCAR S 1.9011 [Temporary] Musculo-skeletal schedule; shoulder.

A. General. For permanent partial disability to the shoulder, disability of the whole body is as set forth in B.-C.:

B. Range of motion:

1. total ankylosis in optimum position, abduction 60 degrees, flexion ten degrees, rotation, neutral position, 30 percent;

2. total ankylosis in mal-position, grade upward to 50 percent;

3. mild limitation of motion: no abduction beyond 90 degrees, rotation no more than 40 degrees with full flexion and extension, 3 percent;

4. moderate limitation of motion: no abduction beyond 60 degrees, rotation no more than 20 degrees, with flexion and extension limited to 30 degrees, 12 percent;

5. severe limitation of motion: no abduction beyond 25 degrees, rotation no more than ten degrees, flexion and extension limited to 20 degrees, 30 percent;

C. Procedures or conditions:

1. acromio-clavicular separation of the following severity:

a. grade 1, 0 percent;

b. grade 2, 3 percent;

c. grade 3, 6 percent.

2. anterior or posterior shoulder dislocation, no surgery, single episode, 3 percent.

3. recurrent dislocation, at least three times in six months, 10 percent.

4. repair recurrent shoulder dislocation, no loss of motion, 6 percent.

5. resection distal end of clavicle, 3 percent.

6. humeral shaft fracture, normal range of motion both joints, 0 percent.

7. humeral shaft fracture, open reduction, mild restriction of shoulder and elbow motion, 6 percent.

8. surgical neck fracture, healed, mild loss of motion, 0 percent.

9. greater tuberosity fracture, mild loss of motion, mild pain on abduction, 2 percent.

8 MCAR S 1.9012 [Temporary] Musculo-skeletal schedule; elbow.

A. General. Permanent partial disability of the elbow is disability of the whole body as set forth in B.-C.

B. Range of motion. Flexion and extension of forearm is 85 percent of the arm. Rotation of the forearm is 15 percent of the arm.

1. Total ankylosis in optimum position approximating midway between 90 degrees flexion and 180 degrees extension, a 45-degree angle, 30 percent.

2. Total ankylosis in mal-position, 40 percent.

3. Limitation of motion:

a. mild, motion limited from ten degrees flexion to 100 degrees of further flexion, 6 percent;

b. moderate, motion limited from 20 degrees flexion to 75 degrees of further flexion, 12 percent;

c. severe, motion limited from 45 degrees flexion to

90 degrees of further flexion, 21 percent;

4. Flail elbow, pseudarthrosis above joint line, wide motion but very unstable, 39 percent.

5. Resection head of radius, 9 percent.

C. Procedures or conditions:

1. radial or ulnar shaft fracture, full motion, 0 percent;

2. radial or ulnar fracture, open reduction, mild limitation of motion as defined in B.3., 9 percent;

3. olecranon fracture, no loss of motion, 0 percent;

4. olecranon fracture, open reduction internal fixation, mild limitation of motion as defined in B.3., 6 percent;

5. epicondylar fracture, no loss of motion, 0 percent;

6. epicondylar fracture, mild loss of motion as defined in B.3., 6 percent;

7. release medial or lateral epicondyle, 2 percent;

8. ulnar nerve transposition, 2 percent.

8 MCAR S 1.9013 [Temporary] Musculo-skeletal schedule; wrist.

A. General. Permanent partial disability of wrist is disability of the whole body as set in B.-C.

B. Range of motion:

1. excision distal end of ulna, flexion and extension credited with 75 percent of hand, and rotation 25 percent of hand, 5 percent;

2. total ankylosis in optimum position, 19 percent;

3. total ankylosis in mal-position of extreme flexion or extension, 25 percent;

4. limitation of motion:

a. mild, rotation normal, loss of 15 degrees palmar flexion and loss of 20 degrees dorsiflexion, 5 percent;

b. moderate, rotation limited to 60 degrees in pronation-supination, loss of 25 degrees palmar flexion, loss of 30 degrees dorsiflexion, 10 percent;

c. severe, rotation limited to 30 degrees in pronation-supination, palmer flexion less than 25 degrees, dorsi-flexion less than 30 degrees, 15 percent.

C. Procedure or conditions.

1. Colles/Smith, extraarticular:

a. no loss of motion, 0 percent;

b. mild loss of motion as defined in B.4.a., 3 percent.

2. Colles/Smith/Barton, intraarticular.

a. no loss of motion, 0 percent;

b. mild loss of motion as defined in B.4.a., 6 percent;

c. moderate loss of motion as defined in B.4.b., 10 percent.

3. Carpal bone fracture, no loss of motion, 3 percent.

4. Carpal dislocation, mild loss of motion as defined in B.4.a., 6 percent.

5. Carpal tunnel release, 0.5 percent.

6. Carpal tunnel release with moderate paresthesias, 3 percent.

7. DeQuervain's release, 0 percent.

8. Ganglion excision, 0 percent.

9. Scaphoid graft, 3 percent.

8 MCAR S 1.9014 [Temporary] Musculo-skeletal schedule, fingers.

A. General. Permanent partial disability of fingers is a disability of the whole body as set forth in B.-C.

B. Ankylosis of joints.

1. Any digit, excluding the thumb.

a. Total ankylosis of distal interphalangeal joint:

(1) optimum position, 4 percent;

(2) mal-position, flexed 35 degrees or more, 5 percent.

b. Total ankylosis of proximal interphalangeal joint:

(1) optimum position, flexed 25 to 40 degrees, 8 percent;

(2) mal-position, any position other than (1) above, 9 percent.

c. Total ankylosis of both distal and proximal interphalangeal joints. If total ankylosis of distal and proximal interphalangeal joints occurs, calculate disability according to a., and then add c. (1) or (2) as appropriate:

(1) optimum position, 1 percent;

(2) mal-position, 2 percent.

d. Total ankylosis metacarpophalangeal joint:

(1) optimum position, 35-50 degree flexion; 0.5 percent;

(2) mal-position, any position other than (1), 1 percent.

e. Total ankylosis both interphalangeal joints and metacarpophalangeal joint, add an additional 2 percent.

2. Thumb.

a. Total ankylosis interphalangeal joint:

(1) optimum position, 0 to 15 degrees, 1 percent;

(2) mal-position, flexion greater than 15 degrees, 2 percent.

b. Total ankylosis metacarpophalangeal joint:

(1) optimum position, up to 25 degree flexion, 1 percent;

(2) mal-position, flexion greater than 25 degrees, 2 percent.

c. Total ankylosis both interphalangeal and metacarpophalangeal joints:

(1) optimum position, 4 percent;

(2) mal-position, 5 percent.

d. Total ankylosis carpometacarpal joint alone:

(1) optimum position, 4 percent;

(2) mal-position, 8 percent.

e. Total ankylosis interphalangeal, metacarpophalangeal, and carpometacarpophalangeal joints:

(1) optimum position, 21 percent;

(2) mal-position, 23 percent.

3. Limitation of motion, fingers and thumb:

a. mild, total closing motion tip of digit, can flex to touch palm and thumb, and extend to 15 degrees flexion, strength of grip normal, 3 percent;

b. moderate, total closing motion, tip of digit, lacks 1/2 inch of touching palm and can extend to 30 degrees flexion, 6 percent;

c. severe, total closing motion tip of digit lacks one inch of touching palm and can extend to 45 degrees flexion, 9 percent;

d. soft tissue loss, isolated soft tissue loss of the end of digit, 20 percent of the disability to the whole body for amputation of that digit as set forth at 8 MCAR S 1.9009 [Temporary] A.1.-19.

B. Procedures or conditions:

1. release of trigger finger or thumb, 0 percent;

2. release of Guyon's Canal, 0 percent;

3. Boutonniere repair, 3 percent;

4. extensor tendon repair, 0 percent.

8 MCAR S 1.9015 [Temporary] Musculo-skeletal schedule; amputations of lower extremities.

For permanent partial disability due to amputation of lower extremities the disability of the whole body is:

1. hemipelvectomy, 50 percent;

2. disarticulation at hip joint, 40 percent;

3. amputation above knee joint with short thigh stump, 3 inch or less below tuberosity of ischium, 40 percent;

4. amputation above knee joint with functional stump, 36 percent;

5. disarticulation at knee joint, 36 percent;

6. amputation below knee joint with short stump, 3 inch or less below intercondular notch, 36 percent;

7. amputation below knee joint with functional stump, 28 percent;

8. amputation at ankle, Syme type, 28 percent;

9. partial amputation of foot, Chopart's type, 21 percent;

10. mid-metatarsal amputation, 14 percent;

11. amputation of all toes at metatarsophalangeal joints, 8 percent;

12. amputation of great toe:

a. with resection of metatarsal bone, 8 percent;

b. at metatarsophalangeal joint, 5 percent;

c. at interphalangeal joint, 4 percent;

13. amputation of lesser toe, 2nd-5th:

a. with resection of metatarsal bone, 2 percent;

b. at metatarsophalangeal joint, 1 percent;

c. at proximal interphalangeal joint, 0 percent;

d. at distal interphalangeal joint, 0 percent.

8 MCAR S 1.9016 [Temporary] Musculo-skeletal schedule; nerve injury or motor and sensory loss, lower extremities.

A. Total loss. Total loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is:

1. femoral, anterior crural, 13 percent;

2. femoral, anterior crural, below iliacus nerve, 11 percent;

3. genitofemoral, genito crural, 2 percent;

4. inferior gluteal, 9 percent;

5. lateral femoral cutaneous, 3 percent;

6. posterior cutaneous of thigh, 2 percent;

7. superior gluteal, 7 percent;

8. sciatic, above hamstring innervation, 31 percent;

9. common peroneal, lateral, or external popliteal, 13 percent;

10. deep peroneal, above midshin, 9 percent;

11. deep peroneal, below midshin, anterior tibial, 2 percent;

12. superficial peroneal, 5 percent;

13. tibial nerve, medial, or internal popliteal:

a. above knee, 15 percent;

b. posterior tibial, midcalf and knee, 11 percent;

c. below midcalf, 9 percent;

d. lateral plantar branch, 3 percent;

e. medial plantar branch, 3 percent;

14. sural, external saphenous, 1 percent;

15. L-4 nerve root, 11 percent;

16. L-5 nerve root, 13 percent;

17. S-1 nerve root, 15 percent;

18. Lumbosacral plexus, 40 percent.

B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity, and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-18.

8 MCAR S 1.9017 [Temporary] Musculo-skeletal schedule; joints.

A. General. For permanent partial disability of joints, disability of the whole body is set forth in B.-I.

B. Surgical or traumatic shortening of lower extremity.

1. 1/4 inch to 3/4 inch, 3 percent;

2. 3/4 to 1-1/4 inches, 4.5 percent;

3. 1-1/4 to 1-3/4 inches, 6 percent;

4. 1-3/4 inches and above, 9 percent;

C. Hip.

1. range of motion.

a. limitation of motion:

(1) mild, anterior posterior movement from 0 degree to 120 degree flexion, rotation and lateral motion, abduction, adduction free to 50 percent of normal, 6 percent;

(2) moderate, anterior posterior motion from 15 degrees flexion deformity to 110 degrees further flexion, rotation, lateral motion, abduction, and adduction free to 25 percent normal, 12 percent;

(3) severe, anterior posterior motion from 30 degrees flexion deformity to 90 degrees further flexion, 22 percent.

2. Procedures or conditions:

a. nonunion proximal femur fracture without reconstruction, 33 percent;

b. arthroplasty, able to stand at work and walk, motion 25 percent to 50 percent of normal, 18 percent;

c. total hip arthroplasty, normal result, 13 percent;

d. femoral endoprosthesis:

(1) minimal pain, near normal range of motion, able to walk unsupported, 15 percent;

(2) mild to moderate pain with weight bearing, motion 50 percent of normal, 20 percent;

e. hip pinning for fracture.

(1) minimal pain, near normal range of motion, able to walk unsupported, 5 percent;

(2) mild to moderate pain, motion 50 percent of normal, 10 percent.

D. Femur:

1. shaft fracture, closed, healed, 0 percent;

2. femoral shaft fracture, open reduction, loss of less than 20 degrees of movement of any one plane of either the hip or the knee, no malalignment, 2 percent.

E. Knee:

1. Range of motion.

a. ankylosis and limited motion, total ankylosis optimum position, 15 degrees flexion, 22 percent;

b. limitation of motion:

(1) mild, 0 degrees to at least 110 degrees flexion, 2 percent;

(2) moderate, 5 degrees to at least 80 degrees flexion, 7 percent;

(3) severe, 5 degrees to at least 60 degrees flexion, 15 percent;

(4) extremely severe, limited from 15 degrees flexion deformity with further flexion to 90 degree, 18 percent.

2. Procedures or conditions:

a. surgical removal of medial or lateral semilunar cartilage, no complications, 3 percent;

b. surgical removal both cartilages, 9 percent;

c. ruptured cruciate ligament, repaired or unrepaired:

(1) mild laxity, 3 percent;

(2) moderate laxity, 7 percent;

(3) severe laxity, 10 percent;

d. excision of patella, 9 percent;

e. plateau fracture, depressed bone elevated, semilunar excised, 9 percent;

f. plateau fracture, undisplaced, 2 percent;

g. supracondylar or intercondylar fracture, displaced, 7 percent;

h. supracondylar or intercondylar fracture, undisplaced, 2 percent;

i. patella fracture, open reduction or partial patellectomy, displaced, 5 percent;

j. patella fracture, open reduction or partial patellectomy, undisplaced, 2 percent;

k. arthroscopy, 0 percent;

l. repair collateral ligament, mild laxity, 2 percent;

m. repair collateral ligament, moderate laxity, 4 percent;

n. repair patellar dislocation, 5 percent;

o. total knee arthroplasty, flexion to 90 degrees, extension to 0 degrees, 13 percent;

p. total knee unicondylar, 7 percent;

q. lateral retinacular release, 1 percent;

n. proximal tibial osteotomy, flexion to 90 degrees, extension to 0 degrees, 5 percent.

F. Tibia:

1. tibial shaft fracture, undisplaced, healed, normal motion and alignment, 0 percent;

2. tibial shaft fracture, open reduction, loss of less than 20 degrees of movement in any one plane in either the knee or the ankle with full knee extension, no malalignment, 5 percent.

G. Ankle and foot.

1. Range of motion:

a. total ankylosis ankle and foot, pantalar arthrodesis:

(1) in 10 degrees plantar flexion, 15 percent;

(2) mal-position 30 degrees plantar flexion, 20 percent;

b. ankylosis of foot, subtalar or triple arthrodesis tarsal bones, ankle, normal motion, 7.5 percent;

(1) decreased motion, subtalar joint, 3.5 percent;

(2) ankylosis in mal-position, 8 percent;

c. ankylosis of tibia and talus, subtalar joints free, optimum position 15 degrees plantar flexion, 12 percent;

d. limitation of motion in the ankle:

(1) mild, motion limited from position of 90 degrees right angle to 20 degrees plantar flexion, 3 percent;

(2) moderate, motion limited from position of 10 degrees flexion to 20 degrees plantar flexion, 6 percent;

(3) severe, motion limited from position of 20 degrees plantar flexion to 30 degrees plantar flexion, 12 percent.

2. Procedures or conditions:

a. achilles tendon rupture with treatment surgically or nonsurgically, able to stand on toes, 2 percent;

b. achilles tendon rupture with treatment surgically or nonsurgically, unable to sustain body weight on toes, 4 percent;

c. open reduction ankle:

(1) normal range of motion:

(a) medial malleolus only, 2 percent;

(b) lateral malleolus only, 2 percent;

(2) mild restriction on range of motion:

(a) medial and lateral malleolus, 4 percent;

(b) trimalleolar, 4 percent;

d. ankle, lateral ligament reconstruction, mild laxity, normal range of motion, 2 percent.

H. Foot.

1. Range of motion:

a. ankylosis of tarsal metatarsal or mild tarsal joints:

(1) normal position, 2.5 percent;

(2) mal-position, 5 percent;

b. limited motion in the foot:

(1) mild, limited motion with mild pain with weight bearing, no change in activities, 2.5 percent;

(2) moderate, limitation of motion with pain with weight bearing, no reduction in athletic or vigorous activities, 5 percent;

(3) severe, limitation of motion with pain with weight bearing, sedentary activities not affected, 10 percent;

2. Procedures or conditions:

a. calcaneal fracture, extra articular, pain with weight bearing, 6 percent;

b. calcaneal fracture, intra articular:

(1) mild limitation of motion as in 1.b.(1), 6 percent;

(2) moderate limitation of motion as in 1.b.(2), 12 percent;

(3) severe limitation of motion as in 1.b.(3), 18 percent;

c. avascular necrosis talus:

(1) mild limitation of motion as in 1.b.(1), 6 percent;

(2) moderate limitation of motion as in 1.b.(2), 12 percent;

(3) severe limitation of motion as in 1.b.(3), 18 percent;

d. tarsal fractures, healed, mild pain, 3 percent;

e. metatarsal fractures, healed, 0 percent;

f. phalyngeal fractures, healed, 0 percent.

I. Toes.

1. complete ankylosis of metatarsophalangeal joint, any toe, 3 percent;

2. complete ankylosis any toe, interphalangeal joint, optimum position semi-flexion, 1 percent.

8 MCAR S 1.9018 [Temporary] Respiratory system.

A. Evaluation procedures. The procedures used in evaluating permanent partial disability of the respiratory system shall include the following:

1. complete history and physical examination with special reference to cardiopulmonary symptoms and signs;

2. chest roentgenography (posteroanterior in full inspiration, posteroanterior in full expiration timed, three seconds, lateral);

3. hematocrit or hemoglobin determination;

4. electrocardiogram;

5. performance of the following tests of ventilation:

a. one second forced expiratory volume (FEV1), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 69 and 71;

b. forced vital capacity (FVC), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 70 and 72.

6. diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits.

B. Measurement of respiratory loss of function. Table 1 shall be used to calculate the percentage of disability of the whole body due to permanent partial disability of the respiratory system.

TABLE 1

	Forced Spirometry Measurements 1/2 (FEV1 + FVC) (Test three times)	Diffusing Capacity*	Percent Disability of Whole Body
Symptoms			
When dyspnea occurs, is consistent with the circumstances of activity.	Not less than 85 percent of normal	Not Applicable	0
Dyspnea does not occur at	70 to 85 percent of normal	Not Applicable	15

rest and seldom occurs during the performance of the usual activities of daily living.			
Dyspnea does not occur at rest but does occur during the usual activities of daily living.	50 to 70 percent of normal	Usually Not Applicable	30
Dyspnea occurs during activities such as climbing one flight of stairs or walking one block on the level.	25 to 50 percent of normal	40 percent or less of normal	60
Confined to bed and oxygen dependent.	Less than 25 percent of normal	20 percent or less of normal	85

* The diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits set forth in Table 1.

C. Asthma. Asthma which is not medically controllable and which requires at least six hospitalizations in 12 months, 25

percent.

8 MCAR S 1.9019 [Temporary] Organic heart disease.

A. General. For permanent partial disability due to organic heart disease, the disability of the whole body is set forth in B.

B. Heart ratings. The following ratings may be applied only after a compilation of a patient's complete history and a physical examination. Testing must include chest X-ray and electrocardiogram. The testing may include echocardiography, exercise testing, and radionuclide studies.

The following table sets forth symptoms of organic heart disease. The percentage of disability of the whole body is determined by the symptoms present.

Organic Heart Disease Schedule

Percentage Disability of Whole Body	10 percent	30 percent	60 percent	85 percent
Organic Heart Disease	Present	Present	Present	Present
Symptoms	Not present	Not present at rest	Not present at rest	Present at rest
Level of activity causing symptoms	No symptoms from usual activities of daily living, including such activities as stair- or hill-	No symptoms from usual activities of daily living	Symptoms from a one or more block walk or from climbing stairs. Symptoms also from activities of daily living	Worsening of symptoms with any activity

	climbing, and walking			
Level of unusual activity causing symptoms	No symptoms from walking quickly, recreation, hill- or stair-climbing, arm-work, and similar activities	Symptoms from hill- or stair-climbing, walking quickly, arm-work, or recreation	Symptoms from emotional stress, walking quickly, and similar activities	May be present at rest or may awaken patient
Signs of heart failure	No	No	Relieved by therapy	Not usually relieved by therapy
Signs of symptoms of angina	No	With prolonged or severe exertion	With mild exertion	Rest or nocturnal symptoms

8 MCAR S 1.9020 [Temporary] Vascular disease affecting the extremities.

The following schedule shall be used to determine the percentage of disability of the whole body for permanent partial disability due to vascular disease. Permanent partial disability from vascular disease affecting the extremities must be rated according to the following classifications. The system shall be used only after a complete history and physical examination. The full evaluation shall include imaging examination (X-ray with and without contrast, computer axial tomography scanning, sonography, radionuclide studies) volume studies, or flow studies.

Vascular Disease Schedule

Percentage of disability of whole body	0 percent	10 percent	30 percent	60 percent	90 percent
Intermittant claudication distance	No	Approx. one city block	Approx. 1/4 city block	Less than 1/4 city block	Constant pain
Pain at rest	No	No	No	Sometimes	Constant
Physical signs of diagnosis	None No ulceration	Healed, painless stump, or healed ulcer	Healed stump but persistent signs of activity, or persistent superficial ulcer	Amputation above wrist or ankle with continued sign of disease, or widespread deep ulcer	Amputation above wrist or ankle in more than one limb, or wide, deep ulceration of more than one limb
Edema	Rare and transient	Persistent, incompletely controlled	Very severe and only partially controlled	Marked and uncontrollable	Marked and uncontrollable

8 MCAR S 1.9021 [Temporary] Gastrointestinal tract.

A. General. The following schedule is for the evaluation of permanent partial disability of the gastrointestinal tract. The evaluation must include a thorough history and physical examination. Additional studies, such as radiographic, metabolic, absorptive, endoscopic, and biopsy may be necessary to determine the functioning of these organs. Disability shall not be determined until after completion of all medically accepted diagnostic and therapeutic efforts. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

For evaluative purposes, the digestive tract has been divided into (1) the esophagus, stomach, duodenum, small intestine, and pancreas, (2) the colon and rectum, (3) the anus, and (4) the liver and biliary tract.

B. Upper digestive tract (esophagus, stomach, duodenum, small intestine, and pancreas).

1. Class 1, 2 percent.

a. Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; continuous treatment is not required; and weight can be maintained at the desirable level; or

b. There are no complications after surgical procedures.

2. Class 2, 15 percent. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; dietary restriction and drugs are required for control of symptoms, signs, or nutritional deficiency; and loss of weight below the desirable weight does not exceed 10 percent.

3. Class 3, 35 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state; or

b. There is 10 to 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder

of the upper digestive tract.

4. Class 4, 65 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and symptoms are not controlled by treatment; or

b. There is greater than a 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder of the upper digestive tract.

C. Colon and rectum.

1. Class 1, 2 percent:

a. signs and symptoms of colonic or rectal disease are infrequent;

b. limitation of activities, special diet, or medication is not required; no systemic manifestations are present and weight and nutritional state can be maintained at a desirable level; or

c. there are no complications after surgical procedures.

2. Class 2, 15 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration. There are mild gastrointestinal symptoms with intermittent disturbance of bowel function, accompanied by periodic or continual pain. Minimal restriction of diet or mild symptomatic therapy may be necessary. No impairment of nutrition results.

3. Class 3, 30 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration; there are moderate to severe exacerbations with disturbance of bowel habit, accompanied by periodic or continual pain; restriction of activity, special diet and drugs are required during attacks; and there are constitutional manifestations such as fever, anemia, or weight loss.

4. Class 4, 50 percent. There is objective evidence of colonic and rectal disease or anatomic loss or alteration; there are persistent disturbances of bowel function present at rest with severe persistent pain; complete limitation of activity, continued restriction of diet, and medication do not entirely

control the symptoms; there are constitutional manifestations such as fever, weight loss, or anemia present; and there is no prolonged remission.

D. Anus.

1. Class 1, 2 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; or there is mild incontinence involving gas or liquid stool; or anal symptoms are mild, intermittent, and controlled by treatment.

2. Class 2, 12 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; and moderate but partial fecal incontinence is present requiring continual treatment; or continual anal symptoms are present and incompletely controlled by treatment.

3. Class 3, 22 percent.

a. Signs of organic anal diseases are present and there is anatomic loss or alteration; and complete fecal incontinence is present; or

b. Signs of organic anal disease are present and severe anal symptoms are unresponsive or not amenable to therapy.

E. Liver and biliary tract.

1. Class 1, 5 percent.

a. There is objective evidence of persistent liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate minimal disturbance of the liver function; or

b. Primary disorders of bilirubin metabolism are present.

2. Class 2, 20 percent. There is objective evidence of chronic liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate more severe liver damage than Class 1.

3. Class 3, 40 percent. There is objective evidence of

progressive chronic liver disease, or history of jaundice, ascites, or bleeding esophageal or gastric varices within the past year; nutrition and strength may be affected; and there is intermittent ammonia and meat intoxication.

4. Class 4, 75 percent. There is objective evidence of progressive chronic liver disease, or persistent ascites or persistent jaundice or bleeding esophageal or gastric varices, with central nervous system manifestations or hepatic insufficiency; and nutrition state is below normal.

F. Biliary tract.

1. Class 1, 5 percent. There is an occasional episode of biliary tract dysfunction.

2. Class 2, 20 percent. There is recurrent biliary tract impairment irrespective of treatment.

3. Class 3, 40 percent. There is irreparable obstruction of the bile tract with recurrent cholangitis.

4. Class 4, 75 percent. There is persistent jaundice and progressive liver disease due to obstruction of the common bile duct.

8 MCAR S 1.9022 [Temporary] Reproductive and urinary tract schedule.

A. General. This rule sets forth the percentage of disability of the whole body for permanent partial disability of the reproductive and urinary systems. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

B. Evaluative procedures. For evaluative purposes the reproductive and urinary systems are divided into the: (1) upper urinary tract, (2) bladder, (3) urethra, (4) male reproductive organs, and (5) female reproductive organs.

Procedures for evaluating permanent partial disability of the genitourinary and reproductive systems shall include:

1. a complete history and physical examination with special reference to genitourinary/reproductive symptoms and signs, including psychological evaluation when indicated by the symptoms;

2. laboratory tests to identify the presence or absence of associated disease. The tests may include multi-channel chemistry profile, complete blood count, complete urinalysis, including microscopic examination of centrifuged sediment, chest X-ray, both posterior/anterior and left lateral views, electrocardiogram, performance of a measurement of total renal functions--endogenous creatinine clearance corrected for total body surface area. Other tests may include:

a. kidney function tests, such as arterial blood gases and determinations of other chemistries that would reflect the metabolic effects of decreased kidney function;

b. special examinations such as cystocopy, voiding cystograms, cystometrograms; and

c. a description of the anatomy of the reproduction or urinary system.

C. Upper urinary tract.

1. Solitary kidney, 10 percent. This category shall apply only when a solitary kidney is the only upper urinary tract permanent partial disability. When a solitary kidney occurs in combination with any one of the following four classes, the disability rating for that class shall be increased by 10 percent.

2. Class 1, 5 percent. Diminution of kidney function as evidenced by a creatinine clearance of 50 to 70 percent of age and sex adjusted normal values, other underlying causes absent.

3. Class 2, 22 percent. Diminution of the upper urinary tract function as evidenced by a creatinine clearance of 40 to 50 percent of age and sex adjusted normal values, no other underlying disease.

4. Class 3, 47 percent. Diminution of upper urinary tract function, as evidenced by creatinine clearance of 25 to 40 percent of age and sex adjusted normal values.

5. Class 4, 77 percent. Diminution of upper urinary tract function as evidenced by creatinine clearance below 25 percent of age and sex adjusted normal values.

D. Bladder.

1. Class 1, 5 percent. Symptoms and signs of bladder disorder requiring intermittent treatment, but without evidence of intervening malfunction between periods of treatments or symptomatology.

2. Class 2, 15 percent. Symptoms and signs of bladder disorder requiring continuous treatment, or there is bladder reflex activity but loss of voluntary control.

3. Class 3, 20 percent. Poor reflex activity evidenced by intermittent dribbling, and no voluntary control.

4. Class 4, 30 percent. Continuous dribbling.

E. Urethra.

1. Class 1, 2 percent. Symptoms and signs of urethral disorder are present which require intermittent therapy for control.

2. Class 2, 15 percent. Symptoms and signs of urethral disorder that cannot be effectively controlled by treatment.

F. Penis.

1. Class 1, 10 percent. Impaired sexual function but vaginal penetration is possible.

2. Class 2, 20 percent. Impaired sexual function and vaginal penetration is not possible.

G. Testes, epididymides, and spermatic cords

1. Class 1, 5 percent.

a. Symptoms and signs of testicular, epididymal, or spermatic cord disease are present and there is anatomic alteration; and

b. Continuous treatment is not required; and

c. There are no abnormalities of seminal or hormonal functions; or

d. Solitary teste is present.

2. Class 2, 10 percent.

a. Symptoms and signs of testicular, epididymal or spermatic cord disease are present and there is anatomic alteration; and

b. Frequent or continuous treatment is required; and

c. There are detectable seminal or hormonal

abnormalities.

3. Class 3, 20 percent. Trauma or disease produces bilateral anatomical loss or there is no detectable seminal or hormonal function of testes, epididymides, or spermatic cords.

H. Prostate and seminal vesicles.

1. Class 1, 5 percent.

a. there are symptoms and signs of prostatic or seminal vesicular dysfunction or disease;

b. anatomic alteration is present; and

c. continuous treatment is not required.

2. Class 2, 10 percent.

a. frequent severe symptoms and signs of prostatic or seminal vesicular dysfunction or disease are present; and

b. anatomic alteration is present; and

c. continuous treatment is required.

3. Class 3, 20 percent. There has been ablation of the prostate or seminal vesicles.

I. Vulva and vagina.

1. Class 1, 10 percent. Impaired sexual function but penile containment is possible.

2. Class 2, 20 percent. Impaired sexual function and penile containment is not possible.

J. Cervix and uterus.

1. Class 1, 5 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which do not require continuous treatment; or

b. Cervical stenosis, if present, requires no treatment; or

c. There is anatomic loss of the cervix or uterus in the postmenopausal years.

2. Class 2, 10 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which require continuous treatment; or

b. Cervical stenosis, if present, requires periodic

treatment.

3. Class 3, 20 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which are not controlled by treatment; or

b. Cervical stenosis is complete; or

c. Anatomic or complete functional loss of the cervix or uterus occurs in premenopausal years.

K. Fallopian tubes and ovaries.

1. Class 1, 5 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which do not require continuous treatment; or

b. Only one fallopian tube or ovary is functioning in the premenopausal years.

2. Class 2, 10 percent. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which require continuous treatment, but tubal patency persists and ovulation is possible.

3. Class 3, 20 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present and there is total loss of tubal patency or total failure to produce ova in the premenopausal years; or

b. Bilateral loss of the fallopian tubes or ovaries occurs in the premenopausal years.

8 MCAR S 1.9023 [Temporary] Skin disorders.

Permanent partial disability resulting from skin disorders are a disability of the whole body as set forth in this rule. This schedule is based upon the effect of the disorder on the ability to function and perform activities of daily living and the degree of treatment required for the disorder. The schedule is not based upon the location or the percentage of the body affected by a specific skin disorder. Impairment due to burns shall be rated under 8 MCAR S 1.9024 and not under this schedule.

1. Class 1, 2 percent. Signs or symptoms of skin

disorder are present and supported by objective skin findings. With treatment there is no or minimal limitation in the performance of the activities of daily living, although certain physical or chemical agents might temporarily increase the extent of limitation.

2. Class 2, 10 percent. Signs and symptoms of skin disorder are present and intermittent treatment is required. There is limitation in the performance of some of the activities of daily living.

3. Class 3, 20 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required. There is limitation in the performance of many of the activities of daily living.

4. Class 4, 45 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which may include periodic confinement at home or other domicile. There is limitation in the performance of many of the activities of daily living.

5. Class 5, 70 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which necessitates confinement at home or other domicile. There is severe limitation in the performance of nearly all of the activities of daily living.

8 MCAR S 1.9024 [Temporary] Burns.

A. General. The whole body disability due to burns is not equal to the percent of body surface area which is burned. The percentage of body surface area affected must be determined according to Lund and Browder. The ratings determined under A.-D. must be combined as set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c), provided that the maximum disability to the whole body under this schedule must not exceed 70 percent. Loss of motion or body parts except the face must be rated under the musculoskeletal schedules and must not be considered as included in a rating under this rule unless specifically provided otherwise.

B. Burns other than electrical conduction. A rating under

this section is the ratings assigned by the following paragraphs combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c):

1. Any burn that heals within one month and leaves no hypertrophic scar, 0 percent.

2. Cold intolerance of the hands, face, or head as evidenced by the wearing of heavy gloves or additional scarves at 35 degrees Fahrenheit, 10 percent.

3. Heat intolerance is evidenced by fatigue, malaise, nausea, and an oral temperature of at least 100 degrees Fahrenheit upon exposure to an environmental temperature of 90 degrees Fahrenheit at 60 percent relative humidity, 5 percent.

4. Sensitivity to sun exposure as evidenced by the need to cover the skin or use sun screen to prevent sunburn, 10 percent.

5. Sensitivity to dust, chemical, or petroleum exposure; altered sweating; or apocrine gland dysfunction. For one or any combination of these conditions, the whole body disability is:

a. If the sensitivity affects less than 5 percent of the body surface area, 0 percent.

b. If the sensitivity affects 5 to 20 percent of the body surface area, 2 percent.

c. If the sensitivity affects 20 percent or more of the body surface area, 3 percent.

6. Sensory loss due to burns:

a. Loss of sensation on palmar surface of hands shall be rated as provided by 8 MCAR S 1.9009 C.

b. Sensory loss in less than 5 percent of the body surface area, 0 percent.

c. Sensory loss in 5 to 20 percent of the body surface area, 2 percent.

d. Sensory loss in more than 20 percent of the body surface area, 5 percent.

C. Electrical conduction injuries.

1. Associated sensory loss and concommitant thermal injuries must be rated as provided in A.

2. Peripheral nerve deficits must be rated as provided in the musculoskeletal schedule.

The ratings under 1. and 2. must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

D. Cosmetic disfigurement. This section applies to disfigurement on the face, the head, the neck, or the hands due to burns. Where there is surgery, this rating is done after correction by plastic surgery. The final rating under this schedule shall not be done until hypertrophic scarring is matured or more than 24 months after the injury. The ratings under the paragraphs of this section must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

1. Face. The face is the anterior head from the forehead, to and including the chin.

a. Loss of facial features:

(1) Deformity of nasal tip or deformity, thinning, or eversion of ala nasi, 5 percent.

(2) Loss of more than 50 percent of nasal cartilage or of both ala nasi, 25 percent.

b. Eyes:

(1) Loss of one eyebrow, 2.5 percent.

(2) Loss of two eyebrows, 5 percent.

(3) Ectropian unaccompanied by visual impairment:

(a) Lower lid pulled from eye when mouth is opened and neck extended, 5 percent.

(b) Lower lid pulled away with no movement of face or neck, 10 percent.

(c) Cornea unprotected when sleeping, 15 percent.

(4) Epiphora unaccompanied by visual impairment, 10 percent.

c. Mouth. A rating under this paragraph is the arithmetic sum of (1)-(4).

(1) Noncongenital microstomia or distortion affecting eating and dental hygiene, 10 percent.

(2) Eversion of the upper lip, 7.5 percent.

(3) Eversion of the lower lip, 7.5 percent.

(4) Distortion of vermillion border, 10 percent.

d. Ear. Loss of 75 percent or more of one external ear, 5 percent.

e. Hypertrophic scarring of face in areas other than those covered in a.-d.:

(1) Affecting only forehead above the eyebrows, 10 percent.

(2) Affecting the lower face from eyebrows to chin, 25 percent.

(3) Affecting both the forehead above the eyebrows and the lower face from the eyebrows to chin, 35 percent.

f. Wrinkling of face in areas other than those covered in a.-e., one-third of percentages in e.

2. Head, Alopecia:

a. Anterior hairline:

(1) Loss of less than 20 percent of hair on anterior hairline, 0 percent.

(2) Loss of 20 to 50 percent of hair on anterior hairline, 2 percent.

(3) Loss of more than 50 percent of hair on anterior hairline, 3 percent.

b. Elsewhere on head and not affecting anterior hairline:

(1) Loss of 0 to 15 percent of hair, 0 percent.

(2) Loss of 15 to 30 percent of hair, 1 percent.

(3) Loss of 20 to 50 percent of hair, 2 percent.

(4) Loss of more than 50 percent of hair, 3 percent.

The ratings under a. and b. must be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

3. Anterior neck. The anterior neck extends from the ear lobule anteriorally to the ear lobule and downward to mid clavicle. Disfigurement on the posterior neck from the ear lobule posteriorally to the ear lobule shall not be rated under

this rule. Ratings under a. and b. shall be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

a. Hypertrophic scarring or banding:

(1) Affecting less than 10 percent of the anterior neck, 0 percent.

(2) Affecting 10 to 30 percent of the anterior neck, 10 percent.

(3) Affecting 30 to 50 percent of the anterior neck, 12 percent.

(4) Affecting more than 50 percent of the anterior neck, 15 percent.

b. Chin shelf. The chin shelf is the area from the chin backwards to the neck.

(1) Chin shelf extends less than 2 inches, 3 percent.

(2) Chin shelf extends less than 1 inch, 10 percent.

4. Hands. The hand extends from the carpus outward. Loss of body parts and loss of motion are rated in the musculoskeletal schedule.

a. Hypertrophic scarring affecting less than 30 percent of dorsum of one hand, 0 percent.

b. Hypertrophic scarring affecting 30 to 50 percent of dorsum of one hand, 3 percent.

c. Hypertrophic scarring affecting 50 percent or more of dorsum of one hand, 7 percent.

8 MCAR S 1.9025 [Temporary] Pre-existing impairments.

Where a disability is subject to apportionment under Minnesota Statutes, section 176.101, subdivision 4a, the rating for the disabled condition under a category of the schedules of these rules must be reduced as provided in this rule. As used in this rule, the term disabled condition includes the pre-existing disability.

A. This section applies where the pre-existing disability has not been rated and neither B. nor C. is applicable.

1. The pre-existing disability must be rated under a category of the schedules of these rules.

2. The whole body disability rating assigned to the disabled condition of the member by the schedules of these rules must be reduced by the rating assigned to the pre-existing disability of the member in 1.

3. For example, the medical report establishes a pre-existing impairment of amputation of the index finger at the metacarpophalangeal joint. This injury is a 13.5 percent pre-existing disability to the body as a whole under 8 MCAR S 1.9008 [Temporary] A.12.a. The disabled condition is amputation of all fingers except the thumb at the metacarpophalangeal joint, a 32.5 percent disability under 8 MCAR S 1.9008 A.10. 32.5 percent less 13.5 percent gives the disability (adjusted for the pre-existing impairment) of 19 percent. Payment is made for the 19 percent disability at the rate appropriate for a 32.5 percent disability. Thus, if economic recovery benefits are paid, 19 percent is multiplied by 680 weeks; for impairment benefits, 19 percent is multiplied by $85,000.

B. This section applies where the pre-existing disability of a member has been rated in another proceeding or state and the rating represents a percentage of disability to the whole body. The rating of the disabled condition under a category of these schedules shall be reduced by the rating assigned to the pre-existing disability of the member.

C. This section applies where the injury producing the pre-existing disability occurred prior to January 1, 1984, and the pre-existing disability has been rated under Minnesota Statutes, section 176.101, subdivision 3; or where Minnesota Statutes, chapter 176 is inapplicable and the rating represents a percentage of disability of a member.

1. From Table 1, determine the maximum whole body disability assignable to the pre-existing disability. Use Table 2 where disability to an internal organ is rated as a percentage of disability to the particular organ rather than a percentage of disability to internal organs. Where the pre-existing disability is not listed in Table 1 or Table 2, the maximum whole body disability is the maximum disability assigned to the

affected member by the schedules of 8 MCAR SS 1.9001-1.9024 [Temporary].

TABLE 1

Member	Maximum Whole Body Disability (Percent)
Thumb	16
Index finger	11
Middle finger	9
Ring finger	4
Little finger	2
Great toe	5
Lesser toe	1
Hand	54
Hand and wrist	54
Arm	60
Foot	21
Foot and ankle	28
Leg	40
Eye	24
Eyes (both)	85
Hearing loss (both ears)	35
Back	71
Voice	70
Burns and skin impairments, including disfigurement	70
Internal organs, excluding brain	85
Brain	100
Head	20

TABLE 2

Member	Maximum Whole Body Disability (Percent)

Stomach	65
Pancreas	65
Colon	50
Spleen	0
Bladder	30
Sexual organs or function	20
Circulatory system	90
Heart	85
Lungs	85
Liver	75
Solitary kidney	10
Kidney, excluding solitary kidney	77

2. Multiply the prior rating of the member's pre-existing disability by the maximum whole body disability determined in 1. Where a disputed rating has been closed out to a stipulated rating but payments were made on a different rating, the rating for purposes of this rule is the closed-out rating.

3. Subtract the percentage amount determined in 2. from the whole body disability rating assigned to the disabled condition of the member by the schedules of these rules. The remainder is the amount due for the disabled condition after apportionment for the pre-existing disability.

4. For example, a pre-1984 back injury was rated at 25 percent of the back. The whole body disability attributable to this injury is 25 percent by 71 percent equals 17.75 percent. After 1984, a second back injury is rated at 24.5 percent under these rules (24.5 percent minus 17.75 percent equals 6.75 percent). Six and three-fourths (6.75) percent is the amount assigned to the disabled condition after apportionment.

D. Where the pre-existing disability and the subsequent permanent partial disability affect more than one member, apportionment must be determined as follows:

1. For each member, determine the percentage of whole body disability under A.-C., as appropriate.

2. Combine the percentages obtained in 1. in the manner set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c). Prior to the next application of the formula, the result of an application of the formula must be stated as a decimal, not as a percentage, that is rounded up or down to four decimal places.

Effective Date. Rules 8 MCAR SS 1.9001-1.9025 [Temporary] are effective January 1, 1984.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JAN 5 1984
1:15 p.m.
Secretary of State

APPROVED AS TO FORM AND LEGALITY
January 1 1984
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY Martha J Cassedy
SPECIAL ASSISTANT ATTORNEY GENERAL

this version is the same as rules as adopted except for additional language on page 74 as noted in "Notice of Submission to Atty. Gen"

Department of Labor and Industry
Workers' Compensation Division

Proposed Amendments to Proposed Temporary Rules Governing Workers' Compensation Permanent Partial Disability Schedule

Temporary Rules as Proposed

8 MCAR S 1.9001 [Temporary] Workers' compensation permanent partial disability schedule rules.

A. Purpose of schedules. Laws of Minnesota 1983, chapter 290, section 86, requires the commissioner of labor and industry to promulgate temporary rules assigning specific percentages of disability of the whole body for specific permanent partial disabilities. Rules 8 MCAR SS 1.9001-~~1.9023~~ 1.9025 [Temporary] assign percentages of disability of the whole body for permanent partial disabilities.

B. Interpretation of schedules. Only the categories set forth in the schedules in 8 MCAR SS 1.9001-~~1.9023~~ 1.9025 [Temporary] may be used when rating the extent of a disability. Where a category represents the disabling condition, the disability determination shall not be based on the cumulation of lesser included categories. If more than one category may apply to a condition, the category most closely representing the condition shall be selected. Where more than one category is necessary to represent the disabling condition, categories shall be selected to avoid double compensation for any part of a condition. The percentages of disability to the whole body as set forth in two or more categories shall not be averaged, prorated, or otherwise deviated from, unless specifically provided in the schedule. Unless provided otherwise, where an impairment must be rated under more than one category, the ratings must be combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c). With respect to the musculo-skeletal schedule, the percent of whole body disability for motor or sensory loss of a member shall not exceed the

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percent of whole body disability for amputation of that member.

C. Disabilities not part of schedules. A category not found within 8 MCAR SS 1.9001-~~1.9023~~ 1.9025 [Temporary] shall not be used to determine permanent partial disability.

D. Rules of construction. The technical terms in 8 MCAR SS 1.9001-~~1.9023~~ 1.9025 [Temporary] are defined in either 8 MCAR S 1.9002 [Temporary], or by the documents incorporated by reference in this rule. Documents are incorporated by reference only to the extent necessary for definition or to the extent specifically referenced in a schedule. These documents are as follows: FofF 3

1. Guides to the Evaluation of Permanent Impairment, published by the American Medical Association, Committee on Rating of Mental and Physical Impairment, ~~1971~~ 1976 FF4 edition. This document is also known as the A.M.A. Guides.

2. Snellen Charts, published by American Medical Association Committee for Eye Injuries and designated Industrial Vision Test Charts. These charts are also known and referred to as A.M.A. charts;

3. American Medical Association Rating Reading Card of 1932, published by the American Medical Association Committee for Eye Injuries. This document is also ~~know~~ known FF5 as the A.M.A. Card.

4. American National Standard Institutes, Inc., S3.1-1977 Criteria for Permissible Ambient Noise during Audiometric Testing and S3.6-1969 (R1973) FF6 Specification for Audiometers;

5. Metropolitan Life Insurance Company Height and FF7 Weight Tables, published by the Metropolitan Life Insurance Company, 1983;

6. The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, Sister Kenny Institute, 1973;

7. Dorland's Illustrated Medical Dictionary, 25th edition, 1974. This document is also know as Dorland's;

8. D.S.M. III, Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1980. This

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document is also known as D.S.M. III;

9. Fractures, Charles A. Rockwood and David Green, 1975; and

10. Textbook on Anatomy, William Henry Hollinshead, 1974; and

11. "The Estimation of Areas of Burns," in Surgery, Gynecology and Obstetrics, by Lund and Browder, pages 352-358, volume 79, 1944. This document is referred to as Lund and Browder.

E. Severability. If any provision of these rules is held to conflict with a governing statute, applicable provisions of the Minnesota Administrative Procedure Act, or other relevant law; to exceed the statutory authority conferred; to lack a reasonable relationship to statutory purposes or to be unconstitutional, arbitrary, or unreasonable; or to be invalid for any other reason; the validity and enforceability of the remaining provisions of the rule shall in no manner be affected.

8 MCAR S 1.9002 [Temporary] Definitions.

A. Scope. For the purpose of 8 MCAR SS 1.9001-1.9023 1.9025 [Temporary] the terms defined in this rule have the meanings given them unless the context clearly indicates otherwise. Terms not defined in this rule are defined in Dorland's or other documents incorporated by reference. If the definition in a document incorporated by reference conflicts with or differs from the definition set forth in 8 MCAR S 1.9001-1.9023 1.9025 [Temporary], the specific definitions set forth in these rules shall govern.

B. Acromio-clavicular grade 1. "Acromio-clavicular grade 1" means an undisplaced acromio-clavicular joint.

C. Acromio-clavicular grade 2. "Acromio-clavicular grade 2" means a 50 percent displacement of the clavicle in relationship to the acromion at the acromio-clavicular joint.

D. Acromio-clavicular grade 3. "Acromio-clavicular grade 3" means a completely disrupted acromio-clavicular joint.

E. Activities of daily living. "Activities of daily living" means the ability to perform self cares, to perform housework

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and related tasks, to ride in or operate a motor vehicle, and to perform vocational tasks not requiring physical labor.

F. Ankylosis. "Ankylosis" means the stiffening or fixation of a joint.

G. ANSI. "ANSI" means the American National Standards Institute.

H. Banding. "Banding" means a thick, rope-like cord of hypertrophic scarring resulting from burns. FF 11

I. Category. "Category" means a permanent partial disability as described in these rules and the corresponding percent of disability to the whole body for that permanent partial disability.

~~I.~~ J. Chronic. "Chronic" means the repeated or continuous occurrence of a specific condition or symptom.

K. Demonstrable degenerative changes. "Demonstrable degenerative changes" means radiographic findings demonstrating the presence of degeneration of intervertebral disc or facet joints. Examples of demonstrable degenerative changes are disc space narrowing, small osteophytes, and facet joint hypertrophic changes. FF 13

~~J.~~ L. Desirable level of weight. "Desirable level of weight" means preferred weights set forth in tables created by the Metropolitan Life Insurance Company.

~~K.~~ M. Disarticulation. "Disarticulation" means an amputation occurring through a joint.

~~L.~~ N. Distance vision. "Distance vision" means the ability to distinguish letters at a distance of 20 feet according to the Snellen and A.M.A. Charts.

~~M.~~ O. Family member. "Family member" means cohabitants and is not limited to those related by blood or marriage. In cases of institutionalization or similar nonhome environment, family member may include staff members who care for the individual on a regular basis.

~~N.~~ P. Fore-quarter. "Fore-quarter" means the amputation of the upper extremity involving the scapula, clavicle, and muscles that attach to the chest.

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~~O.~~ Q. Fusion. "Fusion" means the surgical uniting of one vertebral segment to an adjoining vertebral segment.

~~P.~~ R. Gastrostomy. "Gastrostomy" means a surgical creation of a gastric fistula through the abdominal wall for the purpose of introducing food into the stomach.

~~Q.~~ S. Glossopharyngeal. "Glossopharyngeal" means the ninth cranial nerve with sensory fibers to the tongue and pharynx. It affects taste and swallowing.

T. Gross motor weakness. "Gross motor weakness" means total or partial loss as described at 8 MCAR S 1.9016 A. and B. FF14

U. Hypertrophic scar. "Hypertrophic scar" means an elevated irregularly shaped mass of scar tissue. FF15

~~R.~~ V. Hypoglossal. "Hypoglossal" means the motor nerve to the tongue. It is the 12th cranial nerve and carries impulses from the brain to the tongue, including movement of muscles and secretion of glands and motor movement.

~~S.~~ W. Kenny scale. "Kenny scale" means the Kenny self-care evaluation system as set forth in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence of Activities of Daily Living.

~~T.~~ X. Laminectomy. "Laminectomy" means the removal of part or all of the lamina of one vertebral segment, usually with associated disc excision.

~~U.~~ Y. Lethargy. "Lethargy" means, in relation to a nervous system injury to the brain, that an individual is drowsy, but can be aroused.

~~V.~~ Z. Moderate referred shoulder and arm pain. "Moderate referred shoulder and arm pain" means pain of an intensity necessitating decreased activity in order to avoid the pain. This pain is demonstrated in a dermatomal distribution into the shoulder and upper extremity.

~~W.~~ AA. Moderate partial dislocation. "Moderate partial dislocation" means a loss of normal vertebral alignment of up to 50 percent of the vertebral body on the adjacent vertebral body associated with vertebral fractures.

~~X.~~ BB. Near vision. "Near vision" means clearness of vision

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at the distance of 14 inches.

~~Y.~~ CC. Nonpreferred extremity. "Nonpreferred extremity" means the arm or leg not used dominantly, as for example, the left hand of a right-handed writer.

~~Z.~~ DD. Objective clinical findings. "Objective clinical findings" as used in 8 MCAR S 1.9007 [Temporary] means examination results which are reproducible and consistent. Examples of objective clinical findings are involuntary muscle spasms, consistent postural abnormalities, and changes in deep tendon reflexes.

~~AA.~~ EE. Postural abnormality. "Postural abnormality" means a deviation from normal posture, as found on anterior/posterior or lateral X-rays, that involves the spine and pelvis or segments of the spine or pelvis, such as kyphosis, lordosis, or scoliosis.

~~BB.~~ FF. Preferred extremity. "Preferred extremity" means the dominant leg or arm, as for example, the right arm of a right-handed person.

~~CC.~~ GG. Presbycusis. "Presbycusis" means a decline in hearing acuity that occurs with the aging process.

~~DD.~~ HH. Pseudophakia. "Pseudophakia" means that the crystalline lens of the eye has been replaced with a surgically implanted lens.

EE. II. Self cares. "Self cares" means bed activities, transfers, locomotion, dressing, personal hygiene, bowel and bladder, and feeding as described in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, pages 10-24.

~~FF.~~ JJ. Spinal stenosis. "Spinal stenosis" means the narrowing of the spinal canal.

~~GG.~~ KK. Spondylolisthesis. "Spondylolisthesis" means the forward movement of one vertebral body of one of the lower lumbar vertebrae on the vertebrae below it or upon the sacrum.

~~HH.~~ LL. Spondylolisthesis grade 1. "Spondylolisthesis grade 1" means forward movement from zero to 25 percent of the vertebral body.

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~~II.~~ MM. Spondylolisthesis grade 2. "Spondylolisthesis grade 2" means forward movement from 25 to 50 percent of the vertebral body.

~~JJ.~~ NN. Spondylolisthesis grade 3. "Spondylolisthesis grade 3" means movement from 50 to 75 percent of the vertebral body.

~~KK.~~ OO. Spondylolisthesis grade 4. "Spondylolisthesis grade 4" means forward movement from 75 to 100 percent of the vertebral body.

~~LL.~~ PP. Stupor. "Stupor" means, in relation to a nervous system injury to the brain, that a strong stimulus or pain is needed to arouse consciousness or response.

~~MM.~~ QQ. Tinnitus. "Tinnitus" means a subjective sense of noises in the head or ringing in the ear for which there is no observable external cause.

~~NN.~~ RR. Trigeminal. "Trigeminal" means the mixed nerve with sensory fibers to the face, cornea, anterior scalp, nasal and oral cavities, tongue and supertentorial dura matter. It also has motor fibers to the muscles of mastication. It is the fifth cranial nerve.

~~OO.~~ SS. Vertigo. "Vertigo" means a sensation of moving around in space or having objects move about the person. It is the result of a disturbance of the equilibratory apparatus.

~~PP.~~ TT. Vestibular. "Vestibular" means the main division of the auditory nerve. It is the eighth cranial nerve and deals with equilibrium.

UU. Wrinkling. "Wrinkling" means small ridges on the skin formed by shrinking or contraction as a result of burns.

~~QQ.~~ VV. 14/14. "14/14" is a term used in the measurement of near vision. It is the clearness of vision at a distance of 14 inches. The numerator is the test distance in inches. The denominator is the distance at which the smallest letter on the A.M.A. card can be seen.

~~RR.~~ WW. 20/20 Snellen or A.M.A. Chart. "20/20 Snellen or A.M.A. Chart" refers to a chart imprinted with block letters or numbers in gradually decreasing sizes, identified according to distances at which they are ordinarily visible. It is used in

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testing visual acuity. The numerator is the test distance in feet. The denominator is the distance at which the smallest letter discriminated by a patient would subtend five minutes of arc.

8 MCAR S 1.9003 [Temporary] Eye schedule.

A. Complete loss of vision. For complete loss of vision in both eyes, disability of the whole body is 85 percent. For complete loss of vision in one eye, disability of the whole body is 24 percent. In determining the degree of vision impairment and of whole body disability, B.-F. shall be used.

B. Examination. Disability shall not be determined until all medically acceptable attempts to correct the defect have been made. Prior to the final examination on which disability is to be determined, at least six months shall elapse after all visible inflammation has disappeared. In cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, injury of the retina, sympathetic ophthalmia, and traumatic cataract, at least 12 months shall elapse before the final examination is made. Testing shall be conducted with corrective lenses applied, unless indicated otherwise in this rule.

C. Maximum and minimum limits of primary coordinate factors of vision. The primary coordinate factors of vision are central visual acuity, visual field efficiency, and ocular motility. The determination of maximum and minimum limits for each of the coordinate functions is established below.

1. Maximum limit.

a. The maximum limit of central visual acuity is the ability to recognize letters or characters which subtend an angle of five minutes, each unit part of which subtends a one-minute angle at the distance viewed. A 20/20 Snellen or A.M.A. chart is 100 percent (maximum) central visual acuity for distance vision. 14/14 A.M.A. card is 100 percent (maximum) central visual acuity for near vision.

b. ~~A visual field is 500 degrees. A visual field which extends from the point of fixation outward 85 degrees, down and out 85 degrees, down 65 degrees, down and in 50~~

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degrees,-inward-60-degrees,-in-and-up-55-degrees,-upward-45 degrees,-and-up-and-out-55-degrees-is-100-percent-visual-field efficiency The maximum visual field is defined as 500 degrees. It is the sum of the degrees in the eight principal meridians from the point of fixation to the outermost limits of visual perception and defines the area in which a three millimeter white target is visible at 33 centimeters. One hundred percent visual field efficiency is that visual field which extends from the point of fixation outward 85 degrees, down 65 degrees, down and in 50 degrees, inward 60 degrees, in and up 55 degrees, upward 45 degrees, and up and out 55 degrees.

c. Maximum ocular motility is present if there is absence of diplopia in all parts of the field of binocular fixation, and if normal binocular motor coordination is present.

2. Minimum limit.

a. The minimum limit of central visual acuity is

(1) for distance vision, 20/800 Snellen or A.M.A. chart;

(2) for near vision, 14/560 A.M.A. card.

b. The minimum limit for field vision is established as a concentric central contraction of the visual field to five degrees. Five degrees of contraction of the visual field reduces the visual efficiency of the eye to zero.

c. The minimum limit for ocular motility is established by the presence of diplopia in all parts of the field of binocular fixation or by absence of binocular motor coordination. The minimum limit is 50 percent ocular motility efficiency.

D. Measurement of coordinate factors of vision and the computation of their partial loss.

1. Central visual acuity efficiency. Central visual acuity shall be measured both for distance vision and for near vision, each eye being measured separately, both with and without correction. A Snellen or A.M.A. chart shall be used for distance vision and an A.M.A. card shall be used for near vision. Illumination shall be at least five footcandles.

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a. Table 1 shows the percentage of visual efficency corresponding to the notations for distance vision and for near vision. For test readings between those listed on the chart, round up from the midpoint to the nearest reading, and round down from below the midpoint.

Where distance vision is less than 20/200 and the A.M.A. chart is used, readings are at ten feet. The test reading is translated to the corresponding distance reading in Table 1 by multiplying both the numerator and the denominator of the test reading by two.

TABLE 1

Central Visual Acuity

A.M.A. Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Central Visual Acuity Efficiency
20/20	14/14	100.00
20/25	14/17.5	95.7
20/25.7	.....	95.0
20/30	14/21	91.5
20/32.1	.....	90.0
20/35	14/24.5	87.5
20/38.4	.....	85.0
20/40	14/28	83.6
20/44.9	14/31.5	80.0
20/50	14/35	76.5
20/52.1	....	75.0
20/60	14/42	69.9
20/60.2	.....	70.0

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	20/68.2	.....	65.0
	20/70	14/49	64.0
	20/77.5	.....	60.0
	20/80	14/56	58.5
	20/86.8	.....	55.0
	20/90	14/63	53.4
	20/97.5	.....	50.0
	20/100	14/70	48.9
	20/109.4	.....	45.0
	20/120	14/84	40.9
	.....	14/89	38.4
	20/122.5	.....	40.0
	20/137.3	.....	35.0
	20/140	14/98	34.2
	20/155	.....	30.0
	20/160	14/112	28.6
	20/175	.....	25.0
	20/180	14/126	23.9
	20/200	14/140	20.0
	20/220	14/154	16.7
	20/240	14/168	14.0
	....	14/178	12.3
	20/260	14/182	11.7
	20/280	14/196	9.7
	20/300	14/210	8.2
	20/320	14/224	6.8
	20/340	14/238	5.7

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20/360	14/252	4.8
20/380	14/266	4.0
20/400	14/280	3.3
20/450	14/315	2.1
20/500	14/350	1.4
20/600	14/420	0.6
20/700	14/490	0.3
20/800	14/560	0.1

b. The percentage of central visual acuity efficiency of the eye for distance vision is that percentage in Table 1 which corresponds to the test reading for distance vision for that eye.

c. The percentage of central visual acuity efficiency of the eye for near vision is that percentage in Table 1 which corresponds to the test reading for near vision for that eye.

d. The percentage of central visual acuity efficiency of the eye in question is determined as follows:

(1) Multiply by two the value determined for corrected near vision in c.

(2) Add the product obtained in step 1 to the value determined for corrected distance vision in b.

(3) Divide the sum obtained in step 2 by three.

The following is an example of this calculation. If the central visual acuity efficiency for distance is 70 percent, and that for near is 25 percent, the percentage of central visual acuity efficiency for the eye is:

$$\frac{70\% + (2 \times 25)}{3} = 40\% \text{ central visual acuity efficiency}$$

e. For traumatic aphakia, the corrected central visual acuity efficiency of the eye is 50 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

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f. For traumatic pseudophakia, the corrected central visual acuity efficiency of the eye is 80 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

2. Visual field efficiency. For each eye, the extent of the field of vision shall be determined by perimetric test methods. A three millimeter white disk which subtends a 0.5-degree angle under illumination of not less than seven footcandles shall be used. For aphakia, a six millimeter white disk shall be used. The result shall be plotted on the visual field chart as illustrated in the A.M.A. Guides, page 94.

a. The amount of radial contraction in the eight principal meridians shall be determined. The sum of the degrees of field vision remaining on these meridians, divided by 500, is the visual field efficiency of one eye, expressed as a percentage. If the eye has a concentric central contraction of the field to a diameter of five degrees, the visual efficiency is zero.

b. When the impairment of field is irregular and not fairly disclosed by the eight radii, the determination shall be based on a number of radii greater than eight and the divisor in a. shall be changed accordingly.

c. Where there is a loss of a quadrant or a half-field, the degrees of field vision remaining in each meridian are added to one-half the sum of the two boundary meridians.

3. Ocular motility. Ocular motility shall be measured in all parts of the motor field with any useful correction applied.

a. All directions of gaze shall be tested with use of a test light and without the addition of colored lenses or correcting prisms. The extent of diplopia is determined on the perimeter at 330 millimeters or on a tangent screen at a distance of one meter from the eye.

b. ~~For each eye,~~ FF18 Plot the test results on a motility

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chart as illustrated in the A.M.A. Guides, page 97.

c. Determine the percentage loss of ocular motility from the motility chart. This percentage is assigned to the injured eye or, if both eyes are injured, to the eye with the greatest impairment of central visual acuity and field vision. The eye with the greatest impairment means the eye for which the product of central visual acuity efficiency and visual field efficiency is the least. For the purpose of calculation, a value of zero percent is deemed to be one percent. For the other eye, the percentage loss of ocular motility is zero.

FF19

d. The percentage loss of ocular motility is subtracted from 100 percent to obtain the ocular motility efficiency. The minimum ocular motility efficiency of one eye is 50 percent.

E. Visual efficiency. The visual efficiency of one eye is the product of the efficiency values of central visual acuity, of visual field, and of ocular motility. For the purpose of this calculation, these values shall be expressed as decimals and not as percentages; a value of zero percent is deemed to be one percent.

1. For example, if central visual acuity efficiency is 50 percent, visual field efficiency is 80 percent, and ocular motility efficiency is 100 percent, the visual efficiency of the eye is .50 times .80 times 1.00, equals 40 percent. If ocular motility efficiency is changed to 50 percent, the visual efficiency is .50 times .80 times .50, equals 20 percent.

2. Visual efficiency shall be adjusted as set in this clause. Visual efficiency may not be less than zero percent. No adjustment for glasses or contacts shall be made in cases of aphakia or pseudophakia where the central visual efficiency was adjusted pursuant to D.1.e. or f.

a. Visual efficiency shall be decreased by subtracting two percent for any of the following conditions which are present due to the injury: loss of color vision; loss of adaptation to light and dark; metamorphosis; entropion or ectropion uncorrected by surgery; lagophthalmos; epiphora; and

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muscle disturbances such as ocular ticks not included under diplopia.

b. If glasses are required as a result of the injury, or if as a result of the injury the refractive error increases by at least one diopeter of sphere or of cylinder or of both, subtract five percent from the visual efficiency. Where the glasses contain prisms, subtract six percent.

c. If a noncosmetic contact lens is required in one or both eyes as a result of the injury, subtract seven percent from the visual efficiency.

~~d.--Adjustments-for-preexisting-impairments-shall-be made-pursuant-to-Minnesota-Statutes,-section-176.101, subdivision-4,-clause-(a).~~

F. Procedure for determining whole body disability due to vision loss. For each eye, subtract the percentage of visual efficiency as determined in E. from 100 percent. The difference is the percentage impairment of each eye. The better eye has the lower percentage impairment. The poorer eye has the greater percentage impairment.

1. Multiply the percentage impairment of the better eye by three.

2. Add the percentage impairment of the poorer eye to the product obtained in step 1.

3. Divide the sum obtained in step 2 by four.

4. The quotient obtained in step 3 is the percentage impairment of the visual system. Fractions shall be rounded to the nearest whole number percentage as provided in D.1.a.

5. The percentage impairment of the visual system is translated to the percentage disability of the whole body by Table 2.

Table 2

Eye Schedule

Impairment of Visual System, %	Disability of Whole Man, %	Impairment of Visual System, %	Disability of Whole Man, %
0	0	45	42
1	1	46	43
2	2	47	44
3	3	48	45

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1	4	4	49	46
2	5	5	50	47
3	6	6	51	48
4	7	7	52	49
5	8	8	53	50
6	9	8	54	51
7	10	9	55	52
8	11	10	56	53
9	12	11	57	54
10	13	12	58	55
11	14	13	59	56
12	15	14	60	57
13	16	15	61	58
14	17	16	62	59
15	18	17	63	59
16	19	18	64	60
17	20	19	65	61
18	21	20	66	62
19	22	21	67	63
20	23	22	68	64
21	24	23	69	65
22	25	24	70	66
23	26	25	71	67
24	27	25	72	68
25	28	26	73	69
26	29	27	74	70
27	30	28	75	71
28	31	29	76	72
29	32	30	77	73
30	33	31	78	74
31	34	32	79	75
32	35	33	80	76
33	36	34	81	76
34	37	35	82	77
35	38	36	83	78
36	39	37	84	79
37	40	38	85	80
38	41	39	86	81
39	42	40	87	82
40	43	41	88	83
41	44	42	89	84
42			90 - 100	85

8 MCAR S 1.9004 [Temporary] Ear schedule.

A. General. For hearing loss, the maximum disability of the whole body is 35 percent. The procedures in B.-G. shall be used to determine the extent of binaural hearing loss and of whole body disability.

B. Medical diagnosis. Otological evaluation shall be the method for determining the degree of permanent partial hearing loss. The medical diagnosis shall include the following:

1. A complete history of occupational, military, and recreational noise exposure. This medical history shall include documentation of any previous hearing loss, if that information is available;

2. A complete physical examination of the ear; and

3. An audiological evaluation which shall include pure

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tone air conduction and bone conduction testing.

C. Standards for audiometric calibration and test environment. To ensure accurate measurement of hearing loss, the following standards shall be observed in conducting the tests required in B.:

1. The audiometer used to measure hearing loss shall be calibrated to meet the specifications of ANSI S3.6-1969 (R1973), Specifications for Audiometers. The following are also required:

a. Biological or electroacoustical calibration checks of the audiometer shall be performed monthly;

b. Electroacoustical calibration shall be performed annually to certify the audiometer to the ANSI standard in 1; and

c. The calibration records shall be preserved and shall be provided upon request; and

2. Audiometric test rooms or booths shall meet the specifications of ANSI S3.1-1977, Criteria for Permissible Ambient Noise during Audiometric Testing.

D. Waiting period for final evaluation of hearing loss. A waiting period of at least three months shall elapse between the date of the occurrence of the noise injury and the final evaluation of the permanent partial hearing loss.

E. Procedure for determining disability of whole body due to hearing loss.

1. The binaural hearing loss is determined. The calculation for the percent of binaural hearing loss consists of the following steps:

a. For each ear, test the hearing threshold levels at the four frequences of 500, 1,000, 2,000, and 3,000 Hertz;

b. For each ear, determine the average four-frequency hearing level. The average four-frequency hearing level is one-fourth of the sum of the threshold levels at each of the four tested frequencies. The average four-frequency hearing level is expressed in decibels;

c. For each ear, subtract 25 decibels from the average four-frequency hearing level for that ear. The remainder,

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expressed in decibels, is the adjusted average four-frequency hearing level;

d. For each ear, multiply the adjusted average four-frequency hearing level by 1.5 percent. The product is the monaural hearing loss, expressed as a percentage. A product less than zero percent is deemed to be zero. A product greater than 100 percent is deemed to be 100 percent;

e. Considering both ears, compare the monaural hearing losses as determined in d. The ear with the smaller monaural hearing loss is the better ear. The ear with the larger monaural hearing loss is the poorer ear; and

f. Multiply the monaural hearing loss of the better ear by five, add this product to the monaural hearing loss of the poorer ear, and divide the sum by six. The quotient is the binaural hearing loss, expressed as a percentage. The formula is:

$$\frac{5 \times (\text{monaural hearing loss of better ear}) + (\text{monaural hearing loss of poorer ear})}{6} = \text{percent binaural hearing loss}$$

2. The calculation of the percent of binaural hearing loss is illustrated by the following examples.

Example 1

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	15	25	45	55
Left ear	30	45	60	85

a. Calculation of the average four-frequency hearing level:

$$\text{Right ear} = \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = \frac{220}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level:

Right ear = 35 decibels - 25 decibels = 10 decibels;
Left ear = 55 decibels - 25 decibels = 30 decibels;

c. Calculation of monaural hearing loss:

Right ear = 10 x 1.5% = 15%
Left ear = 30 x 1.5% = 45%

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d. Calculation of binaural hearing loss:

$$\frac{(15\% \times 5) + 45\%}{6} = 20 \text{ percent binaural hearing loss}$$

Example 2

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	20	25	30	35
Left ear	30	45	60	85

a. Calculation of average four-frequency hearing level.

$$\text{Right ear} = \frac{20 + 25 + 30 + 35}{4} = 25 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level.

Right ear = 25 decibels - 25 decibels = 0 decibels
Left ear = 55 decibels - 25 decibels = 30 decibels

c. Calculation of monaural hearing loss:

Right ear = 0 x 1.5 percent = 0
Left ear = 30 x 1.5 percent = 45 percent

d. Calculation of binaural hearing loss:

$$\frac{(0\% \times 5) + 45\%}{6} = 7.5 \text{ percent binaural hearing loss}$$

3. The binaural hearing loss is translated to a percentage of disability of the whole body by the ear schedule set forth below:

EAR SCHEDULE

Binaural Hearing Loss, Percent	Disability of Whole Body Percent
0 - 1.7	0
1.8 - 4.2	1
4.3 - 7.4	2
7.5 - 9.9	3
10.0 - 13.1	4
13.2 - 15.9	5
16.0 - 18.8	6
18.9 - 21.4	7
21.5 - 24.5	8
24.6 - 27.1	9
27.2 - 30.0	10
30.1 - 32.8	11
32.9 - 35.9	12
36.0 - 38.5	13
38.6 - 41.7	14

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41.8 - 44.2	15
44.3 - 47.4	16
47.5 - 49.9	17
50.0 - 53.1	18
53.2 - 55.7	19
55.8 - 58.8	20
58.9 - 61.4	21
61.5 - 64.5	22
64.6 - 67.1	23
67.2 - 70.0	24
70.1 - 72.8	25
72.9 - 75.9	26
76.0 - 78.5	27
78.6 - 81.7	28
81.8 - 84.2	29
84.3 - 87.4	30
87.5 - 89.9	31
90.0 - 93.1	32
93.2 - 95.7	33
95.8 - 98.8	34
98.9 -100.0	35

F. Presbycusis. The calculation of the binaural hearing loss shall not include an additional adjustment for presbycusis.

G. Tinnitus. No additional percentage of permanent partial disability for hearing loss shall be allowed for tinnitus.

8 MCAR S 1.9005 [Temporary] Skull defects.

A. Skull depressions. FF23 For skull defects the percent of disability of the whole body is provided by the following schedule:

	Unfilled defect	Filled defect
	Percent	Percent
0 - 1-1/2 square inches	0	0
1-1/2 - 2-1/2 square inches	5	0
2-1/2 - 4 square inches	10	2
4 - 6-1/2 square inches	15	3
6-1/2 or more square inches	20	5

B. Skull fractures.

1. Basilar skull fracture with persistent spinal fluid leak, 20 percent.

2. Basilar skull fracture without cerebrospinal fluid leak, 0 percent. FF24

8 MCAR S 1.9006 [Temporary] Central nervous system.

A. General. For permanent partial disability of the central

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nervous system the percentage of disability of the whole body is as provided in B.-I.

B. Trigeminal nerve. Permanent partial disability of the trigeminal nerve is a disability of the whole body as set forth below:

1. Partial unilateral sensory loss, 3 percent;

2. Complete unilateral sensory loss, 5 percent;

3. Partial bilateral sensory loss, 10 percent;

4. Complete bilateral sensory loss, 25 percent;

5. Intractable trigeminal neuralgia, 20 percent;

6. Atypical facial pain, 5 percent;

7. Partial unilateral motor loss, 2 percent;

8. Complete unilateral motor loss, 5 percent;

9. Partial bilateral motor loss, 10 percent; or

10. Complete bilateral motor loss, 30 percent.

C. Facial nerve. Permanent partial disability of the facial nerve is a disability of the whole body as set forth below:

1. Total loss of taste, 3 percent;

2. Partial unilateral motor loss, 25 to 75 percent of function lost, 5 3 percent;

3. Unilateral motor loss, more than 75 percent of function lost, ~~15~~ 10 percent;

4. Partial bilateral motor loss, 25 to 75 percent of function lost, ~~15~~ 10 percent;

5. Bilateral motor loss, more than 75 percent of function lost, ~~30~~ 20 percent.

FF 25

D. Vestibular loss with vertigo or disequilibrium is a disability of the whole body as set forth below:

1. A score of ~~4~~ 24 to 28 on the Kenny scale, and restricted in activities involving personal or public safety, such as operating a motor vehicle or riding a bicycle, 10 percent;

2. A score of ~~3 or 4~~ 16 to 28 on the Kenny scale, and ambulation impaired due to equilibrium disturbance, 30 percent;

3. A score of ~~2~~ 10 to 16 on the Kenny scale, 40 percent;

4. A score of ~~1 or~~ 0 to 10 on the Kenny scale, 70 percent.

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E. Glossopharyngeal, vagus and spinal accessory nerves. Permanent partial disability to glossopharyngeal, vagus and spinal accessory nerves is a disability of the whole body as set forth below:

1. Swallowing impairment caused by disability to any one or more of these nerves:

a. diet restricted to semi-solids, 10 percent;

b. diet restricted to liquids, 25 percent; or

c. diet by tube feeding or gastrostomy, 50 percent.

2. Mechanical disturbances of articulation due to disability to any one or more of these nerves:

a. 95 percent or more of words are understood by those who are not family members and others outside the immediate family, but speech is distorted, 5 percent;

b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by those who are not family members, 10 percent;

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent;

d. more than 50 percent of words are understood by family members, 20 percent;

e. less than 50 percent of words are understood by family members, 25 percent;

f. 10 percent or less of words are understood by family members, 30 percent.

G. Hypoglossal nerve. Permanent partial disability of hypoglossal nerve is a disability of the whole body as listed below:

1. Bilateral paralysis; swallowing impairment:

a. diet restricted to semi-solids, 10 percent;

b. diet restricted to liquids, 25 percent; and

c. diet by tube feeding or gastrostomy, 50 percent.

2. Mechanical disturbances of articulation:

a. 95 percent or more of words are understood by family members and others outside the immediate family, but speech is distorted, 5 percent;

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b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by nonfamily members, 10 percent;

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent;

d. more than 50 percent of words are understood by family members, 20 percent;

e. less than 50 percent of words are understood by family members, 25 percent;

f. 10 percent or less of words are understood by family members, 30 percent.

H. ~~Spinal-cord-and-brain-nervous-system.--Permanent-partial disability-of-the-spinal-cord-and-brain-is-a-disability-of-the whole-body-as-set-forth-below:~~ Spinal cord. To rate under this section, determine the disability to the lower extremities, upper extremities, respiration, urinary bladder, anorectal, and sexual functions as set forth below. The percentage of whole body disability under this section is determined by combining the disabilities under 1.-6. in the manner described at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

1. Lower extremities. A permanent partial disability in the use of lower extremities is a disability of the whole body as set forth below:

a. can rise to a standing position and can walk, but has difficulty walking onto elevations, grades, steps, and distances, 15 percent;

b. can stand but can walk only on a level surface, 30 percent;

c. can stand but cannot walk, 45 percent; and

d. can neither stand nor walk, 65 percent.

2. Upper extremities. Permanent partial disability in the use of upper extremities is a disability of the whole body as set forth below:

Whole Body Disability, Percentages

	Preferred extremity	Nonpreferred extremity	Both

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score of ~~4~~ 24 to 28 on Kenny scale, but some difficulty with digital dexterity	10	5	15
score of ~~3 or 4~~ 16 to 28 on Kenny scale, but no digital dexterity	20	10	30
score of ~~2~~ 10 to 16 on Kenny scale	40	40	50
score of ~~1 or~~ 0 to 10 on Kenny scale	70	70	85

3. Respiration. Permanent partial disability of the respiratory function is a disability of the whole body as set forth below:

a. difficulty only where extra exertion is required, such as running, climbing stairs, heavy lifting, or carrying loads, 10 percent;

b. restricted to limited walking ~~not beyond~~, confined to one's own home, 35 percent;

c. restricted to bed, 75 percent; and

d. has no spontaneous respiration, 95 percent.

4. Urinary bladder function. Permanent partial disability of the bladder is a disability of the whole body as set forth below. Evaluative procedures to be followed are set forth in 8 MCAR S 1.9022 [Temporary] B.

a. Impaired voluntary control evidenced by urgency or hesitancy, but continent without collecting devices, 10 percent.

b. Impaired voluntary control, incontinent requiring external collecting devices, 20 percent.

c. Impaired voluntary control, incontinent requiring internal collecting or continence devices, 30 percent.

5. Anorectal function. The permanent partial disability of the anorectal function is a disability of the whole body as set forth below:

a. impaired voluntary control with urgency, 10 percent;

b. impaired voluntary control without reflex

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regulation, 20 percent;

c. impaired voluntary control, incontinent without diversion, 30 percent.

6. Sexual function. Permanent partial disability of sexual function is a disability of the whole body as set forth below.

a. Male:

(1) impaired sexual function, but vaginal penetration possible, 10 percent;

(2) impaired sexual function, and vaginal penetration not possible, 20 percent.

b. Female:

(1) impaired sexual function, but penile containment possible, 10 percent;

(2) impaired sexual function, and penile containment not possible, 20 percent.

I. Brain injury. Supporting objective evidence of structural injury, neurological deficit, or psychomotor findings is required to substantiate the permanent partial disability. Permanent partial disability of the brain is a disability of the whole body as set forth below.

1. Communications disturbances, expressive:

a. mild disturbance of expressive language ability not significantly impairing ability to be understood, such as mild word-finding difficulties, mild degree of paraphasias, or mild dysarthria, 10 percent;

b. severe impairment of expressive language ability, but still capable of functional communication with the use of additional methods such as gestures, facial expression, writing, word board, or alphabet board, 35 percent;

c. unable to produce any functional expressive language, 70 percent.

2. Communication disturbances, receptive:

a. mild impairment of comprehension of aural speech, but comprehension functional with the addition of visual cues such as gestures, facial expressions, or written material, 40

high ?

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percent;

b. some ability to comprehend language is present, but significant impairment even with use of visual cues such as gestures, facial expressions, and written material, 60 percent;

c. no evidence of functional comprehension of language, 90 percent.

3. Complex integrated cerebral function disturbances must be determined by medical observation ~~in a controlled setting~~ FF 29 and organic dysfunctions supported by psychometric testing. Functional overlay or primary psychiatric disturbances shall not be rated under this rule. The permanent partial disabilities are as follows:

a. mild impairment of higher level cognitive function or memory, but able to live independently and function in the community as evidenced by independence in activities such as shopping and taking a bus, 20 percent;

b. same as a., and also requires supporting devices and direction to carry out limited vocational tasks, 30 percent;

c. moderate impairment of memory, judgment, or other higher level cognitive abilities, can live alone with some supervision such as for money management, some limitation in ability to function independently outside the home in activities such as shopping and traveling, 50 percent;

d. moderately severe impairment of memory, judgment, or other higher cognitive abilities, unable to live alone and some supervision required at all times, but able to perform self cares independently, 70 percent;

e. severe impairment of memory, judgment, or other higher cognitive abilities such that constant supervision and assistance in self cares are required, 95 percent.

4. Emotional disturbances and personality changes must be substantiated by medical observation ~~in a controlled setting~~ FF29 and by organic dysfunction supported by psychometric testing. Permanent partial disability is a disability of the whole body as set forth below:

a. only present under stressful situation such as

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losing one's job, getting a divorce, or a death in the family, 10 percent;

b. present at all times but not significantly impairing ability to relate to others, to live with others, or to perform self cares, 30 percent;

c. present at all times in moderate to severe degree, minimal ability to live with others, some supervision required, 65 percent;

d. severe degree of emotional disturbance which, because of danger to self and others, requires continuous supervision, 95 percent.

5. Psychotic disorders, as described in D.S.M. III, not caused by organic dysfunction ~~must be~~ and substantiated by medical observation ~~in a controlled setting as described in D.S.M. III~~:

FF 30

a. only present under stressful situation, such as losing one's job, getting divorced, a death in the family, 10 percent;

b. present at all times but not significantly impairing ability to relate to others, live with others, or perform self cares, 30 percent;

c. present at all times in moderate to severe degree significantly affecting ability to live with others, and requiring some supervision, 65 percent;

d. severe degree of emotional disturbance which, because of danger to self or others, requires continuous supervision, 95 percent.

6. Consciousness disturbances; permanent partial disability of the whole body is as set forth below:

a. mild or intermittent decreased level of consciousness manifested by periodic mild confusion or lethargy, a score of ~~3 or 4~~ 16 to 28 on the Kenny scale, 40 percent;

b. moderate intermittent or continuous decreased level of consciousness manifested by a moderate level of confusion or lethargy, and a score of ~~2~~ 10 to 16 on the Kenny scale, 70 percent;

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c. severe decreased level of consciousness manifested as stupor with inability to function independently, and a score of ~~1 or~~ 0 to 10 on the Kenny scale, 95 percent;

d. ~~persistent, comatose state, manifest by absence of any response to environmental stimuli~~ comatose or persistent vegetative state, 99 percent. FF31

~~7. Paralysis of one side of body; permanent partial disability due to paralysis of one side of body is disability of the whole body as set forth below:~~

~~a. mild paresis or spasticity involving upper, lower, or both extremities on one side only, resulting in some difficulties in function, and a score of 3 or 4 on the Kenny scale, 20 percent;~~

~~b. moderate degree of spasticity or paresis affecting upper, lower, or both extremities on one side only, and a score of 3 on the Kenny scale, 40 percent;~~

~~c. moderately severe paresis and spasticity involving lower extremity and upper extremity, and a score of 2 on the Kenny scale, 75 percent;~~ FF32

~~d. severe hemiparesis and spasticity, and a score of 1 or 0 on the Kenny scale, 90 percent.~~ Motor dysfunction, movement disorder, paralysis, spasticity, sensory loss, or neglect. Where these impairments are due to brain or brain stem injury, rate as provided in H.1. and 2.

2 what is this?

8. Other impairments; impairments of respiration, urinary bladder function, anorectal function, or sexual function due to brain or brain stem injury are rated as provided in H.3.-6. FF33

~~8.~~ 9. Epilepsy; permanent partial disability due to epilepsy is a disability of the whole body as set forth below:

a. well controlled, on medication for one year or more, able to enter work force but with restrictions preventing operation of motor vehicles or dangerous machinery and climbing above six feet in height, 10 percent;

b. seizures occurring at least once a year, but not severely limiting ability to live independently, 20 percent;

c. seizures occurring at least six times per year,

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some supervision required, 40 percent;

d. seizures poorly controlled with at least 15 seizures per year, supervision required, protective care required with activities restricted, 75 percent;

e. frequency of seizures requires continuous supervision and protective care, activities restricted, unable to perform self cares, 95 percent.

9. 10. Headaches; permanent partial disability due to vascular headaches with nausea or vomiting is a five percent disability of the whole body.

8 MCAR S 1.9007 [Temporary] Musculo-skeletal schedule; back.

A. Lumbar spine. The spine rating is inclusive of leg symptoms except for gross motor weakness, bladder or bowel dysfunction, or sexual dysfunction. Permanent partial disability of the lumbar spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

~~a.--Subjective-symptoms-of-pain-not-substantiated-by demonstrable-structural-pathology,-0-percent.~~

~~b.--For-(1)-(6),-chronic-muscle-spasm,-rigidity-(loss of-motion-or-postural-abnormality),-and-pain-are-present,-and each-is-substantiated-by-objective-clinical-findings:~~

~~(1)-demonstrable-degenerative-changes,-such-as-small osteophytes,-are-revealed-by-X-ray;-involvement-of-single vertebral-level;-3.5-percent;~~

~~(2)-demonstrable-degenerative-changes,-such-as-small osteophytes,-are-revealed-by-X-ray;-involvement-of-multiple vertebral-levels;-7-percent;~~

~~(3)-demonstrable-degenerative-changes,-such-as-large osteophytes,-are-revealed-by-X-ray;-involvement-of-multiple vertebral-levels;-10.5-percent;~~

~~(4)-demonstrable-degenerative-changes,-such-as spondylolysis-or-spondylolisthesis-grade-1-or-2,-are-revealed-by X-ray;-no-previous-surgery-for-treatment;-14-percent;~~

~~(5)-demonstrable-degenerative-changes,-such-as spondylolysis-or-spondylolisthesis-grade-3-or-4,-are-revealed-by~~

FE 3A

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~~X-ray;-no-previous-surgery-for-treatment;-without-fusion surgery;-24.5-percent;~~

~~(6)-demonstrable-degenerative-changes-revealed-by X-ray;-spinal-fusion-surgery-for-single-vertebral-level-with-or without-a-laminectomy;-after-surgery-pain-is-moderated;-17.5 percent.~~

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

d. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings.

(1) Spondylolisthesis grade I, no surgery, 7 percent.

(2) Spondylolisthesis grade II, no surgery, 14 percent.

(3) Spondylolisthesis grade III or IV, without fusion, 24.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. back and specific radicular pain present with objective neurologic findings;~~-computer~~ and X-ray or computerized axial tomography;~~-X-ray-or-electromyelogram~~ or myelogram specifically positive; for herniated disc; and no surgery is performed for treatment, 14 percent;

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b. condition treated by surgery:

(1) surgery or chemonucleolysis with excellent results such as mild low back pain, no leg pain, and no neurologic deficit, 9 percent;

(2) surgery or chemonucleolysis with average results such as mild increase in symptoms with bending or lifting, and mild to moderate restriction of activities related to back and leg pain, ~~14~~ 11 percent;

FF36

(3) surgery or chemonucleolysis with poor surgical results such as persistent or increased symptoms with bending or lifting, and major restriction of activities because of back and leg pain, ~~21~~ 13 percent;

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(4) multiple operations on low back with poor surgical results such as persisting or increased symptoms of back and leg pain, ~~28~~ 15 percent;

c. recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery or chemonucleolysis, add five percent to b.(1)-(4);

d. herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

3. Spinal stenosis, central or lateral, proven by ~~computer~~ computerized axial tomography or myelogram:

a. mild symptoms such as occasional back pain with athletic activities or repetitive bending or lifting, leg pain with radicular symptoms, one vertebral level and no surgery, 14 percent;

b. severe spinal stenosis with bilateral leg pain requiring decompressive laminectomy, single vertebral level, with or without surgery (if multiple vertebral levels, add five percent per vertebral level), 18 percent.

4. Fusion surgery. ~~Single vertebral level for degenerative disease, add five percent per additional vertebral levels, 17.5 percent~~ Spinal fusion surgery for single vertebral level with or without laminectomy, 17.5 percent. Add five percent for each additional vertebral level.

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5. Fractures:

~~a. vertebral compression with a decrease of 25 percent or less in vertebral height, 10.5 percent;~~

~~b. vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, 15 percent;~~

~~c.~~ vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, ~~14~~ 10.5 percent;

~~d.~~ b. vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, ~~19~~ 15 percent;

~~e.~~ c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent radicular pain, ~~with mild motor and sensory manifestations, 17.5~~ 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

~~f.~~ d. severe dislocation, ~~normal reduction with surgical fusion:~~

~~(1) no residual motor or sensory changes, 17.5~~ normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular pain, ~~motor involvement, mild weakness and numbness, 24.5~~ 17.5 percent;

~~(3) poor reduction with fusion, persistent radicular pain, motor involvement, mild weakness and numbness with partial paralysis as defined in 8 MCAR S 1.9006 [Temporary] H.1.b., 30 percent.~~

B. Cervical spine. ~~For the permanent partial disability of cervical spine, the disability of the whole body is as follows:~~

~~1. Healed sprain, strain, or contusion:~~

~~a. subjective symptoms of pain not substantiated by~~

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~~demonstrable-structural-pathology,-0-percent;~~

~~b.--chronic-muscle-spasm,-rigidity-(loss-of-motion-or postural-abnormality),-and-pain,-each-substantiated-by-objective clinical-findings;-loss-of-anterior-curve-revealed-by-X-ray, although-no-demonstrable-structural-pathology;-moderate-referred shoulder-and-arm-pain,-7-percent;~~

~~c.--same-as-b.-but-with-gross-degenerative-changes consisting-of-narrowing-of-intervertebral-spaces-and-small osteophytes-at-the-vertebral-margins,-14-percent.~~ The spine rating is inclusive of arm symptoms except for gross motor weakness; sensory loss; and bladder, bowel, or sexual dysfunction. Bladder, bowel, or sexual dysfunction must be rated as provided in 8 MCAR S 1.9006 H. Permanent partial disability of the cervical spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. Neck and specific radicular pain present with objective neurologic findings; and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc; and no surgery is performed for treatment, 14 percent.

FF40

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b. Condition treated by surgery:

(1) Surgery with excellent results such as mild neck pain, no arm pain, and no neurologic deficit, 9 percent.

(2) Surgery with average results such as mild increase in symptoms with neck motion or lifting, and mild to moderate restriction of activities related to neck and arm pain, 11 percent.

(3) Surgery with poor surgical results such as persistent or increased symptoms with neck motion or lifting, and major restriction of activities because of neck and arm pain, 13 percent.

(4) Multiple operations on neck with poor surgical results such as persisting or increased symptoms of neck and arm pain, 15 percent.

c. Recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery, add five percent to b.(1)-(4).

d. Herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

3. Spinal stenosis, proven by computerized axial tomography or myelogram.

a. With myelopathy verified by objective neurologic findings, no loss of function, 14 percent.

b. Loss of function. Rate as provided in 8 MCAR S 1.9006 H.

4. Fusion surgery. Anterior or posterior. Fusion of a single vertebral level with or without a laminectomy, 11.5 percent. Add five percent for each additional vertebral level.

~~2.~~ 5. Fracture:

a. vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 14 percent;

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b. vertebral compression with a decrease of more than 25 percent of vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 19 percent;

c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent pain, ~~with partial motor and sensory loss, 17.5~~ 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

d. severe dislocation~~, normal reduction with surgical fusion~~:

(1) ~~no residual motor or sensory changes, 17.5~~ normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular pain, ~~partial motor loss, only slight weakness and numbness, 24.5~~ 17.5 percent;

~~(3) same as (2) with partial paralysis as defined in 8 MCAR S 1.9006 [Temporary] H.1.b., 30 percent.~~

~~C. Cervical intervertebral disc.--For permanent partial disability of cervical intervertebral disc, the disability of the whole body is as follows:~~

~~1.--successful surgical removal of disc, with relief of acute pain, no surgical fusion, no neurologic residual, 7 percent;~~

~~2.--same as 1. with neurological manifestations such as persistent pain, numbness, weakness in fingers, 14 percent.~~

Thoracic spine. The spine rating is inclusive of all symptoms including radicular gross motor weakness and sensory loss, but excluding spinal cord injury. Permanent partial disability of the thoracic spine is a disabilty of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

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a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with chronic muscle spasm. The chronic muscle spasm is substantiated by objective clinical findings and is associated with demonstrable degenerative changes, single or multiple level, 3.5 percent.

2. Herniated intervertebral disc, symptomatic:

a. Specific radicular pain present with objective neurologic findings, and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc, and no surgery is performed for treatment, 5 percent.

b. Condition treated by surgery:

(1) Surgery with excellent results such as mild thoracic pain, no radicular pain, and no neurological deficit, 5 percent;

(2) Surgery with poor surgical results such as persistence of increased symptoms with lifting, and major restriction of activities, 10 percent.

3. Fractures:

a. Vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 10.5 percent.

b. Vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 15 percent.

c. Vertebral fracture with involvement of posterior elements with x-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent pain, with mild motor and sensory manifestations, 17.5 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent.

d. Severe dislocation, normal reduction with surgical

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fusion:

(1) No residual motor or sensory changes, 12 percent;

(2) Poor reduction with fusion, persistent radicular pain, motor involvement, 17.5 percent;

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8 MCAR S 1.9008 [Temporary] Musculo-skeletal schedule; amputations of upper extremity.

A. Permanent partial disability due to amputation of upper extremities is a disability of the whole body as set forth below:

1. forequarter amputation, 70 percent;

2. disarticulation at shoulder joint, 60 percent;

3. amputation of arm above deltoid insertion, 60 percent;

4. amputation of arm between deltoid insertion and elbow joint, 57 percent;

5. disarticulation at elbow joint, 57 percent;

6. amputation of forearm below elbow joint proximal to insertion of biceps tendon, 57 percent;

7. amputation of forearm below elbow joint distal to insertion of biceps tendon, 54 percent;

8. disarticulation at wrist joint, 54 percent;

9. midcarpal or midmetacarpal amputation of hand, 54 percent;

10. amputation of all fingers except thumb at metacarpophalangeal joints, 32.5 percent;

11. amputation of thumb:

a. at metacarpophalangeal joint or with resection of metacarpal bone, 21.5 percent;

b. at interphalangeal joint or through proximal phalynx, 16 percent;

c. from interphalangeal joint to midportion distal phalynx, 13 percent;

12. amputation of index finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 13.5 percent;

b. at proximal interphalangeal joint or through middle phalynx, 11 percent;

c. at distal interphalangeal joint to middistal

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phalynx, 5 percent;

d. from middistal phalynx, distal, 2.5 percent;

13. amputation of middle finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 11 percent;

b. at proximal interphalangeal joint or through middle phalynx, 9 percent;

c. at distal interphalangeal joint to middistal phalynx, 5 percent;

d. from middistal phalynx, distal, 2.5 percent;

14. amputation of ring finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 5.5 percent;

b. at proximal interphalangeal joint or through middle phalynx, 4 percent;

c. at distal interphalangeal joint to middistal phalynx, 3 percent;

d. from middistal phalynx, distal, 1.5 percent;

15. amputation of little finger:

a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 3 percent;

b. at proximal interphalangeal joint or through middle phalynx, 2 percent;

c. at distal interphalangeal joint to middistal phalanx, 1 percent;

d. from middistal phalynx, distal, 0.5 percent.

8 MCAR S 1.9009 [Temporary] Musculo-skeletal schedule; sensory loss, upper extremities.

A. General. For sensory loss to the upper extremities resulting from ~~peripheral~~ nerve injury, the disability of the whole body is set forth in B.-D. For the portion of the body described in ~~the category~~ B., there must be a total loss of the sensory function. FF 43

B. Sensory loss, complete: FF 44

1. median function at wrist, ~~32.5~~ 22.5 percent;

2. ulnar function at wrist, 11 percent;

3. radial function at wrist, 5.5 percent;

4. medial antebrachial cutaneous, 3 percent;

5. medial brachial cutaneous, 3 percent;

6. loss of thumb, whole, 11 percent;

a. radial digital nerve, 4 percent;

b. ulnar digital nerve, 6.5 percent;

7. index finger, whole, 5.5 percent;

a. radial digital nerve, whole, 3.5 percent;

b. ulnar digital nerve, 2 percent;

8. long finger, whole, 5.5 percent;

a. radial digital nerve, 3.5 percent;

b. ulnar digital nerve, 2 percent;

9. ring finger, whole, 3 percent;

a. radial digital nerve, 2 percent;

b. ulnar digital nerve, 1 percent;

10. little finger, whole, 3 percent;

a. radial digital nerve, 1 percent;

b. ulnar digital nerve, 2 percent;

11. sensory loss distal to proximal interphalangeal joint, 50 percent of the value of entire digital nerve as set forth in B., either radial or ulnar as applicable;

12. sensory loss distal to one-half distal phalanx, 25 percent of entire digital nerve as set forth in B.

C. Quality of sensory loss in the hand. FF45 The levels of sensory loss and the corresponding disabilities of the whole body are measured as follows:

1. minimal, 2-point discrimination at 6 millimeters or less, 0 percent;

2. moderate, 2-point discrimination greater than 6 millimeters, 1/2 of value in B.;

3. severe, 2-point discrimination at greater than 10 millimeters, 3/4 of value in B.;

4. total, 2-point discrimination at greater than 15 millimeters, same value as in B.

D. Causalgia. When objective medical evidence shows persistent causalgia despite treatment, there is loss of sensory

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and motor function, loss of joint function, and inability to use the extremity in any useful manner. The permanent partial disability to the member, rating from the most proximal joint involved, and the percentage disability of the whole body is 50 percent of that set forth in 8 MCAR S 1.9008 [Temporary] A.1.-15.

8 MCAR S 1.9010 [Temporary] Musculo-skeletal schedule; motor loss or motor and sensory loss, upper extremities.

A. ~~General.--Permanent partial disability due to motor loss of the upper extremities is a disability of the whole body as set forth in B.-C.~~ Total or complete loss. Total or complete loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is:

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~~B.~~ 1. Motor loss, complete:

~~1.~~ a. median nerve above mid forearm, 30 percent;

~~2.~~ b. median nerve below mid forearm, 19 percent;

~~3.~~ c. radial nerve, 19 percent;

~~4.~~ d. ulnar nerve above mid forearm, 19 percent;

~~5.~~ e. ulnar nerve below mid forearm, 13.5 percent.

~~C.~~ 2. Complete motor and sensory loss:

~~1.~~ a. median nerve above mid forearm, 40.5 percent;

~~2.~~ b. median nerve below mid forearm, 35 percent;

~~3.~~ c. radial nerve, 27 percent;

~~4.~~ d. ulnar nerve above mid forearm, 21.5 percent;

~~5.~~ e. ulnar nerve below mid forearm, 16 percent.

~~D.~~ 3. Complete loss of motor function:

~~1.~~ a. brachial plexus complete, 60 percent:

~~a.~~ (1) upper trunk C5-6, 47 percent;

~~b.~~ (2) mid trunk C7, 23 percent;

~~c.~~ (3) lower trunk C8-T1, 46 percent;

~~2.~~ b. anterior thoracic, 3 percent;

~~3.~~ c. axillary nerve, 23 percent;

~~4.~~ d. dorsal scapular, 3 percent;

~~5.~~ e. long thoracic, 9 percent;

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6. f. musculo cutaneous, 17.5 percent;

7. g. subscapular, 3 percent;

8. h. suprascapular, 11.5 percent;

9. i. thoraco dorsal, 6 percent.

4. Complete loss of function, motor and sensory:

a. C-5 root, 11 percent;

b. C-6 root, 12 percent;

c. C-7 root, 11 percent;

d. C-8 root, 13 percent.

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B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity, and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-4.

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8 MCAR S 1.9011 [Temporary] Musculo-skeletal schedule; shoulder.

A. General. For permanent partial disability to the shoulder, disability of the whole body is as set forth in B.-C.:

B. Range of motion:

1. total ankylosis in optimum position, abduction 60 degrees, flexion ten degrees, rotation, neutral position, 30 percent;

2. total ankylosis in mal-position, grade upward to 50 percent;

3. mild limitation of motion: no abduction beyond 90 degrees, rotation no more than 40 degrees with full flexion and extension, 3 percent;

4. moderate limitation of motion: no abduction beyond 60 degrees, rotation no more than 20 degrees, with flexion and extension limited to 30 degrees, 12 percent;

5. severe limitation of motion: no abduction beyond 25 degrees, rotation no more than ten degrees, flexion and extension limited to 20 degrees, 30 percent;

C. Procedures or conditions:

1. acromio-clavicular separation of the following severity:

a. grade 1, 0 percent;

b. grade 2, 3 percent;

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c. grade 3, 6 percent.

2. anterior or posterior shoulder dislocation, no surgery, single episode, 3 percent.

3. recurrent dislocation, at least three times in six months, 10 percent.

4. repair recurrent shoulder dislocation, no loss of motion, 6 percent.

5. resection distal end of clavicle, 3 percent.

6. humeral shaft fracture, normal range of motion both joints, 0 percent.

7. humeral shaft fracture, open reduction, mild restriction of shoulder and elbow motion, 6 percent.

8. surgical neck fracture, healed, mild loss of motion, 0 percent.

9. greater tuberosity fracture, mild loss of motion, mild pain on abduction, 2 percent.

8 MCAR S 1.9012 [Temporary] Musculo-skeletal schedule; elbow.

A. General. Permanent partial disability of the elbow is disability of the whole body as set forth in B.-C.

B. Range of motion. Flexion and extension of forearm is 85 percent of the arm. Rotation of the forearm is 15 percent of the arm.

1. Total ankylosis in optimum position approximating midway between 90 degrees flexion and 180 degrees extension, a 45-degree angle, 30 percent.

2. Total ankylosis in mal-position, 40 percent.

3. Limitation of motion:

a. mild, motion limited from ten degrees flexion to 100 degrees of further flexion, 6 percent;

b. moderate, motion limited from 20 degrees flexion to 75 degrees of further flexion, 12 percent;

c. severe, motion limited from 45 degrees flexion to 90 degrees of further flexion, 21 percent;

4. Flail elbow, pseudarthrosis above joint line, wide motion but very unstable, 39 percent.

5. Resection head of radius, 9 percent.

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C. Procedures or conditions:

1. radial or ulnar shaft fracture, full motion, 0 percent;

2. radial or ulnar fracture, open reduction, mild limitation of motion as defined in B.3., 9 percent;

3. olecranon fracture, no loss of motion, 0 percent;

4. olecranon fracture, open reduction internal fixation, mild limitation of motion as defined in B.3., 6 percent;

5. epicondylar fracture, no loss of motion, 0 percent;

6. epicondylar fracture, mild loss of motion as defined in B.3., 6 percent;

7. release medial or lateral epicondyle, 2 percent;

8. ulnar nerve transposition, 2 percent.

8 MCAR S 1.9013 [Temporary] Musculo-skeletal schedule; wrist.

A. General. Permanent partial disability of wrist is disability of the whole body as set in B.-C.

B. Range of motion:

1. excision distal end of ulna, flexion and extension credited with 75 percent of hand, and rotation 25 percent of hand, 5 percent;

2. total ankylosis in optimum position, 19 percent;

3. total ankylosis in mal-position of extreme flexion or extension, 25 percent;

4. limitation of motion:

a. mild, rotation normal, loss of 15 degrees palmar flexion and loss of 20 degrees dorsiflexion, 5 percent;

b. moderate, rotation limited to 60 degrees in pronation-supination, loss of 25 degrees palmar flexion, loss of 30 degrees dorsiflexion, 10 percent;

c. severe, rotation limited to 30 degrees in pronation-supination, palmer flexion less than 25 degrees, dorsi-flexion less than 30 degrees, 15 percent.

C. Procedure or conditions.

1. Colles/Smith, extraarticular:

a. no loss of motion, 0 percent;

b. mild loss of motion as defined in B.4.a., 3 percent.

2. Colles/Smith/Barton, intraarticular.

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a. no loss of motion, 0 percent;

b. mild loss of motion as defined in B.4.a., 6 percent;

c. moderate loss of motion as defined in B.4.b., 10 percent.

3. Carpal bone fracture, no loss of motion, 3 percent.

4. Carpal dislocation, mild loss of motion as defined in B.4.a., 6 percent.

5. Carpal tunnel release, 0.5 percent.

6. Carpal tunnel release with moderate paresthesias, 3 percent.

7. DeQuervain's release, 0 percent.

8. Ganglion excision, 0 percent.

9. Scaphoid graft, 3 percent.

8 MCAR S 1.9014 [Temporary] Musculo-skeletal schedule, fingers.

A. General. Permanent partial disability of fingers is a disability of the whole body as set forth in B.-C.

B. Ankylosis of joints.

1. Any digit, excluding the thumb.

a. Total ankylosis of distal interphalangeal joint:

(1) optimum position, 4 percent;

(2) mal-position, flexed 35 degrees or more, 5 percent.

b. Total ankylosis of proximal interphalangeal joint:

(1) optimum position, flexed 25 to 40 degrees, 8 percent;

(2) mal-position, any position other than (1) above, 9 percent.

c. Total ankylosis of both distal and proximal interphalangeal joints. If total ankylosis of distal and proximal interphalangeal joints occurs, calculate disability according to a., and then add c. (1) or (2) as appropriate:

(1) optimum position, 1 percent;

(2) mal-position, 2 percent.

d. Total ankylosis metacarpophalangeal joint:

(1) optimum position, 35-50 degree flexion; 0.5 percent;

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(2) mal-position, any position other than (1), 1 percent.

e. Total ankylosis both interphalangeal joints and metacarpophalangeal joint, add an additional 2 percent.

2. Thumb.

a. Total ankylosis interphalangeal joint:

(1) optimum position, 0 to 15 degrees, 1 percent;

(2) mal-position, flexion greater than 15 degrees, 2 percent.

b. Total ankylosis metacarpophalangeal joint:

(1) optimum position, up to 25 degree flexion, 1 percent;

(2) mal-position, flexion greater than 25 degrees, 2 percent.

c. Total ankylosis both interphalangeal and metacarpophalangeal joints:

(1) optimum position, 4 percent;

(2) mal-position, 5 percent.

d. Total ankylosis carpometacarpal joint alone:

(1) optimum position, 4 percent;

(2) mal-position, 8 percent.

e. Total ankylosis interphalangeal, metacarpophalangeal, and carpometacarpophalangeal joints:

(1) optimum position, 21 percent;

(2) mal-position, 23 percent.

3. Limitation of motion, fingers and thumb:

a. mild, total closing motion tip of digit, can flex to touch palm and thumb, and extend to 15 degrees flexion, strength of grip normal, 3 percent;

b. moderate, total closing motion, tip of digit, lacks 1/2 inch of touching palm and can extend to 30 degrees flexion, 6 percent;

c. severe, total closing motion tip of digit lacks one inch of touching palm and can extend to 45 degrees flexion, 9 percent;

d. soft tissue loss, isolated soft tissue loss of the

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end of digit, 20 percent of the disability to the whole body for amputation of that digit as set forth at 8 MCAR S 1.9009 [Temporary] A.1.-19.

B. Procedures or conditions:

1. release of trigger finger or thumb, 0 percent;

2. release of Guyon's Canal, 0 percent;

3. Boutonniere repair, 3 percent;

4. extensor tendon repair, 0 percent.

8 MCAR S 1.9015 [Temporary] Musculo-skeletal schedule; amputations of lower extremities.

For permanent partial disability due to amputation of lower extremities the disability of the whole body is:

1. hemipelvectomy, 50 percent;

2. disarticulation at hip joint, 40 percent;

3. amputation above knee joint with short thigh stump, 3 inch or less below tuberosity of ischium, 40 percent;

4. amputation above knee joint with functional stump, 36 percent;

5. disarticulation at knee joint, 36 percent;

6. amputation below knee joint with short stump, 3 inch or less below intercondular notch, 36 percent;

7. amputation below knee joint with functional stump, 28 percent;

8. amputation at ankle, Syme type, 28 percent;

9. partial amputation of foot, Chopart's type, 21 percent;

10. mid-metatarsal amputation, 14 percent;

11. amputation of all toes at metatarsophalangeal joints, 8 percent;

12. amputation of great toe:

a. with resection of metatarsal bone, 8 percent;

b. at metatarsophalangeal joint, 5 percent;

c. at interphalangeal joint, 4 percent;

13. amputation of lesser toe, 2nd-5th:

a. with resection of metatarsal bone, 2 percent;

b. at metatarsophalangeal joint, 1 percent;

c. at proximal interphalangeal joint, 0 percent;

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d. at distal interphalangeal joint, 0 percent.

8 MCAR S 1.9016 [Temporary] Musculo-skeletal schedule; ~~sensory loss~~ nerve injury or motor and sensory loss, lower extremities.

~~For sensory loss to the lower extremities resulting from nerve injury, and where there is total loss of the sensory function for those particular portions of the body, the disability of the whole body is~~ FF50

A. Total loss. Total loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is: FF51

1. femoral, anterior crural, 13 percent;

2. femoral, anterior crural, below iliacus nerve, 11 percent;

3. genitofemoral, genito crural, 2 percent;

4. inferior gluteal, 9 percent;

5. lateral femoral cutaneous, 3 percent;

~~6. obturator, 3 percent;~~ FF52

~~7.~~ posterior cutaneous of thigh, 2 percent;

~~8.~~ 7. superior gluteal, 7 percent;

~~9.~~ 8. sciatic, above hamstring innervation, 31 percent;

~~10.~~ 9. common peroneal, lateral, or external popliteal, 13 percent;

~~11.~~ 10. deep peroneal, above midshin, 9 percent;

~~12.~~ 11. deep peroneal, below midshin, anterior tibial, 2 percent;

~~13.~~ 12. superficial peroneal, 5 percent;

~~14.~~ 13. tibial nerve, medial, or internal popliteal:

a. above knee, 15 percent;

b. posterior tibial, midcalf and knee, 11 percent;

c. below midcalf, 9 percent;

d. lateral plantar branch, 3 percent;

e. medial plantar branch, 3 percent;

~~15.~~ 14. sural, external saphenous, 1 percent;

15. L-4 nerve root, 11 percent; FF54

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16. L-5 nerve root, 13 percent;

17. S-1 nerve root, 15 percent;

18. Lumbosacral plexus, 40 percent. FF54

B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity, and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-18. FF55

8 MCAR S 1.9017 [Temporary] Musculo-skeletal schedule; joints.

A. General. For permanent partial disability of joints, disability of the whole body is set forth in B.-I.

B. Surgical or traumatic shortening of lower extremity.

1. 1/4 inch to 3/4 inch, 3 percent;

2. 3/4 to 1-1/4 inches, 4.5 percent;

3. 1-1/4 to 1-3/4 inches, 6 percent;

4. 1-3/4 inches and above, 9 percent;

C. Hip.

1. range of motion.

a. limitation of motion:

(1) mild, anterior posterior movement from 0 degree to 120 degree flexion, rotation and lateral motion, abduction, adduction free to 50 percent of normal, 6 percent;

(2) moderate, anterior posterior motion from 15 degrees flexion deformity to 110 degrees further flexion, rotation, lateral motion, abduction, and adduction free to 25 percent normal, 12 percent;

(3) severe, anterior posterior motion from 30 degrees flexion deformity to 90 degrees further flexion, 22 percent.

2. Procedures or conditions:

a. nonunion proximal femur fracture without reconstruction, 33 percent;

b. arthroplasty, able to stand at work and walk, motion 25 percent to 50 percent of normal, 18 percent;

c. total hip arthroplasty, normal result, 13 percent;

d. femoral endoprosthesis:

(1) minimal pain, near normal range of motion, able

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to walk unsupported, 15 percent;

(2) mild to moderate pain with weight bearing, motion 50 percent of normal, 20 percent;

e. hip pinning for fracture.

(1) minimal pain, near normal range of motion, able to walk unsupported, 5 percent;

(2) mild to moderate pain, motion 50 percent of normal, 10 percent.

D. Femur:

1. shaft fracture, closed, healed, 0 percent;

2. femoral shaft fracture, open reduction, loss of less than 20 degrees of movement of any one plane of either the hip or the knee, no malalignment, 2 percent.

E. Knee:

1. Range of motion.

a. ankylosis and limited motion, total ankylosis optimum position, 15 degrees flexion, 22 percent;

b. limitation of motion:

(1) mild, 0 degrees to at least 110 degrees flexion, 2 percent;

(2) moderate, 5 degrees to at least 80 degrees flexion, 7 percent;

(3) severe, 5 degrees to at least 60 degrees flexion, 15 percent;

(4) extremely severe, limited from 15 degrees flexion deformity with further flexion to 90 degree, 18 percent.

2. Procedures or conditions:

a. surgical removal of medial or lateral semilunar cartilage, no complications, 3 percent;

b. surgical removal both cartilages, 9 percent;

c. ruptured cruciate ligament, repaired or unrepaired:

(1) mild laxity, 3 percent;

(2) moderate laxity, 7 percent;

(3) severe laxity, 10 percent;

d. excision of patella, 9 percent;

e. plateau fracture, depressed bone elevated,

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semilunar excised, 9 percent;

f. plateau fracture, undisplaced, 2 percent;

g. supracondylar or intercondylar fracture, displaced, 7 percent;

h. supracondylar or intercondylar fracture, undisplaced, 2 percent;

i. patella fracture, open reduction or partial patellectomy, displaced, 5 percent;

j. patella fracture, open reduction or partial patellectomy, undisplaced, 2 percent;

k. arthroscopy, 0 percent;

l. repair collateral ligament, mild laxity, 2 percent;

m. repair collateral ligament, moderate laxity, 4 percent;

n. repair patellar dislocation, 5 percent;

o. total knee arthroplasty, flexion to 90 degrees, extension to 0 degrees, 13 percent;

p. total knee unicondylar, 7 percent;

q. lateral retinacular release, 1 percent;

n. proximal tibial osteotomy, flexion to 90 degrees, extension to 0 degrees, 5 percent.

F. Tibia:

1. tibial shaft fracture, undisplaced, healed, normal motion and alignment, 0 percent;

2. tibial shaft fracture, open reduction, loss of less than 20 degrees of movement in any one plane in either the knee or the ankle with full knee extension, no malalignment, 5 percent.

G. Ankle and foot.

1. Range of motion:

a. total ankylosis ankle and foot, pantalar arthrodesis:

(1) in 10 degrees plantar flexion, 15 percent;

(2) mal-position 30 degrees plantar flexion, 20 percent;

b. ankylosis of foot, subtalar or triple arthrodesis

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tarsal bones, ankle, normal motion, 7.5 percent;

(1) decreased motion, subtalar joint, 3.5 percent;

(2) ankylosis in mal-position, 8 percent;

c. ankylosis of tibia and talus, subtalar joints free, optimum position 15 degrees plantar flexion, 12 percent;

d. limitation of motion in the ankle:

(1) mild, motion limited from position of 90 degrees right angle to 20 degrees plantar flexion, 3 percent;

(2) moderate, motion limited from position of 10 degrees flexion to 20 degrees plantar flexion, 6 percent;

(3) severe, motion limited from position of 20 degrees plantar flexion to 30 degrees plantar flexion, 12 percent.

2. Procedures or conditions:

a. achilles tendon rupture with treatment surgically or nonsurgically, able to stand on toes, 2 percent;

b. achilles tendon rupture with treatment surgically or nonsurgically, unable to sustain body weight on toes, 4 percent;

c. open reduction ankle:

(1) normal range of motion:

(a) medial malleolus only, 2 percent;

(b) lateral malleolus only, 2 percent;

(2) mild restriction on range of motion:

(a) medial and lateral malleolus, 4 percent;

(b) trimalleolar, 4 percent;

d. ankle, lateral ligament reconstruction, mild laxity, normal range of motion, 2 percent.

H. Foot.

1. Range of motion:

a. ankylosis of tarsal metatarsal or mild tarsal joints:

(1) normal position, 2.5 percent;

(2) mal-position, 5 percent;

b. limited motion in the foot:

(1) mild, limited motion with mild pain with weight

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bearing, no change in activities, 2.5 percent;

(2) moderate, limitation of motion with pain with weight bearing, no reduction in athletic or vigorous activities, 5 percent;

(3) severe, limitation of motion with pain with weight bearing, sedentary activities not affected, 10 percent;

2. Procedures or conditions:

a. calcaneal fracture, extra articular, pain with weight bearing, 6 percent;

b. calcaneal fracture, intra articular:

(1) mild limitation of motion as in 1.b.(1), 6 percent;

(2) moderate limitation of motion as in 1.b.(2), 12 percent;

(3) severe limitation of motion as in 1.b.(3), 18 percent;

c. avascular necrosis talus:

(1) mild limitation of motion as in 1.b.(1), 6 percent;

(2) moderate limitation of motion as in 1.b.(2), 12 percent;

(3) severe limitation of motion as in 1.b.(3), 18 percent;

d. tarsal fractures, healed, mild pain, 3 percent;

e. metatarsal fractures, healed, 0 percent;

f. phalyngeal fractures, healed, 0 percent.

I. Toes.

1. complete ankylosis of metatarsophalangeal joint, any toe, 3 percent;

2. complete ankylosis any toe, interphalangeal joint, optimum position semi-flexion, 1 percent.

8 MCAR S 1.9018 [Temporary] Respiratory system.

A. Evaluation procedures. The procedures used in evaluating permanent partial disability of the respiratory system shall include the following:

1. complete history and physical examination with special

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reference to cardiopulmonary symptoms and signs;

2. chest roentgenography (posteroanterior in full inspiration, posteroanterior in full expiration timed, three seconds, lateral);

3. hematocrit or hemoglobin determination;

4. electrocardiogram;

5. performance of ~~not-less-than-two-of~~ the following tests of ventilation:

~~a. one-second-forced-expiratory-volume;~~

~~b. forced-vital-capacity;~~

~~c. forced-expiratory-volume-(FEV)/forced-vital capacity-(FVC)-ratio-expressed-as-a-percentage;~~ and one second forced expiratory volume (FEV1), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 69 and 71;

b. forced vital capacity (FVC), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 70 and 72.

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6. ~~at-least-one-pulmonary-function-test,-such-as-a diffusing-capacity-study~~ diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits.

B. Measurement of respiratory loss of function. Table 1 shall be used to calculate the percentage of disability of the whole body due to permanent partial disability of the respiratory system.

TABLE 1

	Forced Spirometry Measurements $\frac{FEV_{1.0}-FVC-FEV_1/FVC\%}{1/2\ (FEV1 + FVC)}$ (Test three times)	Diffusing Capacity*	Percent Disability of Whole Body
Symptoms			
When dyspnea		Not	0

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occurs, is consistent with the circumstances of activity.	Not less than 85 percent of normal	Applicable	
Dyspnea does not occur at rest and seldom occurs during the performance of the usual activities of daily living.	70 to 85 percent of normal	Not Applicable	15
Dyspnea does not occur at rest but does occur during the usual activities of daily living.	50 to 70 percent of normal	Usually Not Applicable	30
Dyspnea occurs during activities such as climbing one flight of stairs or walking one block on the level.	25 to 50 percent of ~~predicted~~ normal	40 percent or less of normal	60
Confined to bed and oxygen	Less than 25 percent of normal	20 percent or less of normal	85

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dependent.

* The diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits set forth in Table 1.

C. Asthma. Asthma which is not medically controllable and which requires at least six hospitalizations in 12 months, 25 percent.

8 MCAR S 1.9019 [Temporary] Organic heart disease.

A. General. For permanent partial disability due to organic heart disease, the disability of the whole body is set forth in B.

B. Heart ratings. The following ratings may be applied only after a compilation of a patient's complete history and a physical examination. Testing must include chest X-ray and electrocardiogram. The testing may include echocardiography, exercise testing, and radionuclide studies.

The following table sets forth symptoms of organic heart disease. The percentage of disability of the whole body is determined by the symptoms present.

Organic Heart Disease Schedule

Percentage Disability of Whole Body	10 percent	30 percent	60 percent	85 percent
Organic Heart Disease	Present	Present	Present	Present
Symptoms	Not present	Not present at rest	Not present at rest	Present at rest
Level of activity	No symptoms from usual	No symptoms from usual	Symptoms from a one or more	Worsening of symptoms

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causing symptoms	activities of daily living, including such activities as stair- or hill- climbing, and walking	activities of daily living	block walk or from climbing stairs. Symptoms also from activities of daily living	with any activity
Level of unusual activity causing symptoms	No symptoms from walking quickly, recreation, hill- or stair- climbing, arm-work, and similar activities	Symptoms from hill- or stair- climbing, walking quickly, arm-work, or recreation	Symptoms from emotional stress, walking quickly, and similar activities	May be present at rest or may awaken patient
Signs of heart failure	No	No	Relieved by therapy	Not usually relieved by therapy
Signs of symptoms of angina	No	With prolonged or severe exertion	With mild exertion	Rest or nocturnal symptoms

8 MCAR S 1.9020 [Temporary] Vascular disease affecting the extremities.

The following schedule shall be used to determine the percentage of disability of the whole body for permanent partial disability due to vascular disease. Permanent partial

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disability from vascular disease affecting the extremities must be rated according to the following classifications. The system shall be used only after a complete history and physical examination. The full evaluation shall include imaging examination (X-ray with and without contrast, computer axial tomography scanning, sonography, radionuclide studies) volume studies, or flow studies.

Vascular Disease Schedule

Percentage of disability of whole body	0 percent	10 percent	30 percent	60 percent	90 percent
Intermittant claudication distance	No	Approx. one city block	Approx. 1/4 city block	Less than 1/4 city block	Constant pain
Pain at rest	No	No	No	Sometimes	Constant
Physical signs of diagnosis	None No ulceration	Healed, painless stump, or healed ulcer	Healed stump but persistent signs of activity, or persistent superficial ulcer	Amputation above wrist or ankle with continued sign of disease, or widespread deep ulcer	Amputation above wrist or ankle in more than one limb, or wide, deep ulceration of more than one limb

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Edema	Rare and transi-ent	Persis-tent, incom-pletely con-trolled	Very severe and only partially con-trolled	Marked and uncon-trollable	Marked and uncon-trollable

8 MCAR S 1.9021 [Temporary] Gastrointestinal tract.

A. General. The following schedule is for the evaluation of permanent partial disability of the gastrointestinal tract. The evaluation must include a thorough history and physical examination. Additional studies, such as radiographic, metabolic, absorptive, endoscopic, and biopsy may be necessary to determine the functioning of these organs. Disability shall not be determined until after completion of all medically accepted diagnostic and therapeutic efforts. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

For evaluative purposes, the digestive tract has been divided into (1) the esophagus, stomach, duodenum, small intestine, and pancreas, (2) the colon and rectum, (3) the anus, and (4) the liver and biliary tract.

B. Upper digestive tract (esophagus, stomach, duodenum, small intestine, and pancreas).

1. Class 1, 2 percent.

a. Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; continuous treatment is not required; and weight can be maintained at the desirable level; or

b. There are no complications after surgical procedures.

2. Class 2, 15 percent. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; dietary restriction and drugs are required for control of symptoms, signs, or nutritional deficiency; and loss of weight below the desirable weight does not exceed 10

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percent.

3. Class 3, 35 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state; or

b. There is 10 to 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder of the upper digestive tract.

4. Class 4, 65 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and symptoms are not controlled by treatment; or

b. There is greater than a 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder of the upper digestive tract.

C. Colon and rectum.

1. Class 1, 2 percent:

a. signs and symptoms of colonic or rectal disease are infrequent;

b. limitation of activities, special diet, or medication is not required; no systemic manifestations are present and weight and nutritional state can be maintained at a desirable level; or

c. there are no complications after surgical procedures.

2. Class 2, 15 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration. There are mild gastrointestinal symptoms with intermittent disturbance of bowel function, accompanied by periodic or continual pain. Minimal restriction of diet or mild symptomatic therapy may be necessary. No impairment of nutrition results.

3. Class 3, 30 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration; there are moderate to severe exacerbations with disturbance of bowel habit, accompanied by periodic or continual pain; restriction of

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activity, special diet and drugs are required during attacks; and there are constitutional manifestations such as fever, anemia, or weight loss.

4. Class 4, 50 percent. There is objective evidence of colonic and rectal disease or anatomic loss or alteration; there are persistent disturbances of bowel function present at rest with severe persistent pain; complete limitation of activity, continued restriction of diet, and medication do not entirely control the symptoms; there are constitutional manifestations such as fever, weight loss, or anemia present; and there is no prolonged remission.

D. Anus.

1. Class 1, 2 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; or there is mild incontinence involving gas or liquid stool; or anal symptoms are mild, intermittent, and controlled by treatment.

2. Class 2, 12 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; and moderate but partial fecal incontinence is present requiring continual treatment; or continual anal symptoms are present and incompletely controlled by treatment.

3. Class 3, 22 percent.

a. Signs of organic anal diseases are present and there is anatomic loss or alteration; and complete fecal incontinence is present; or

b. Signs of organic anal disease are present and severe anal symptoms are unresponsive or not amenable to therapy.

E. Liver and biliary tract.

1. Class 1, 5 percent.

a. There is objective evidence of persistent liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate minimal disturbance of the liver function; or

b. Primary disorders of bilirubin metabolism are

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present.

2. Class 2, 20 percent. There is objective evidence of chronic liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate more severe liver damage than Class 1.

3. Class 3, 40 percent. There is objective evidence of progressive chronic liver disease, or history of jaundice, ascites, or bleeding esophageal or gastric varices within the past year; nutrition and strength may be affected; and there is intermittent ammonia and meat intoxication.

4. Class 4, 75 percent. There is objective evidence of progressive chronic liver disease, or persistent ascites or persistent jaundice or bleeding esophageal or gastric varices, with central nervous system manifestations or hepatic insufficiency; and nutrition state is below normal.

F. Biliary tract.

1. Class 1, 5 percent. There is an occasional episode of biliary tract dysfunction.

2. Class 2, 20 percent. There is recurrent biliary tract impairment irrespective of treatment.

3. Class 3, 40 percent. There is irreparable obstruction of the bile tract with recurrent cholangitis.

4. Class 4, 75 percent. There is persistent jaundice and progressive liver disease due to obstruction of the common bile duct.

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8 MCAR S 1.9022 [Temporary] Reproductive <u>and urinary</u> tract schedule.

A. General. This rule sets forth the percentage of disability of the whole body for permanent partial disability of the reproductive and urinary systems. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

B. Evaluative procedures. For evaluative purposes the reproductive and urinary systems are divided into the: (1)

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upper urinary tract, (2) bladder, (3) urethra, (4) male reproductive organs, and (5) female reproductive organs.

Procedures for evaluating permanent partial disability of the genitourinary and reproductive systems shall include:

1. a complete history and physical examination with special reference to genitourinary/reproductive symptoms and signs, including psychological evaluation when indicated by the symptoms;

2. laboratory tests to identify the presence or absence of associated disease. The tests may include multi-channel chemistry profile, complete blood count, complete urinalysis, including microscopic examination of centrifuged sediment, chest X-ray, both posterior/anterior and left lateral views, electrocardiogram, performance of a measurement of total renal functions--endogenous creatinine clearance corrected for total body surface area. Other tests may include:

a. kidney function tests, such as arterial blood gases and determinations of other chemistries that would reflect the metabolic effects of decreased kidney function;

b. special examinations such as cystocopy, voiding cystograms, cystometrograms; and

c. a description of the anatomy of the reproduction or urinary system.

~~B.~~ C. Upper urinary tract.

1. Solitary kidney, 10 percent. This category shall apply only when a solitary kidney is the only upper urinary tract permanent partial disability. When a solitary kidney occurs in combination with any one of the following four classes, the disability rating for that class shall be increased by 10 percent.

2. Class 1, 5 percent. Diminution of kidney function as evidenced by a creatinine clearance of 50 to 70 percent of age and sex adjusted normal values, other underlying causes absent.

3. Class 2, 22 percent. Diminution of the upper urinary tract function as evidenced by a creatinine clearance of 40 to 50 percent of age and sex adjusted normal values, no other

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underlying disease.

4. Class 3, 47 percent. Diminution of upper urinary tract function, as evidenced by creatinine clearance of 25 to 40 percent of age and sex adjusted normal values.

5. Class 4, 77 percent. Diminution of upper urinary tract function as evidenced by creatinine clearance below 25 percent of age and sex adjusted normal values.

~~C.~~ D. Bladder.

1. Class 1, 5 percent. Symptoms and signs of bladder disorder requiring intermittent treatment, but without evidence of intervening malfunction between periods of treatments or symptomatology.

2. Class 2, 15 percent. Symptoms and signs of bladder disorder requiring continuous treatment, or there is bladder reflex activity but loss of voluntary control.

3. Class 3, 20 percent. Poor reflex activity evidenced by intermittent dribbling, and no voluntary control.

4. Class 4, 30 percent. Continuous dribbling.

~~D.~~ E. Urethra.

1. Class 1, 2 percent. Symptoms and signs of urethral disorder are present which require intermittent therapy for control.

2. Class 2, 15 percent. Symptoms and signs of urethral disorder that cannot be effectively controlled by treatment.

~~E.~~ F. Penis.

1. Class 1, 10 percent. Impaired sexual function but vaginal penetration is possible.

2. Class 2, 20 percent. Impaired sexual function and vaginal penetration is not possible.

~~F.~~ G. Testes, epididymides, and spermatic cords

1. Class 1, 5 percent.

a. Symptoms and signs of testicular, epididymal, or spermatic cord disease are present and there is anatomic alteration; and

b. Continuous treatment is not required; and

c. There are no abnormalities of seminal or hormonal

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functions; or

d. Solitary teste is present.

2. Class 2, 10 percent.

a. Symptoms and signs of testicular, epididymal or spermatic cord disease are present and there is anatomic alteration; and

b. Frequent or continuous treatment is required; and

c. There are detectable seminal or hormonal abnormalities.

3. Class 3, 20 percent. Trauma or disease produces bilateral anatomical loss or there is no detectable seminal or hormonal function of testes, epididymides, or spermatic cords.

~~G.~~ H. Prostate and seminal vesicles.

FF61

1. Class 1, 5 percent. ~~A patient belongs in Class 1 when:~~

a. there are symptoms and signs of prostatic or seminal vesicular dysfunction or disease;

b. anatomic alteration is present; and

c. continuous treatment is not required.

2. Class 2, 10 percent.

a. frequent severe symptoms and signs of prostatic or seminal vesicular dysfunction or disease are present; and

b. anatomic alteration is present; and

c. continuous treatment is required.

3. Class 3, 20 percent. There has been ablation of the prostate or seminal vesicles.

~~H.~~ I. Vulva and vagina.

1. Class 1, 10 percent. Impaired sexual function but penile containment is possible.

2. Class 2, 20 percent. Impaired sexual function and penile containment is not possible.

J. Cervix and uterus.

1. Class 1, 5 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which do not require continuous treatment; or

b. Cervical stenosis, if present, requires no

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treatment; or

c. There is anatomic loss of the cervix or uterus in the postmenopausal years.

2. Class 2, 10 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which require continuous treatment; or

b. Cervical stenosis, if present, requires periodic treatment.

3. Class 3, 20 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which are not controlled by treatment; or

b. Cervical stenosis is complete; or

c. Anatomic or complete functional loss of the cervix or uterus occurs in premenopausal years.

K. Fallopian tubes and ovaries.

1. Class 1, 5 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which do not require continuous treatment; or

b. Only one fallopian tube or ovary is functioning in the premenopausal years.

2. Class 2, 10 percent. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which require continuous treatment, but tubal patency persists and ovulation is possible.

3. Class 3, 20 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present and there is total loss of tubal patency or total failure to produce ova in the premenopausal years; or

b. Bilateral loss of the fallopian tubes or ovaries occurs in the premenopausal years.

8 MCAR S 1.9023 [Temporary] Skin disorders.

Permanent partial disability resulting from skin disorders

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are a disability of the whole body as set forth in this rule. This schedule is based upon the effect of the disorder on the ability to function and perform activities of daily living and the degree of treatment required for the disorder. The schedule is not based upon the location or the percentage of the body affected by a specific skin disorder. Impairment due to burns shall be rated under 8 MCAR S 1.9024 and not under this schedule. FF62

1. Class 1, 2 percent. Signs or symptoms of skin disorder are present and supported by objective skin findings. With treatment there is no or minimal limitation in the performance of the activities of daily living, although certain physical or chemical agents might temporarily increase the extent of limitation.

2. Class 2, 10 percent. Signs and symptoms of skin disorder are present and intermittent treatment is required. There is limitation in the performance of some of the activities of daily living.

3. Class 3, 20 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required. There is limitation in the performance of many of the activities of daily living.

4. Class 4, 45 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which may include periodic confinement at home or other domicile. There is limitation in the performance of many of the activities of daily living.

5. Class 5, 70 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which necessitates confinement at home or other domicile. There is severe limitation in the performance of nearly all of the activities of daily living.

8 MCAR S 1.9024 [Temporary] Burns.

A. General. The whole body disability due to burns is not equal to the percent of body surface area which is burned. The percentage of body surface area affected must be determined according to Lund and Browder. The ratings determined under FF63

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A.-D. must be combined as set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c), provided that the maximum disability to the whole body under this schedule must not exceed 70 percent. Loss of motion or body parts except the face must be rated under the musculoskeletal schedules and must not be considered as included in a rating under this rule unless specifically provided otherwise.

B. Burns other than electrical conduction. A rating under this section is the ratings assigned by the following paragraphs combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c):

1. Any burn that heals within one month and leaves no hypertrophic scar, 0 percent.

2. Cold intolerance of the hands, face, or head as evidenced by the wearing of heavy gloves or additional scarves at 35 degrees Fahrenheit, 10 percent.

3. Heat intolerance is evidenced by fatigue, malaise, nausea, and an oral temperature of at least 100 degrees Fahrenheit upon exposure to an environmental temperature of 90 degrees Fahrenheit at 60 percent relative humidity, 5 percent.

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4. Sensitivity to sun exposure as evidenced by the need to cover the skin or use sun screen to prevent sunburn, 10 percent.

5. Sensitivity to dust, chemical, or petroleum exposure; altered sweating; or apocrine gland dysfunction. For one or any combination of these conditions, the whole body disability is:

a. If the sensitivity affects less than 5 percent of the body surface area, 0 percent.

b. If the sensitivity affects 5 to 20 percent of the body surface area, 2 percent.

c. If the sensitivity affects 20 percent or more of the body surface area, 3 percent.

6. Sensory loss due to burns:

a. Loss of sensation on palmar surface of hands shall be rated as provided by 8 MCAR S 1.9009 C.

b. Sensory loss in less than 5 percent of the body

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surface area, 0 percent.

c. Sensory loss in 5 to 20 percent of the body surface area, 2 percent.

d. Sensory loss in more than 20 percent of the body surface area, 5 percent.

C. Electrical conduction injuries.

1. Associated sensory loss and concommitant thermal injuries must be rated as provided in A.

2. Peripheral nerve deficits must be rated as provided in the musculoskeletal schedule.

The ratings under 1. and 2. must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

D. Cosmetic disfigurement. This section applies to disfigurement on the face, the head, the neck, or the hands due to burns. Where there is surgery, this rating is done after correction by plastic surgery. The final rating under this schedule shall not be done until hypertrophic scarring is matured or more than 24 months after the injury. The ratings under the paragraphs of this section must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

FF63

1. Face. The face is the anterior head from the forehead, to and including the chin.

a. Loss of facial features:

(1) Deformity of nasal tip or deformity, thinning, or eversion of ala nasi, 5 percent.

(2) Loss of more than 50 percent of nasal cartilage or of both ala nasi, 25 percent.

b. Eyes:

(1) Loss of one eyebrow, 2.5 percent.

(2) Loss of two eyebrows, 5 percent.

(3) Ectropian unaccompanied by visual impairment:

(a) Lower lid pulled from eye when mouth is opened and neck extended, 5 percent.

(b) Lower lid pulled away with no movement of

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face or neck, 10 percent.

(c) Cornea unprotected when sleeping, 15 percent.

(4) Epiphora unaccompanied by visual impairment, 10 percent.

c. Mouth. A rating under this paragraph is the arithmetic sum of (1)-(4).

(1) Noncongenital microstomia or distortion affecting eating and dental hygiene, 10 percent.

(2) Eversion of the upper lip, 7.5 percent.

(3) Eversion of the lower lip, 7.5 percent.

(4) Distortion of vermillion border, 10 percent.

d. Ear. Loss of 75 percent or more of one external ear, 5 percent.

e. Hypertrophic scarring of face in areas other than those covered in a.-d.:

(1) Affecting only forehead above the eyebrows, 10 percent.

(2) Affecting the lower face from eyebrows to chin, 25 percent.

(3) Affecting both the forehead above the eyebrows and the lower face from the eyebrows to chin, 35 percent.

f. Wrinkling of face in areas other than those covered in a.-e., one-third of percentages in e.

2. Head, Alopecia:

a. Anterior hairline:

(1) Loss of less than 20 percent of hair on anterior hairline, 0 percent.

(2) Loss of 20 to 50 percent of hair on anterior hairline, 2 percent.

(3) Loss of more than 50 percent of hair on anterior hairline, 3 percent.

b. Elsewhere on head and not affecting anterior hairline:

(1) Loss of 0 to 15 percent of hair, 0 percent.

(2) Loss of 15 to 30 percent of hair, 1 percent.

(3) Loss of 20 to 50 percent of hair, 2 percent.

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(4) Loss of more than 50 percent of hair, 3 percent.

The ratings under a. and b. must be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

3. Anterior neck. The anterior neck extends from the ear lobule anteriorally to the ear lobule and downward to mid clavicle. Disfigurement on the posterior neck from the ear lobule posteriorally to the ear lobule shall not be rated under this rule. Ratings under a. and b. shall be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

a. Hypertrophic scarring or banding:

(1) Affecting less than 10 percent of the anterior neck, 0 percent.

(2) Affecting 10 to 30 percent of the anterior neck, 10 percent.

(3) Affecting 30 to 50 percent of the anterior neck, 12 percent.

(4) Affecting more than 50 percent of the anterior neck, 15 percent.

FF63

b. Chin shelf. The chin shelf is the area from the chin backwards to the neck.

(1) Chin shelf extends less than 2 inches, 3 percent.

(2) Chin shelf extends less than 1 inch, 10 percent.

4. Hands. The hand extends from the carpus outward. Loss of body parts and loss of motion are rated in the musculoskeletal schedule.

a. Hypertrophic scarring affecting less than 30 percent of dorsum of one hand, 0 percent.

b. Hypertrophic scarring affecting 30 to 50 percent of dorsum of one hand, 3 percent.

c. Hypertrophic scarring affecting 50 percent or more of dorsum of one hand, 7 percent.

8 MCAR S 1.9025 [Temporary] Pre-existing impairments.

Where a disability is subject to apportionment under Minnesota Statutes, section 176.101, subdivision 4a, the rating

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for the disabled condition under a category of the schedules of these rules must be reduced as provided in this rule. As used in this rule, the term disabled condition includes the pre-existing disability.

A. This section applies where the pre-existing disability has not been rated and neither B. nor C. is applicable.

1. The pre-existing disability must be rated under a category of the schedules of these rules.

2. The whole body disability rating assigned to the disabled condition of the member by the schedules of these rules must be reduced by the rating assigned to the pre-existing disability of the member in 1.

3. For example, the medical report establishes a pre-existing impairment of amputation of the index finger at the metacarpophalangeal joint. This injury is a 13.5 percent pre-existing disability to the body as a whole under 8 MCAR S 1.9008 [Temporary] A.12.a. The disabled condition is amputation of all fingers except the thumb at the metacarpophalangeal joint, a 32.5 percent disability under 8 MCAR S 1.9008 A.10. 32.5 percent less 13.5 percent gives the disability (adjusted for the pre-existing impairment) of 19 percent. Payment is made for the 19 percent disability at the rate appropriate for a 32.5 percent disability. Thus, if economic recovery benefits are paid, 19 percent is multiplied by 680 weeks; for impairment benefits, 19 percent is multiplied by $85,000.

B. This section applies where the pre-existing disability of a member has been rated in another proceeding or state and the rating represents a percentage of disability to the whole body. The rating of the disabled condition under a category of these schedules shall be reduced by the rating assigned to the pre-existing disability of the member.

C. This section applies where the injury producing the pre-existing disability occurred prior to January 1, 1984, and the pre-existing disability has been rated under Minnesota Statutes, section 176.101, subdivision 3; or where Minnesota Statutes, chapter 176 is inapplicable and the rating represents

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a percentage of disability of a member.

1. From Table 1, determine the maximum whole body disability assignable to the pre-existing disability. Use Table 2 where disability to an internal organ is rated as a percentage of disability to the particular organ rather than a percentage of disability to internal organs. Where the pre-existing disability is not listed in Table 1 or Table 2, the maximum whole body disability is the maximum disability assigned to the affected member by the schedules of 8 MCAR SS 1.9001-1.9024 [Temporary].

TABLE 1

Member	Maximum Whole Body Disability (Percent)
Thumb	16
Index finger	11
Middle finger	9
Ring finger	4
Little finger	2
Great toe	5
Lesser toe	1
Hand	54
Hand and wrist	54
Arm	60
Foot	21
Foot and ankle	28
Leg	40
Eye	24
Eyes (both)	85
Hearing loss (both ears)	35
Back	71
Voice	70
Burns and skin impairments, including disfigurement	70
Internal organs,	

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excluding brain	85
Brain	100
Head	20

TABLE 2

Member	Maximum Whole Body Disability (Percent)
Stomach	65
Pancreas	65
Colon	50
Spleen	0
Bladder	30
Sexual organs or function	20
Circulatory system	90
Heart	85
Lungs	85
Liver	75
Solitary kidney	10
Kidney, excluding solitary kidney	77

2. Multiply the prior rating of the member's pre-existing disability by the maximum whole body disability determined in 1. Where a disputed rating has been closed out to a stipulated rating but payments were made on a different rating, the rating for purposes of this rule is the closed-out rating.

3. Subtract the percentage amount determined in 2. from the whole body disability rating assigned to the disabled condition of the member by the schedules of these rules. The remainder is the amount due for the disabled condition after apportionment for the pre-existing disability.

4. For example, a pre-1984 back injury was rated at 25 percent of the back. The whole body disability attributable to this injury is 25 percent by 71 percent equals 17.75 percent. After 1984, a second back injury is rated at 24.5 percent under

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these rules (24.5 percent minus 17.75 percent equals 6.75 percent). Six and three-fourths (6.75) percent is the amount assigned to the disabled condition after apportionment.

D. Where the pre-existing disability and the subsequent permanent partial disability affect more than one member, apportionment must be determined as follows:

1. For each member, determine the percentage of whole body disability under A.-C., as appropriate.

2. Combine the percentages obtained in 1. in the manner set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

Effective Date. Rules 8 MCAR SS 1.9001-~~1.9023~~ 1.9025 [Temporary] are effective January 1, 1984.

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Addition to 8 MCAR § 1.9025

At page 74, line 11, add:

The result of an application of the formula, expressed as a decimal and not as a percentage, shall be rounded to four decimal points prior to the next application of the formula. Where the fifth number after the decimal point is five, round to the nearest even number.

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
DIVISION OF WORKERS' COMPENSATION

In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry, Governing Workers' Compensation Permanent Partial Disability Schedule

ORDER ADOPTING RULES

Notice of the Commissioner's intent to adopt the above-entitled rules was published in the State Register on October 3 and December 5, 1983, and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minn. Stat. § 14.14 (1982) on October 4 and December 1, 1983. After affording interested and affected persons an opportunity to submit comments for 20 days after each Notice, holding a public hearing on November 4, 1983, reviewing and considering the comments, and determining the need for and reasonableness of the above-captioned rules,

NOW, THEREFORE, IT IS ORDERED that these rules identified as te Temporary Rules Governing Workers' Compensation Permanent Partial Disability Schedule are adopted this 28th day of December, 1983 pursuant to the authority vested in me by Minn. Stat. § 176.105, subd. 4 (Supp. 1983).

STATE OF MINNESOTA

Steve Keefe

Steve Keefe, Commissioner
Department of Labor and Industry

Dated: December 28, 1983

The Juvenile Justice Advisory Committee will meet on Friday, June 24, 1983 at 9:00 [illegible] in Conference Room A, East Wing, 1st Floor, Veterans' Service Building, 20 W. 12th St., St. Paul, Mn.

Department of Energy, Planning and Development
Office of Local Government
Planning Division

Notice of Intent to Establish the Minnesota Task Force on Juvenile Code Recodification

The Minnesota Juvenile Justice Advisory Committee (JJAC) proposes to fund a Minnesota Task Force on Juvenile Code Recodification. The Task Force will study the Minnesota juvenile code and its relationship to the child welfare laws, and will make recommendations to the 1985 Legislature on recodifying the juvenile code. Appointments to the Task Force will be made by the Director of the State Planning Agency. The deadline for application is July 15, 1983.

Application forms and further information may be obtained by contacting:

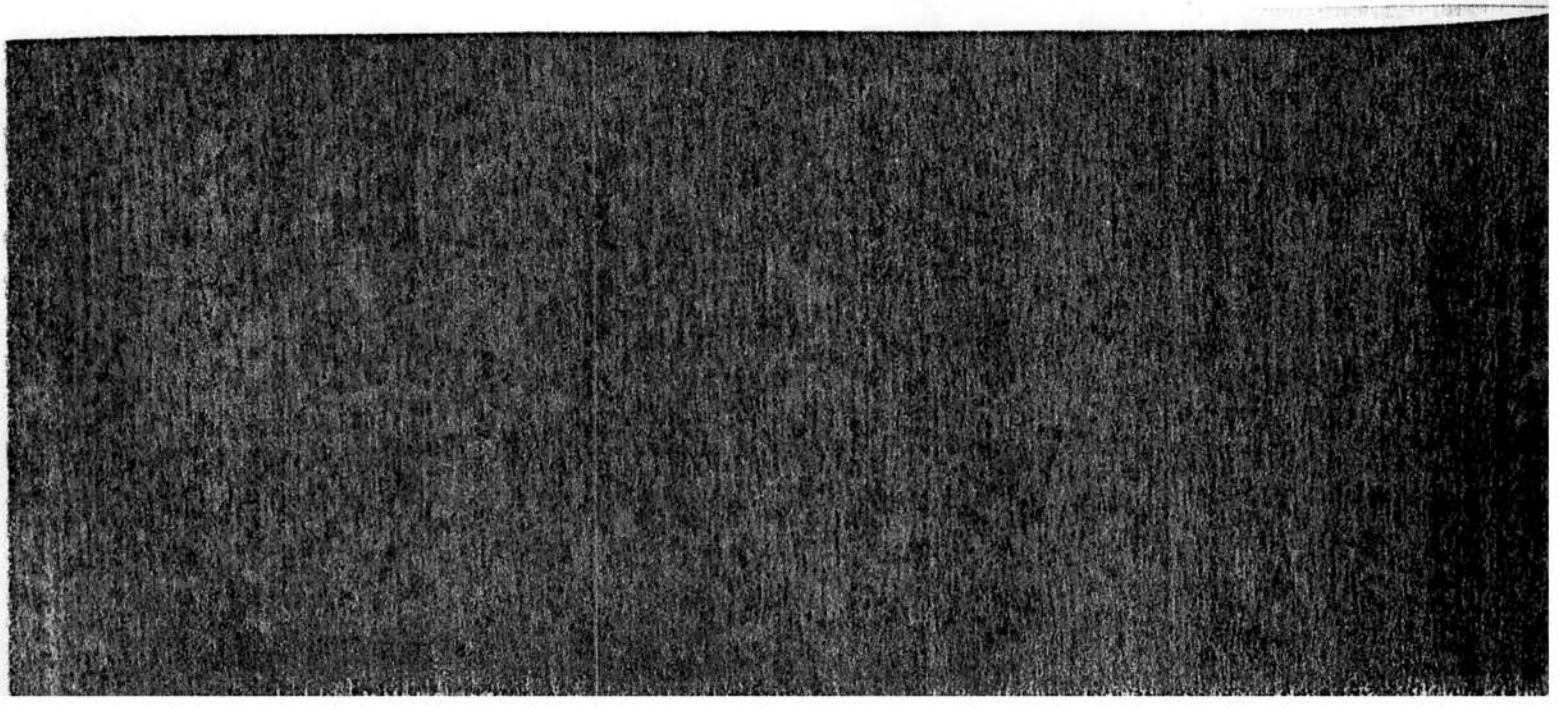
Criminal Justice Program
Office of Local Government
Department of Energy, Planning and Development
100 Hanover Building, 480 Cedar Street
St. Paul, MN 55101
(612) 296-3133

Department of Labor & Industry
Workers' Compensation Division

Notice of Intent to Solicit Outside Opinion Regarding Proposed Temporary Rules Governing Workers' Compensation Disability Schedules

Notice is hereby given that the State Department of Labor & Industry is seeking information or opinions from sources outside the agency in preparing to promulgate temporary rules governing Workers' Compensation Disability Schedules. The promulgation of these rules is authorized by Minnesota Statutes section 176.105, which requires the agency to establish a disability schedule in which the aggregate total of permanent partial disability under the new schedule is approximately equal to the current schedule under Minnesota statute 176.101, Subd. 3.

The State Department of Labor & Industry requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing. Written statements should be addressed to Commissioner Steve Keefe, 444 Lafayette Road, St. Paul, MN 55101.



Oral Statements will be received during regular business hours over the telephone at 296-2342 and in person at the above address. Any written material received by the State Department of Labor & Industry shall become part of the record in the event that the rules are promulgated. All statements of information and comment shall be accepted until July 31.

Steve Keefe
Commissioner of Labor & Industry

Department of Public Welfare
Health Care Programs

Request for Comment on Proposed Sliding Fee Schedule for Alternative Care Grants Program

Under the Alternative Care Grants Program, the Commissioner of the Department of Public Welfare provides grants to participating counties to pay costs of providing alternative care to nursing home care, for eligible individuals.

Minnesota Session Laws of 1983, Chapter 199, requires the commissioner to establish a sliding fee schedule for requiring payment for the cost of providing care to persons who are eligible for alternative care grants but who are not yet eligible for Medical Assistance. The sliding fee schedule is not subject to Minnesota Statutes, chapter 14.

Interested persons may submit comments on the proposed sliding fee schedule until July 20, 1983. The proposed schedule may be changed based upon the comments received. Submit comments to:

Barbara Colliander
Department of Public Welfare
Health Care Programs
Space Center Building
444 Lafayette Road
St. Paul MN 55101

SLIDING FEE SCHEDULE FOR ALTERNATIVE CARE GRANTS PROGRAM

Alternative Care Grant

Sliding fee schedule. The county agency shall assess the person who would be eligible for medical assistance within 180 days of nursing home admission, for part or all of the costs of alternative care services provided to that person.

The monthly amount which a person shall pay is the lesser of the cost of the alternative care services or the sum of the amounts determined from Exhibits 1 and 2.

The amount shall be calculated when alternative care services begin and shall remain constant until the person's income and liquid assets reach the point where the person is eligible for the Medical Assistance Program.

Exhibit 1
Sliding Fee Schedule: Income

	Family Size			
Annual Gross Income	1	2	3	4
0 - 10,000	0	0	0	0
10,001 - 11,000	9	0	0	0
11,001 - 12,000	18	0	0	0
12,001 - 13,000	29	9	0	0
13,001 - 14,000	43	18	0	0
14,001 - 15,000	61	29	9	0
15,001 - 16,000	84	43	18	0
16,001 - 17,000	113	61	29	9
17,001 - 18,000	149	84	43	18
18,001 - 19,000	193	113	61	29
19,001 - 20,000	NE	149	84	43

NE—Not eligible for alternative care grants under 12 MCAR § 2.065 H.1.

Annual gross income is any income, earned or unearned, and any gift or benefit which is received by or available to a person.

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

ORDER FOR PUBLICATION AND FOR NOTICE OF INTENT TO ADOPT AMENDMENTS TO PROPOSED TEMPORARY RULES

IT IS ORDERED this 18 day of November, 1983 that a Notice of Intent to Adopt Amendments to Proposed Temporary Rules in the above-entitled matter be published in the State Register and be given to all persons who have registered their names with the Department of Labor and Industry for that purpose.

Dated: November 18, 1983

STATE OF MINNESOTA

Steve Keefe

STEVE KEEFE, Commissioner
Department of Labor and Industry

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

ORDER FOR HEARING AND PUBLICATION

IT IS ORDERED this 21st day of September, 1983 that the proposed temporary rules in the above-entitled matter be published in the State Register and that a public hearing on them be held in Room 83 of the State Office Building on November 4, 1983 commencing at 8:30 a.m. and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that notice of said hearing be published in the State Register and be given to all persons who have registered their names with the Department of Labor and Industry for that purpose.

Dated: 9/21/83

STATE OF MINNESOTA

Steve Keefe

STEVE KEEFE, Commissioner
Department of Labor and Industry

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

NOTICE OF HEARING AND OF INTENT TO ADOPT TEMPORARY RULES

NOTICE IS HEREBY GIVEN that the Department of Labor and Industry proposes to adopt temporary rules to govern the Workers' Compensation schedule for permanent partial disability, as authorized by Minn. Stat. § 176.105, subd. 4 (1983).

A hearing for the purpose of public comment will be held pursuant to Minn. Stat. § 14.10 (1982) in Room 83, State Office Building on November 4, 1983 commencing at 8:30 a.m. and continuing until all persons or representatives of associations or groups have had an opportunity to be heard. Comments may be made by submitting either oral or written data. Statements or briefs may be submitted without appearing at the hearing provided all written material is submitted prior to hearing to:

Steve Keefe, Commissioner
Department of Labor and Industry
444 Lafayette Road
St. Paul, Minnesota 55101

A copy of the proposed rules follows this notice in the State Register. Additional copies will be available at the hearing. The proposed rules may be modified as a result of the hearing. No hearing examiner's report will be issued. The temporary rules shall remain in effect until permanent rules are adopted. The procedure for adoption of temporary rules is governed by Minn. Stat. §§ 14.29-.36 and 176.105, subd. 4. It is expected that the hearing will last one day and that in excess of fifty (50) people will be in attendance.

Although not required for temporary rules, 25 days prior to the hearing a Statement of Need and Reasonableness will

be available for review at the agency. This Statement of Need and Reasonableness will include a discussion of the factors considered by the agency in promulgating the proposed rules.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, subd. 11 (1982) as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses in membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statutes provide certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

Dated: September 21, 1983.

STATE OF MINNESOTA

Steve Keefe

STEVE KEEFE, Commissioner
Department of Labor and Industry

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

NOTICE OF INTENT TO ADOPT AMENDMENTS TO PROPOSED TEMPORARY RULES

NOTICE IS HEREBY GIVEN that the Department of Labor and Industry proposes to adopt amendments to proposed temporary rules governing the Workers' Compensation Permanent Partial Disability Schedule published in the State Register of October 3, 1983, on pages 562-595.

Persons interested in these amendments shall have twenty (20) days to submit comments on the proposed amendments. The proposed amendments may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Persons who wish to submit comments should submit such comments to:

Steve Keefe, Commissioner
Department of Labor and Industry
444 Lafayette Road
St. Paul, Minnesota 55101

Authority for the adoption of these amendments is contained in Minn. Stat. § 176.105, subd. 4. As required by Minn. Stat. § 176.105, subd. 4, a public hearing was held on November 3, 1983. At that time public comment was received on the proposed temporary rules and on the proposed amendments which were made available at the hearing. In addition, the required analysis of the current permanent partial disability schedule and the required actuarial evaluation of the proposed permanent partial disability schedule have been completed. A statement of need and reasonableness, showing that the Commissioner considered the factors suggested in Minn. Stat. § 176.105, subd. 4 in developing the proposed rules and amendments, was prepared although not required. It is available from the office of the Commissioner upon request.

Upon adoption of the rules, the jurisdictional documents, all written comments received, and the final rules as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written request to:

Steve Keefe, Commissioner
Department of Labor and Industry
444 Lafayette Road
St. Paul, Minnesota 55101

A copy of the proposed amendments to the proposed temporary rules immediately follows this Notice in the State Register. Copies of this Notice and the proposed amendments are available and may be obtained by contacting Commissioner Steve Keefe at the above address.

Dated: November 18, 1983

STATE OF MINNESOTA

Steve Keefe

STEVE KEEFE, Commissioner
Department of Labor and Industry

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

AFFIDAVIT OF MAILING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Abby Struck, being first duly sworn deposes and says:

That on the 1st day of December, 1983, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Amendments to Proposed Temporary Rules by depositing in the State of Minnesota Central Mail System for United States mailing at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the State Department of Labor and Industry for the purpose of receiving notice of the proposed adoption of rules by this Department.

Abby Struck

Subscribed and sworn to before me this 1st day of December, 1983.

Fern Mahnke

Notary Public

FERN MAHNKE
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES OCTOBER 3, 1990

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

Division of Workers' Compensation

IN THE MATTER OF the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule.

CERTIFICATE

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minn. Stat. § 14.14, subd. 1 (1982), that their names be placed on file with and maintained by the State Department of Labor and Industry for the purpose of receiving notice of the proposed adoption of rules by this department is accurate and complete as of 2:00 p.m., this 1st day of December, 1983.

Kathy Stark

1. applies for coverage for only a portion of the employer's statutory liability under Minnesota Statutes, chapter 176, excluding wrap-up policies;

2. has an outstanding debt due and owing to the assigned risk plan at the time of renewal arising from a prior policy;

3. persistently refuses to permit completion of an adequate payroll audit;

4. repeatedly submits misleading or erroneous payroll information; or

5. flagrantly disregards safety or loss control recommendations. Cancellation for nonpayment of premium may be initiated by the service contractor upon 30 days' written notice to the employer pursuant to Minnesota Statues, section 176.185, subdivision 1.

D. Occupational disease exposure. An employer having a significant occupational disease exposure, as determined by the commissioner, to be entitled to coverage shall have physical examinations made:

1. of employees who have not been examined within one year of the date of application for assignment;

2. of new employees before hiring; and

3. of terminated employees. Upon request, the findings and reports of doctors making examinations, together with x-rays and other original exhibits, must be furnished to the assigned risk plan or the Department of Labor and Industry.

4 MCAR § 1.9504 Assigned risk rating plan.

A. Generally. Employers insured through the assigned risk plan are subject to B.-E.

B. Classifications. Classifications shall be assigned according to the Basic Manual, Workers' Compensation and Employers' Liability Insurance, 1980 Edition, National Council on Compensation Insurance, with exceptions approved for Minnesota.

C. Experience modification. Rates shall be modified according to the experience rating plan contained in the Experience Rating Plan Manual for Workers' Compensation and Employers' Liability Insurance, 1980 Edition, National Council on Compensation Insurance, with exceptions approved for Minnesota. Minnesota exceptions approved for section III, rule 1, Eligibility Requirements, are revoked.

D. Small risk merit rating plan. Employers which do not qualify for the experience rating plan are subject to the small risk merit rating plan. The rules and procedures governing the small risk merit rating plan shall be the same as for the assigned risk experience rating plan, except as regards the premium modification factor. The premium modification factor for the small risk merit rating plan shall be based on the number of claims attributable to an experience period of three years commencing four years prior and ending one year prior to the date for which the rating is promulgated, excluding claims for which medical losses only are expected. The merit rating premium modification factor is as follows: zero claims, credit modification factor; one claim, no modification factor; two or more claims, debit modification factor. The amount of the modification factors shall be fixed by the commissioner simultaneously with the schedule of rates pursuant to Minnesota Statutes, section 79.251, subdivision 3.

E. Premium discount. Rates shall be modified according to a premium discount factor whereby standard premium is reduced 0.0 percent for the first $1,000 of premium, and progressively greater percentages for the next $4,000, for the next $95,000, and for all premiums over $100,000. The amount of the percentage reductions shall be fixed by the commissioner simultaneously with the schedule of rates, pursuant to Minnesota Statutes, section 79.251, subdivision 3.

4 MCAR § 1.9505 Reserves.

The commissioner and the assigned risk plan review board shall monitor and have jurisdiction over all reserves maintained for assigned risk plan losses.

Department of Labor and Industry
Division of Workers' Compensation

Proposed Amendments to Temporary Rules of the State Department of Labor and Industry governing Workers' Compensation Permanent Partial Disability Schedule

Notice of Intent to Adopt Amendments to Proposed Temporary Rules

Notice is hereby given that the Department of Labor and Industry proposes to adopt amendments to proposed temporary rules governing the Workers' Compensation Permanent Partial Disability Schedule published in the *State Register* of October 3, 1983, on pages 562-595.

Persons interested in these amendments shall have twenty (20) days to submit comments on the proposed amendments. The

proposed amendments may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Persons who wish to submit comments should submit such comments to:

Steve Keefe, Commissioner
Department of Labor and Industry
~~444~~ Lafayette Road
St. Paul, Minnesota 55101

Authority for the adoption of these amendments is contained in Minn. Stat. § 176.105, subd. 4. As required by Minn. Stat. § 176.105, subd. 4, a public hearing was held on November 4, 1983. At that time public comment was received on the proposed temporary rules and on the proposed amendments which were made available at the hearing. In addition, the required analysis of the current permanent partial disability schedule and the required actuarial evaluation of the proposed permanent partial disability schedule have been completed. A statement of need and reasonableness, showing that the Commissioner considered the factors suggested in Minn. Stat. § 176.105, subd. 4 in developing the proposed rules and amendments, was prepared although not required. It is available from the office of the Commissioner upon request.

Upon adoption of the rules, the jurisdictional documents, all written comments received, and the final rules as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rules as proposed for adoption, should submit a written request to:

Steve Keefe, Commissioner
Department of Labor and Industry
~~444~~ Lafayette Road
St. Paul, Minnesota 55101

A copy of the proposed amendments to the proposed temporary rules immediately follow this Notice in the *State Register*. Copies of this Notice and the proposed amendments are available and may be obtained by contacting Commissioner Steve Keefe at the above address.

November 18, 1983

Steve Keefe, Commissioner
Department of Labor and Industry

Temporary Rules as Proposed

8 MCAR § 1.9001 [Temporary] Workers' compensation permanent partial disability schedule rules.

A. Purpose of schedules. Laws of Minnesota 1983, chapter 290, section 86, requires the commissioner of labor and industry to promulgate temporary rules assigning specific percentages of disability of the whole body for specific permanent partial disabilities. Rules 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] assign percentages of disability of the whole body for permanent partial disabilities.

B. Interpretation of schedules. Only the categories set forth in the schedules in 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] may be used when rating the extent of a disability. Where a category represents the disabling condition, the disability determination shall not be based on the cumulation of lesser included categories. If more than one category may apply to a condition, the category most closely representing the condition shall be selected. Where more than one category is necessary to represent the disabling condition, categories shall be selected to avoid double compensation for any part of a condition. The percentages of disability to the whole body as set forth in two or more categories shall not be averaged, prorated, or otherwise deviated from, unless specifically provided in the schedule. Unless provided otherwise, where an impairment must be rated under more than one category, the ratings must be combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c). With respect to the musculo-skeletal schedule, the percent of whole body disability for motor or sensory loss of a member shall not exceed the percent of whole body disability for amputation of that member.

C. Disabilities not part of schedules. A category not found within 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] shall not be used to determine permanent partial disability.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

D. Rules of construction. The technical terms in 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] are defined in either 8 MCAR § 1.9002 [Temporary], or by the documents incorporated by reference in this rule. Documents are incorporated by reference only to the extent necessary for definition or to the extent specifically referenced in a schedule. These documents are as follows:

1. Guides to the Evaluation of Permanent Impairment, published by the American Medical Association, Committee on Rating of Mental and Physical Impairment, ~~1971~~ 1976 edition. This document is also known as the A.M.A. Guides.

2. Snellen Charts, published by American Medical Association Committee for Eye Injuries and designated Industrial Vision Test Charts. These charts are also known and referred to as A.M.A. charts;

3. American Medical Association Rating Reading Card of 1932, published by the American Medical Association Committee for Eye Injuries. This document is also ~~know~~ known as the A.M.A. Card.

4. American National Standard Institutes, Inc., S3.1-1977 Criteria for Permissible Ambient Noise during Audiometric Testing and S3.6-1969 (R1973) Specification for Audiometers;

5. Metropolitan Life Insurance Company Height and Weight Tables, published by the Metropolitan Life Insurance Company, 1983;

6. The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, Sister Kenny Institute, 1973;

7. Dorland's Illustrated Medical Dictionary, 25th edition, 1974. This document is also known as Dorland's;

8. D.S.M. III, Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 1980. This document is also known as D.S.M. III;

9. Fractures, Charles A. Rockwood and David Green, 1975; ~~and~~

10. Textbook on Anatomy, William Henry Hollinshead, 1974~~.~~; and

11. "The Estimation of Areas of Burns," in Surgery, Gynecology and Obstetrics, by Lund and Browder, pages 352-358, volume 79, 1944. This document is referred to as Lund and Browder.

E. Severability. If any provision of these rules is held to conflict with a governing statute, applicable provisions of the Minnesota Administrative Procedure Act, or other relevant law; to exceed the statutory authority conferred; to lack a reasonable relationship to statutory purposes or to be unconstitutional, arbitrary, or unreasonable; or to be invalid for any other reason; the validity and enforceability of the remaining provisions of the rule shall in no manner be affected.

8 MCAR § 1.9002 [Temporary] Definitions.

A. Scope. For the purpose of 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] the terms defined in this rule have the meanings given them unless the context clearly indicates otherwise. Terms not defined in this rule are defined in Dorland's or other documents incorporated by reference. If the definition in a document incorporated by reference conflicts with or differs from the definition set forth in 8 MCAR § 1.9001~~-1.9023~~ 1.9025 [Temporary], the specific definitions set forth in these rules shall govern.

B. Acromio-clavicular grade 1. "Acromio-clavicular grade 1" means an undisplaced acromio-clavicular joint.

C. Acromio-clavicular grade 2. "Acromio-clavicular grade 2" means a 50 percent displacement of the clavicle in relationship to the acromion at the acromio-clavicular joint.

D. Acromio-clavicular grade 3. "Acromio-clavicular grade 3" means a completely disrupted acromio-clavicular joint.

E. Activities of daily living. "Activities of daily living" means the ability to perform self cares, to perform housework and related tasks, to ride in or operate a motor vehicle, and to perform vocational tasks not requiring physical labor.

F. Ankylosis. "Ankylosis" means the stiffening or fixation of a joint.

G. ANSI. "ANSI" means the American National Standards Institute.

H. Banding. "Banding" means a thick, rope-like cord of hypertrophic scarring resulting from burns.

I. Category. "Category" means a permanent partial disability as described in these rules and the corresponding percent of disability to the whole body for that permanent partial disability.

~~I.~~ J. Chronic. "Chronic" means the repeated or continuous occurrence of a specific condition or symptom.

K. Demonstrable degenerative changes. "Demonstrable degenerative changes" means radiographic findings demonstrating the presence of degeneration of intervertebral disc or facet joints. Examples of demonstrable degenerative changes are disc space narrowing, small osteophytes, and facet joint hypertrophic changes.

~~J.~~ L. Desirable level of weight. "Desirable level of weight" means preferred weights set forth in tables created by the Metropolitan Life Insurance Company.

~~K.~~ M. Disarticulation. "Disarticulation" means an amputation occurring through a joint.

~~L.~~ N. Distance vision. "Distance vision" means the ability to distinguish letters at a distance of 20 feet according to the Snellen and A.M.A. Charts.

~~M.~~ O. Family member. "Family member" means cohabitants and is not limited to those related by blood or marriage. In cases of institutionalization or similar nonhome environment, family member may include staff members who care for the individual on a regular basis.

~~N.~~ P. Fore-quarter. "Fore-quarter" means the amputation of the upper extremity involving the scapula, clavicle, and muscles that attach to the chest.

~~O.~~ Q. Fusion. "Fusion" means the surgical uniting of one vertebral segment to an adjoining vertebral segment.

~~P.~~ R. Gastrostomy. "Gastrostomy" means a surgical creation of a gastric fistula through the abdominal wall for the purpose of introducing food into the stomach.

~~Q.~~ S. Glossopharyngeal. "Glossopharyngeal" means the ninth cranial nerve with sensory fibers to the tongue and pharynx. It affects taste and swallowing.

T. Gross motor weakness. "Gross motor weakness" means total or partial loss as described at 8 MCAR § 1.9016 A. and B.

U. Hypertrophic scar. "Hypertrophic scar" means an elevated irregularly shaped mass of scar tissue.

~~R.~~ V. Hypoglossal. "Hypoglossal" means the motor nerve to the tongue. It is the 12th cranial nerve and carries impulses from the brain to the tongue, including movement of muscles and secretion of glands and motor movement.

~~S.~~ W. Kenny scale. "Kenny scale" means the Kenny self-care evaluation system as set forth in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence of Activities of Daily Living.

~~T.~~ X. Laminectomy. "Laminectomy" means the removal of part or all of the lamina of one vertebral segment, usually with associated disc excision.

~~U.~~ Y. Lethargy. "Lethargy" means, in relation to a nervous system injury to the brain, that an individual is drowsy, but can be aroused.

~~V.~~ Z. Moderate referred shoulder and arm pain. "Moderate referred shoulder and arm pain" means pain of an intensity necessitating decreased activity in order to avoid the pain. This pain is demonstrated in a dermatomal distribution into the shoulder and upper extremity.

~~W.~~ AA. Moderate partial dislocation. "Moderate partial dislocation" means a loss of normal vertebral alignment of up to 50 percent of the vertebral body on the adjacent vertebral body associated with vertebral fractures.

~~X.~~ BB. Near vision. "Near vision" means clearness of vision at the distance of 14 inches.

~~Y.~~ CC. Nonpreferred extremity. "Nonpreferred extremity" means the arm or leg not used dominantly, as for example, the left hand of a right-handed writer.

~~Z.~~ DD. Objective clinical findings. "Objective clinical findings" as used in 8 MCAR § 1.9007 [Temporary] means examination results which are reproducible and consistent. Examples of objective clinical findings are involuntary muscle spasms, consistent postural abnormalities, and changes in deep tendon reflexes.

~~AA.~~ EE. Postural abnormality. "Postural abnormality" means a deviation from normal posture, as found on anterior/posterior or lateral X-rays, that involves the spine and pelvis or segments of the spine or pelvis, such as kyphosis, lordosis, or scoliosis.

~~BB.~~ FF. Preferred extremity. "Preferred extremity" means the dominant leg or arm, as for example, the right arm of a right-handed person.

~~CC.~~ GG. Presbycusis. "Presbycusis" means a decline in hearing acuity that occurs with the aging process.

~~DD.~~ HH. Pseudophakia. "Pseudophakia" means that the crystalline lens of the eye has been replaced with a surgically implanted lens.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

~~EE.~~ II. Self cares. "Self cares" means bed activities, transfers, locomotion, dressing, personal hygiene, bowel and bladder and feeding as described in The Revised Kenny Self-Care Evaluation: A Numerical Measure of Independence in Activities of Daily Living, pages 10-24.

~~FF.~~ JJ. Spinal stenosis. "Spinal stenosis" means the narrowing of the spinal canal.

~~GG.~~ KK. Spondylolisthesis. "Spondylolisthesis" means the forward movement of one vertebral body of one of the lower lumbar vertebrae on the vertebrae below it or upon the sacrum.

~~HH.~~ LL. Spondylolisthesis grade 1. "Spondylolisthesis grade 1" means forward movement from zero to 25 percent of the vertebral body.

~~II.~~ MM. Spondylolisthesis grade 2. "Spondylolisthesis grade 2" means forward movement from 25 to 50 percent of the vertebral body.

~~JJ.~~ NN. Spondylolisthesis grade 3. "Spondylolisthesis grade 3" means movement from 50 to 75 percent of the vertebra body.

~~KK.~~ OO. Spondylolisthesis grade 4. "Spondylolisthesis grade 4" means forward movement from 75 to 100 percent of the vertebral body.

~~LL.~~ PP. Stupor. "Stupor" means, in relation to a nervous system injury to the brain, that a strong stimulus or pain is needed to arouse consciousness or response.

~~MM.~~ QQ. Tinnitus. "Tinnitus" means a subjective sense of noises in the head or ringing in the ear for which there is no observable external cause.

~~NN.~~ RR. Trigeminal. "Trigeminal" means the mixed nerve with sensory fibers to the face, cornea, anterior scalp, nasal and oral cavities, tongue and supertentorial dura matter. It also has motor fibers to the muscles of mastication. It is the fifth cranial nerve.

~~OO.~~ SS. Vertigo. "Vertigo" means a sensation of moving around in space or having objects move about the person. It is the result of a disturbance of the equilibratory apparatus.

~~PP.~~ TT. Vestibular. "Vestibular" means the main division of the auditory nerve. It is the eighth cranial nerve and deals with equilibrium.

UU. Wrinkling. "Wrinkling" means small ridges on the skin formed by shrinking or contraction as a result of burns.

~~QQ.~~ VV. 14/14. "14/14" is a term used in the measurement of near vision. It is the clearness of vision at a distance of 14 inches. The numerator is the test distance in inches. The denominator is the distance at which the smallest letter on the A.M.A. card can be seen.

~~RR.~~ WW. 20/20 Snellen or A.M.A. Chart. "20/20 Snellen or A.M.A. Chart" refers to a chart imprinted with block letters or numbers in gradually decreasing sizes, identified according to distances at which they are ordinarily visible. It is used in testing visual acuity. The numerator is the test distance in feet. The denominator is the distance at which the smallest letter discriminated by a patient would subtend five minutes of arc.

8 MCAR § 1.9003 [Temporary] Eye schedule.

A. Complete loss of vision. For complete loss of vision in both eyes, disability of the whole body is 85 percent. For complete loss of vision in one eye, disability of the whole body is 24 percent. In determining the degree of vision impairment and of whole body disability, B.-F. shall be used.

B. Examination. Disability shall not be determined until all medically acceptable attempts to correct the defect have been made. Prior to the final examination on which disability is to be determined, at least six months shall elapse after all visible inflammation has disappeared. In cases of disturbance of extrinsic ocular muscles, optic nerve atrophy, injury of the retina, sympathetic ophthalmia, and traumatic cataract, at least 12 months shall elapse before the final examination is made. Testing shall be conducted with corrective lenses applied, unless indicated otherwise in this rule.

C. Maximum and minimum limits of primary coordinate factors of vision. The primary coordinate factors of vision are central visual acuity, visual field efficiency, and ocular motility. The determination of maximum and minimum limits for each of the coordinate functions is established below.

1. Maximum limit.

a. The maximum limit of central visual acuity is the ability to recognize letters or characters which subtend an angle of five minutes, each unit part of which subtends a one-minute angle at the distance viewed. A 20/20 Snellen or A.M.A. Chart is 100 percent (maximum) central visual acuity for distance vision. 14/14 A.M.A. card is 100 percent (maximum) central visual acuity for near vision.

b. ~~A visual field is 500 degrees. A visual field which extends from the point of fixation outward 85 degrees, down and out 85 degrees, down 65 degrees, down and in 50 degrees, inward 60 degrees, in and up 55 degrees, upward 45 degrees, and up and out 55 degrees is 100 percent visual field efficiency~~ The maximum visual field is defined as 500 degrees. It is the sum of the degrees in the eight principal meridians from the point of fixation to the outermost limits of visual perception and defines the area in which a three millimeter white target is visible at 33 centimeters. One hundred percent visual field efficiency is that visual field which extends from the point of fixation outward 85 degrees, down 65 degrees, down and in 50 degrees, inward 60 degrees, in and up 55 degrees, upward 45 degrees, and up and out 55 degrees.

c. Maximum ocular motility is present if there is absence of diplopia in all parts of the field of binocular fixation, and if normal binocular motor coordination is present.

2. Minimum limit.

a. The minimum limit of central visual acuity is

(1) for distance vision, 20/800 Snellen or A.M.A. chart;

(2) for near vision, 14/560 A.M.A. card.

b. The minimum limit for field vision is established as a concentric central contraction of the visual field to five degrees. Five degrees of contraction of the visual field reduces the visual efficiency of the eye to zero.

c. The minimum limit for ocular motility is established by the presence of diplopia in all parts of the field of binocular fixation or by absence of binocular motor coordination. The minimum limit is 50 percent ocular motility efficiency.

D. Measurement of coordinate factors of vision and the computation of their partial loss.

1. Central visual acuity efficiency. Central visual acuity shall be measured both for distance vision and for near vision, each eye being measured separately, both with and without correction. A Snellen or A.M.A. chart shall be used for distance vision and an A.M.A. card shall be used for near vision. Illumination shall be at least five footcandles.

a. Table I shows the percentage of visual efficiency corresponding to the notations for distance vision and for near vision. For test readings between those listed on the chart, round up from the midpoint to the nearest reading, and round down from below the midpoint.

Where distance vision is less than 20/200 and the A.M.A. chart is used, readings are at ten feet. The test reading is translated to the corresponding distance reading in Table I by multiplying both the numerator and the denominator of the test reading by two.

TABLE I
Central Visual Acuity

A.M.A. Chart or Snellen Reading for Distance	A.M.A. Card Reading for Near	Percentage of Central Visual Acuity Efficiency
20/20	14/14	100.00
20/25	14/17.5	95.7
20/25.7	. . .	95.0
20/30	14/21	91.5
20/32.1	. . .	90.0
20/35	14/24.5	87.5
20/38.4	. . .	85.0
20/40	14/28	83.6
20/44.9	14/31.5	80.0
20/50	14/35	76.5
20/52.1	. . .	75.0

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20/60	14/42	69.9
20/60.2	. . .	70.0
20/68.2	. . .	65.0
20/70	14/49	64.0
20/77.5	. . .	60.0
20/80	14/56	58.5
20/86.8	. . .	55.0
20/90	14/63	53.4
20/97.5	. . .	50.0
20/100	14/70	48.9
20/109.4	. . .	45.0
20/120	14/84	40.9
. . .	14/89	38.4
20/122.5	. . .	40.0
20/137.3	. . .	35.0
20/140	14/98	34.2
20/155	. . .	30.0
20/160	14/112	28.6
20/175	. . .	25.0
20/180	14/126	23.9
20/200	14/140	20.0
20/220	14/154	16.7
20/240	14/168	14.0
. . .	14/178	12.3
20/260	14/182	11.7
20/280	14/196	9.7
20/300	14/210	8.2
20/320	14/224	6.8
20/340	14/238	5.7
20/360	14/252	4.8
20/380	14/266	4.0
20/400	14/280	3.3
20/450	14/315	2.1
20/500	14/350	1.4
20/600	14/420	0.6
20/700	14/490	0.3
20/800	14/560	0.1

b. The percentage of central visual acuity efficiency of the eye for distance vision is that percentage in Table I which corresponds to the test reading for distance vision for that eye.

c. The percentage of central visual acuity efficiency of the eye for near vision is that percentage in Table I which corresponds to the test reading for near vision for that eye.

d. The percentage of central visual acuity efficiency of the eye in question is determined as follows:

(a) Multiply by two the value determined for corrected near vision in c.

(2) Add the product obtained in step 1 to the value determined for corrected distance vision in b.

(3) Divide the sum obtained in step 2 by three.

The following is an example of this calculation. If the central visual acuity efficiency for distance is 70 percent, and that for near is 25 percent, the percentage of central visual acuity efficiency for the eye is:

$$\frac{70\% + (2 \times 25)}{3} = 40\% \text{ central visual acuity efficiency}$$

e. For traumatic aphakia, the corrected central visual acuity efficiency of the eye is 50 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

f. For traumatic pseudophakia, the corrected central visual acuity efficiency of the eye is 80 percent of the central visual acuity efficiency determined in d. This paragraph shall not apply if an adjustment for glasses or contact lenses pursuant to E.2.b. or c. results in a lower visual efficiency than would be given by application of this paragraph.

2. Visual field efficiency. For each eye, the extent of the field of vision shall be determined by perimetric test methods. A three millimeter white disk which subtends a 0.5-degree angle under illumination of not less than seven footcandles shall be used. For aphakia, a six millimeter white disk shall be used. The result shall be plotted on the visual field chart as illustrated in the A.M.A. Guides, page 94.

a. The amount of radial contraction in the eight principal meridians shall be determined. The sum of the degrees of field vision remaining on these meridians, divided by 500, is the visual field efficiency of one eye, expressed as a percentage. If the eye has a concentric central contraction of the field to a diameter of five degrees, the visual efficiency is zero.

b. When the impairment of field is irregular and not fairly disclosed by the eight radii, the determination shall be based on a number of radii greater than eight and the divisor in a. shall be changed accordingly.

c. Where there is a loss of a quadrant or a half-field, the degrees of field vision remaining in each meridian are added to one-half the sum of the two boundary meridians.

3. Ocular motility. Ocular motility shall be measured in all parts of the motor field with any useful correction applied.

a. All directions of gaze shall be tested with use of a test light and without the addition of colored lenses or correcting prisms. The extent of diplopia is determined on the perimeter at 330 millimeters or on a tangent screen at a distance of one meter from the eye.

b. ~~for each eye.~~ Plot the test results on a motility chart as illustrated in the A.M.A. Guides, page 97.

c. Determine the percentage loss of ocular motility from the motility chart. This percentage is assigned to the injured eye or, if both eyes are injured, to the eye with the greatest impairment of central visual acuity and field vision. The eye with the greatest impairment means the eye for which the product of central visual acuity efficiency and visual field efficiency is the least. For the purpose of calculation, a value of zero percent is deemed to be one percent. For the other eye, the percentage loss of ocular motility is zero.

d. The percentage loss of ocular motility is subtracted from 100 percent to obtain the ocular motility efficiency. The minimum ocular motility efficiency of one eye is 50 percent.

E. Visual efficiency. The visual efficiency of one eye is the product of the efficiency values of central visual acuity, of visual field, and of ocular motility. For the purpose of this calculation, these values shall be expressed as decimals and not as percentages; a value of zero percent is deemed to be one percent.

1. For example, if central visual acuity efficiency is 50 percent, visual field efficiency is 80 percent, and ocular motility efficiency is 100 percent, the visual efficiency of the eye is .50 times .80 times 1.00, equals 40 percent. If ocular motility efficiency is changed to 50 percent, the visual efficiency is .50 times .80 times .50, equals 20 percent.

2. Visual efficiency shall be adjusted as set in this clause. Visual efficiency may not be less than zero percent. No adjustment for glasses or contacts shall be made in cases of aphakia or pseudophakia where the central visual efficiency was adjusted pursuant to D.1.e. or f.

a. Visual efficiency shall be decreased by subtracting two percent for any of the following conditions which are present due to the injury: loss of color vision; loss of adaptation to light and dark; metamorphosis; entropion or ectropion uncorrected by surgery; lagophthalmos; epiphora; and muscle disturbances such as ocular ticks not included under diplopia.

b. If glasses are required as a result of the injury, or if as a result of the injury the refractive error increases by at least one diopeter of sphere or of cylinder or of both, subtract five percent from the visual efficiency. Where the glasses contain prisms, subtract six percent.

c. If a noncosmetic contact lens is required in one or both eyes as a result of the injury, subtract seven percent from the visual efficiency.

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~~d. Adjustments for preexisting impairments shall be made pursuant to Minnesota Statutes, section 176.101, subdivision 1, clause (a).~~

F. Procedure for determining whole body disability due to vision loss. For each eye, subtract the percentage of visual efficiency as determined in E. from 100 percent. The difference is the percentage impairment of each eye. The better eye has the lower percentage impairment. The poorer eye has the greater percentage impairment.

1. Multiply the percentage impairment of the better eye by three.

2. Add the percentage impairment of the poorer eye to the product obtained in step 1.

3. Divide the sum obtained in step 2 by four.

4. The quotient obtained in step 3 is the percentage impairment of the visual system. Fractions shall be rounded to the nearest whole number percentage as provided in D.1.a.

5. The percentage impairment of the visual system is translated to the percentage disability of the whole body by Table 2.

Table 2
Eye Schedule

Impairment of Visual System, %	Disability of Whole Man, %	Impairment of Visual System, %	Disability of Whole Man, %
0	0	45	42
1	1	46	43
2	2	47	44
3	3	48	45
4	4	49	46
5	5	50	47
6	6	51	48
7	7	52	49
8	8	53	50
9	8	54	51
10	9	55	52
11	10	56	53
12	11	57	54
13	12	58	55
14	13	59	56
15	14	60	57
16	15	61	58
17	16	62	59
18	17	63	59
19	18	64	60
20	19	65	61
21	20	66	62
22	21	67	63
23	22	68	64
24	23	69	65
25	24	70	66
26	25	71	67
27	25	72	68
28	26	73	69
29	27	74	70
30	28	75	71
31	29	76	72
32	30	77	73
33	31	78	74
34	32	79	75
35	33	80	76
36	34	81	76

37	35	82	77
38	36	83	78
39	37	84	79
40	38	85	80
41	39	86	81
42	40	87	82
43	41	88	83
44	42	89	84
		90-100	85

8 MCAR § 1.9004 [Temporary] Ear schedule.

A. General. For hearing loss, the maximum disability of the whole body is 35 percent. The procedures in B.-G. shall be used to determine the extent of binaural hearing loss and of whole body disability.

B. Medical diagnosis. Otological evaluation shall be the method for determining the degree of permanent partial hearing loss. The medical diagnosis shall include the following:

1. A complete history of occupational, military, and recreational noise exposure. This medical history shall include documentation of any previous hearing loss, if that information is available;

2. A complete physical examination of the ear; and

3. An audiological evaluation which shall include pure tone air conduction and bone conduction testing.

C. Standards for audiometric calibration and test environment. To ensure accurate measurement of hearing loss, the following standards shall be observed in conducting the tests required in B.:

1. The audiometer used to measure hearing loss shall be calibrated to meet the specifications of ANSI §3.6-1969 (R1973), Specifications for Audiometers. The following are also required:

a. Biological or electroacoustical calibration checks of the audiometer shall be performed monthly;

b. Electroacoustical calibration shall be performed annually to certify the audiometer to the ANSI standard in 1; and

c. The calibration records shall be preserved and shall be provided upon request; and

2. Audiometric test rooms or booths shall meet the specifications of ANSI §3.1-1977, Criteria for Permissible Ambient Noise during Audiometric Testing.

D. Waiting period for final evaluation of hearing loss. A waiting period of at least three months shall elapse between the date of the occurence of the noise injury and the final evaluation of the permanent partial hearing loss.

E. Procedure for determining disability of whole body due to hearing loss.

1. The binaural hearing loss is determined. The calculation for the percent of binaural hearing loss consists of the following steps:

a. For each ear, test the hearing threshold levels at the four frequences of 500, 1,000, 2,000, and 3,000 Hertz;

b. For each ear, determine the average four-frequency hearing level. The average four-frequency hearing level is one-fourth of the sum of the threshold levels at each of the four tested frequencies. The average four-frequency hearing level is expressed in decibels;

c. For each ear, subtract 25 decibels from the average four-frequency hearing level for that ear. The remainder, expressed in decibels, is the adjusted average four-frequency hearing level;

d. For each ear, multiply the adjusted average four-frequency hearing level by 1.5 percent. The product is the monaural hearing loss, expressed as a percentage. A product less than zero percent is deemed to be zero. A product greater than 100 percent is deemed to be 100 percent;

e. Considering both ears, compare the monaural hearing losses as determined in d. The ear with the smaller monaural hearing loss is the better ear. The ear with the larger monaural hearing loss is the poorer ear; and

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f. Multiply the monaural hearing loss of the better ear by five, add this product to the monaural hearing loss of the poorer ear, and divide the sum by six. The quotient is the binaural hearing loss, expressed as a percentage. The formula is:

$$\frac{(\text{monaural hearing loss of better ear}) \times 5 + (\text{monaural hearing loss of poorer ear})}{6} = \text{Percent binaural hearing loss}$$

2. The calculation of the percent of binaural hearing loss is illustrated by the following examples.

Example 1

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	15	25	45	55
Left ear	30	45	60	85

a. Calculation of the average four-frequency hearing level:

$$\text{Right ear} = \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = \frac{220}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level:

Right ear = 35 decibels − 25 decibels = 10 decibels;
Left ear = 55 decibels − 25 decibels = 30 decibels;

c. Calculation of monaural hearing loss:

Right ear = 10 × 1.5% = 15%
Left ear = 30 × 1.5% = 45%

d. Calculation of binaural hearing loss:

$$\frac{(15\% \times 5) + 45\%}{6} = 20 \text{ percent binaural hearing loss}$$

Example 2

	500 Hertz	1,000 Hertz	2,000 Hertz	3,000 Hertz
Right ear	20	25	30	35
Left ear	30	45	60	85

a. Calculation of average four-frequency hearing level.

$$\text{Right ear} = \frac{20 + 25 + 30 + 35}{4} = 25 \text{ decibels}$$

$$\text{Left ear} = \frac{30 + 45 + 60 + 85}{4} = 55 \text{ decibels}$$

b. Calculation of adjusted average four-frequency hearing level.

Right ear = 25 decibels − 25 decibels = 0 decibels
Left ear = 55 decibels − 25 decibels = 30 decibels

c. Calculation of monaural hearing loss:

Right ear = 0 × 1.5 percent = 0
Left ear = 30 × 1.5 percent = 45 percent

d. Calculation of binaural hearing loss:

$$\frac{(0\% \times 5) + 45\%}{6} = 7.5 \text{ percent binaural hearing loss}$$

3. The binaural hearing loss is translated to a percentage of disability of the whole body by the ear schedule set forth below:

EAR SCHEDULE

Binaural Hearing Loss. Percent	Disability of Whole Body Percent
0 - 1.7	0
1.8- 4.2	1
4.3- 7.4	2
7.5- 9.9	3
10.0- 13.1	4
13.2- 15.9	5
16.0- 18.8	6
18.9- 21.4	7
21.5- 24.5	8
24.6- 27.1	9
27.2- 30.0	10
30.1- 32.8	11
32.9- 35.9	12
36.0- 38.5	13
38.6- 41.7	14
41.8- 44.2	15
44.3- 47.4	16
47.5- 49.9	17
50.0- 53.1	18
53.2- 55.7	19
55.8- 58.8	20
58.9- 61.4	21
61.5- 64.5	22
64.6- 67.1	23
67.2- 70.0	24
70.1- 72.8	25
72.9- 75.9	26
76.0- 78.5	27
78.6- 81.7	28
81.8- 84.2	29
84.3- 87.4	30
87.5- 89.9	31
90.0- 93.1	32
93.2- 95.7	33
95.8- 98.8	34
98.9-100.0	35

F. Presbycusis. The calculation of the binaural hearing loss shall not include an additional adjustment for presbycusis.

G. Tinnitus. No additional percentage of permanent partial disability for hearing loss shall be allowed for tinnitus.

8 MCAR § 1.9005 [Temporary] Skull defects.

A. Skull depressions. For skull defects the percent of disability of the whole body is provided by the following schedule:

	Unfilled defect Percent	Filled defect Percent
0-1-1/2 square inches	0	0

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1-1/2-2-1/2 square inches	5	0
2-1/2- 4 square inches	10	2
4 -6-1/2 square inches	15	3
6-1/2 or more square inches	20	5

B. Skull fractures.

1. Basilar skull fracture with persistent spinal fluid leak. 20 percent.

2. Basilar skull fracture without cerebrospinal fluid leak. 0 percent.

8 MCAR § 1.9006 [Temporary] Central nervous system.

A. General. For permanent partial disability of the central nervous system the percentage of disability of the whole body is as provided in B.-I.

B. Trigeminal nerve. Permanent partial disability of the trigeminal nerve is a disability of the whole body as set forth below:

1. Partial unilateral sensory loss. 3 percent:

2. Complete unilateral sensory loss. 5 percent:

3. Partial bilateral sensory loss. 10 percent:

4. Complete bilateral sensory loss. 25 percent:

5. Intractable trigeminal neuralgia. 20 percent:

6. Atypical facial pain. 5 percent:

7. Partial unilateral motor loss. 2 percent:

8. Complete unilateral motor loss. 5 percent:

9. Partial bilateral motor loss. 30 percent; or

10. Complete bilateral motor loss. 30 percent.

C. Facial nerve. Permanent partial disability of the facial nerve is a disability of the whole body as set forth below:

1. Total loss of taste. 3 percent:

2. Partial unilateral motor loss. 25 to 75 percent of function lost. ~~5~~ 3 percent:

3. Unilateral motor loss. more than 75 percent of function lost. ~~15~~ 10 percent:

4. Partial bilateral motor loss. 25 to 75 percent of function lost. ~~15~~ 10 percent:

5. Bilateral motor loss. more than 75 percent of function lost. ~~30~~ 20 percent.

D. Vestibular loss with vertigo or disequilibrium is a disability of the whole body as set forth below:

1. A score of ~~4~~ 24 to 28 on the Kenny scale. and restricted in activities involving personal or public safety. such as operating a motor vehicle or riding a bicycle. 10 percent:

2. A score of ~~3 or 4~~ 16 to 28 on the Kenny scale. and ambulation impaired due to equilibrium disturbance. 30 percent:

3. A score of ~~2~~ 10 to 16 on the Kenny scale. 40 percent:

4. A score of ~~1 or~~ 0 to 10 on the Kenny scale. 70 percent.

E. Glossopharyngeal. vagus and spinal accessory nerves. Permanent partial disability to glossopharyngeal. vagus and spinal accessory nerves is a disability of the whole body as set forth below:

1. Swallowing impairment caused by disability to any one or more of these nerves:

a. diet restricted to semi-solids. 10 percent:

b. diet restricted to liquids. 25 percent: or

c. diet by tube feeding or gastrostomy. 50 percent.

2. Mechanical disturbances of articulation due to disability to any one or more of these nerves:

a. 95 percent or more of words are understood by those who are not family members and others outside the immediate family. but speech is distorted. 5 percent:

b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by those who are not family members, 10 percent:

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent:

d. more than 50 percent of words are understood by family members, 20 percent:

e. less than 50 percent of words are understood by family members, 25 percent:

f. 10 percent or less of words are understood by family members, 30 percent.

G. Hypoglossal nerve. Permanent partial disability of hypoglossal nerve is a disability of the whole body as listed below:

1. Bilateral paralysis; swallowing impairment:

a. diet restricted to semi-solids, 10 percent:

b. diet restricted to liquids, 25 percent; and

c. diet by tube feeding or gastrostomy, 50 percent.

2. Mechanical disturbances of articulation:

a. 95 percent or more of words are understood by family members and others outside the immediate family, but speech is distorted, 5 percent:

b. 95 percent or more of words are understood by family members, but speech is distorted and not easily understood by nonfamily members, 10 percent:

c. 75 percent or more of words are understood by family members, but speech is distorted, 15 percent:

d. more than 50 percent of words are understood by family members, 20 percent:

e. less than 50 percent of words are understood by family members, 25 percent:

f. 10 percent or less of words are understood by family members, 30 percent.

H. ~~Spinal cord and brain nervous system. Permanent partial disability of the spinal cord and brain is a disability of the whole body as set forth below:~~ Spinal cord. To rate under this section, determine the disability to the lower extremities, upper extremities, respiration, urinary bladder, anorectal, and sexual functions as set forth below. The percentage of whole body disability under this section is determined by combining the disabilities under 1.-6. in the manner described at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

1. Lower extremities. A permanent partial disability in the use of lower extremities is a disability of the whole body as set forth below:

a. can rise to a standing position and can walk, but has difficulty walking onto elevations, grades, steps, and distances, 15 percent:

b. can stand but can walk only on a level surface, 30 percent:

c. can stand but cannot walk, 45 percent; and

d. can neither stand nor walk, 65 percent.

2. Upper extremities. Permanent partial disability in the use of upper extremities is a disability of the whole body as set forth below:

	Whole Body Disability, Parcentages		
	Preferred extremity	Nonpreferred extremity	Both
score of ~~4~~ 24 to 28 on Kenny scale, but some difficulty with digital dexterity	10	5	15

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score of ~~3 or 4~~ 16 to 28 on Kenny scale, but no digital dexterity	20	10	30
score of ~~2~~ 10 to 16 on Kenny scale	40	40	50
score of ~~1 or~~ to 10 on Kenny scale	70	70	85

3. Respiration. Permanent partial disability of the respiratory function is a disability of the whole body as set forth below:

a. difficulty only where extra exertion is required, such as running, climbing stairs, heavy lifting, or carrying loads, 10 percent;

b. restricted to limited walking ~~not beyond~~, confined to one's own home, 35 percent;

c. restricted to bed, 75 percent; and

d. has no spontaneous respiration, 95 percent.

4. Urinary bladder function. Permanent partial disability of the bladder is a disability of the whole body as set forth below. Evaluative procedures to be followed are set forth in 8 MCAR § 1.9022 [Temporary] B.

a. Impaired voluntary control evidenced by urgency or hesitancy, but continent without collecting devices, 10 percent.

b. Impaired voluntary control, incontinent requiring external collecting devices, 20 percent.

c. Impaired voluntary control, incontinent requiring internal collecting or continence devices, 30 percent.

5. Anorectal function. The permanent partial disability of the anorectal function is a disability of the whole body as set forth below:

a. impaired voluntary control with urgency, 10 percent;

b. impaired voluntary control without reflex regulation, 20 percent;

c. impaired voluntary control, incontinent without diversion, 30 percent.

6. Sexual function. Permanent partial disability of sexual function is a disability of the whole body as set forth below.

a. Male:

(1) impaired sexual function, but vaginal penetration possible, 10 percent;

(2) impaired sexual function, and vaginal penetration not possible, 20 percent.

b. Female:

(1) impaired sexual function, but penile containment possible, 10 percent;

(2) impaired sexual function, and penile containment not possible, 20 percent.

I. Brain injury. Supporting objective evidence of structural injury, neurological deficit, or psychomotor findings is required to substantiate the permanent partial disability. Permanent partial disability of the brain is a disability of the whole body as set forth below.

1. Communications disturbances, expressive:

a. mild disturbance of expressive language ability not significantly impairing ability to be understood, such as mild word-finding difficulties, mild degree of paraphasias, or mild dysarthria, 10 percent;

b. severe impairment of expressive language ability, but still capable of functional communication with the use of additional methods such as gestures, facial expression, writing, word board, or alphabet board, 35 percent;

c. unable to produce any functional expressive language, 70 percent.

2. Communication disturbances, receptive:

a. mild impairment of comprehension of aural speech, but comprehension functional with the addition of visual cues such as gestures, facial expressions, or written material, 40 percent;

b. some ability to comprehend language is present, but significant impairment even with use of visual cues such as gestures, facial expressions, and written material, 60 percent;

c. no evidence of functional comprehension of language. 90 percent.

3. Complex integrated cerebral function disturbances must be determined by medical observation ~~in a controlled setting~~ and organic dysfunctions supported by psychometric testing. Functional overlay or primary psychiatric disturbances shall not be rated under this rule. The permanent partial disabilities are as follows:

a. mild impairment of higher level cognitive function or memory, but able to live independently and function in the community as evidenced by independence in activities such as shopping and taking a bus. 20 percent;

b. same as a., and also requires supporting devices and direction to carry out limited vocational tasks. 30 percent;

c. moderate impairment of memory, judgment, or other higher level cognitive abilities, can live alone with some supervision such as for money management, some limitation in ability to function independently outside the home in activities such as shopping and traveling. 50 percent;

d. moderately severe impairment of memory, judgment, or other higher cognitive abilities, unable to live alone and some supervision required at all times, but able to perform self cares independently. 70 percent;

e. severe impairment of memory, judgment, or other higher cognitive abilities such that constant supervision and assistance in self cares are required. 95 percent.

4. Emotional disturbances and personality changes must be substantiated by medical observation ~~in a controlled setting~~ and by organic dysfunction supported by psychometric testing. Permanent partial disability is a disability of the whole body as set forth below:

a. only present under stressful situation such as losing one's job, getting a divorce, or a death in the family. 10 percent;

b. present at all times but not significantly impairing ability to relate to others, to live with others, or to perform self cares. 30 percent;

c. present at all times in moderate to severe degree, minimal ability to live with others, some supervision required. 65 percent;

d. severe degree of emotional disturbance which, because of danger to self and others, requires continuous supervision. 95 percent.

5. Psychotic disorders, as described in D.S.M. III, not caused by organic dysfunction ~~must be~~ and substantiated by medical observation ~~in a controlled setting as described in D.S.M. III~~:

a. only present under stressful situation, such as losing one's job, getting divorced, a death in the family. 10 percent;

b. present at all times but not significantly impairing ability to relate to others, live with others, or perform self cares. 30 percent;

c. present at all times in moderate to severe degree significantly affecting ability to live with others, and requiring some supervision. 65 percent;

d. severe degree of emotional disturbance which, because of danger to self or others, requires continuous supervision. 95 percent.

6. Consciousness disturbances; permanent partial disability of the whole body is as set forth below:

a. mild or intermittent decreased level of consciousness manifested by periodic mild confusion or lethargy, a score of ~~3 or 4~~ 16 to 28 on the Kenny scale. 40 percent;

b. moderate intermittent or continuous decreased level of consciousness manifested by a moderate level of confusion or lethargy, and a score of ~~2~~ 10 to 16 on the Kenny scale. 70 percent;

c. severe decreased level of consciousness manifested as stupor with inability to function independently, and a score of ~~1 or~~ 0 to 10 on the Kenny scale. 95 percent;

d. ~~persistent. comatose state. manifest by absence of any response to environmental stimuli~~ comatose or persistent vegetative state. 99 percent.

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7. ~~Paralysis of one side of body: permanent partial disability due to paralysis of one side of body is disability of the whole body as set forth below:~~

~~a. mild paresis or spasticity involving upper, lower, or both extremities on one side only, resulting in some difficulties in function, and a score of 3 or 4 on the Kenny scale. 20 percent:~~

~~b. moderate degree of spasticity or paresis affecting upper, lower, or both extremities on one side only, and a score of 3 on the Kenny scale. 40 percent:~~

~~c. moderately severe paresis and spasticity involving lower extremity and upper extremity, and a score of 2 on the Kenny scale. 75 percent:~~

~~d. severe hemiparesis and spasticity, and a score of 1 or 0 on the Kenny scale. 90 percent.~~ Motor dysfunction, movement disorder, paralysis, spasticity, sensory loss, or neglect. Where these impairments are due to brain or brain stem injury, rate as provided in H.1. and 2.

8. Other impairments: impairments of respiration, urinary bladder function, anorectal function, or sexual function due to brain or brain stem injury are rated as provided in H.3.-6.

~~8.~~ 9. Epilepsy: permanent partial disability due to epilepsy is a disability of the whole body as set forth below:

a. well controlled, on medication for one year or more, able to enter work force but with restrictions preventing operation of motor vehicles or dangerous machinery and climbing above six feet in height, 10 percent;

b. seizures occurring at least once a year, but not severely limiting ability to live independently, 20 percent;

c. seizures occurring at least six times per year, some supervision required, 40 percent;

d. seizures poorly controlled with at least 15 seizures per year, supervision required, protective care required with activities restricted, 75 percent;

e. frequency of seizures requires continuous supervision and protective care, activities restricted, unable to perform self cares, 95 percent.

~~9.~~ 10. Headaches: permanent partial disability due to vascular headaches with nausea or vomiting is a five percent disability of the whole body.

8 MCAR § 1.9007 [Temporary] Musculo-skeletal schedule; back.

A. Lumbar spine. The spine rating is inclusive of leg symptoms except for gross motor weakness, bladder or bowel dysfunction, or sexual dysfunction. Permanent partial disability of the lumbar spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

~~a. Subjective symptoms of pain not substantiated by demonstrable structural pathology. 0 percent.~~

~~b. For (1) (6), chronic muscle spasm, rigidity (loss of motion or postural abnormality), and pain are present, and each is substantiated by objective clinical findings.~~

~~(1) demonstrable degenerative changes, such as small osteophytes, are revealed by X-ray; involvement of single vertebral level: 3.5 percent:~~

~~(2) demonstrable degenerative changes, such as small osteophytes, are revealed by X-ray; involvement of multiple vertebral levels: 7 percent:~~

~~(3) demonstrable degenerative changes, such as large osteophytes, are revealed by X-ray; involvement of multiple vertebral levels: 10.5 percent:~~

~~(4) demonstrable degenerative changes, such as spondylolysis or spondylolisthesis grade 1 or 2, are revealed by X-ray; no previous surgery for treatment: 14 percent:~~

~~(5) demonstrable degenerative changes, such as spondylolysis or spondylolisthesis grade 3 or 4, are revealed by X-ray; no previous surgery for treatment; without fusion surgery; 24.5 percent:~~

~~(6) demonstrable degenerative changes revealed by X-ray, spinal fusion surgery for single vertebral level with or without a laminectomy, after surgery pain is moderated. 17.5 percent.~~

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle

spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

d. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings.

(1) Spondylolisthesis grade I, no surgery, 7 percent.

(2) Spondylolisthesis grade II, no surgery, 14 percent.

(3) Spondylolisthesis grade III or IV, without fusion, 24.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. back and specific radicular pain present with objective neurologic findings~~, computer~~; and X-ray or computerized axial tomography~~, X-ray or electromyelogram~~ or myelogram specifically positive~~,~~ for herniated disc; and no surgery is performed for treatment, 14 percent;

b. condition treated by surgery:

(1) surgery or chemonucleolysis with excellent results such as mild low back pain, no leg pain, and no neurologic deficit, 9 percent;

(2) surgery or chemonucleolysis with average results such as mild increase in symptoms with bending or lifting, and mild to moderate restriction of activities related to back and leg pain, ~~14~~ 11 percent;

(3) surgery or chemonucleolysis with poor surgical results such as persistent or increased symptoms with bending or lifting, and major restriction of activities because of back and leg pain, ~~21~~ 13 percent;

(4) multiple operations on low back with poor surgical results such as persisting or increased symptoms of back and leg pain, ~~28~~ 15 percent;

c. recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery or chemonucleolysis, add five percent to b.(1)-(4);

d. herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

3. Spinal stenosis, central or lateral, proven by ~~computer~~ computerized axial tomography or myelogram:

a. mild symptoms such as occasional back pain with athletic activities or repetitive bending or lifting, leg pain with radicular symptoms, one vertebral level and no surgery, 14 percent;

b. severe spinal stenosis with bilateral leg pain requiring decompressive laminectomy, single vertebral level, with or without surgery (if multiple vertebral levels, add five percent per vertebral level), 18 percent.

4. Fusion surgery. ~~Single vertebral level for degenerative disease, add five percent per additional vertebral levels, 17.5 percent~~ Spinal fusion surgery for single vertebral level with or without laminectomy, 17.5 percent. Add five percent for each additional vertebral level.

5. Fractures:

a. ~~vertebral compression with a decrease of 25 percent or less in vertebral height, 10.5 percent;~~

~~b. vertebral compression fracture, with a decrease of more than 25 percent in vertebral heights, 15 percent;~~

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~~c.~~ vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, ~~14~~ 10.5 percent;

~~d.~~ b. vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, ~~19~~ 15 percent;

~~e.~~ c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent radicular pain, ~~with mild motor and sensory manifestations, 17.5~~ 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

~~f.~~ d. severe dislocation~~, normal reduction with surgical fusion~~:

(1) ~~no residual motor or sensory changes, 17.5~~ normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular pain, ~~motor involvement, mild weakness and numbness, 24.5~~ 17.5 percent;

~~(3) poor reduction with fusion, persistent radicular pain, motor involvement, mild weakness and numbness with partial paralysis as defined in 8 MCAR § 1.9006 [Temporary] H.1.b., 30 percent.~~

B. Cervical spine. ~~For the permanent partial disability of cervical spine, the disability of the whole body is as follows:~~

~~1. Healed sprain, strain, or contusion:~~

~~a. subjective symptoms of pain not substantiated by demonstrable structural pathology, 0 percent;~~

~~b. chronic muscle spasm, rigidity (loss of motion or postural abnormality), and pain, each substantiated by objective clinical findings; loss of anterior curve revealed by X-ray, although no demonstrable structural pathology; moderate referred shoulder and arm pain, 7 percent;~~

~~c. same as b. but with gross degenerative changes consisting of narrowing of intervertebral spaces and small osteophytes at the vertebral margins, 14 percent.~~ The spine rating is inclusive of arm symptoms except for gross motor weakness; sensory loss; and bladder, bowel, or sexual dysfunction. Bladder, bowel, or sexual dysfunction must be rated as provided in 8 MCAR § 1.9006 H. Permanent partial disability of the cervical spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings but without associated demonstrable degenerative changes, 3.5 percent.

c. Pain associated with rigidity (loss of motion or postural abnormality) or chronic muscle spasm. The chronic muscle spasm or rigidity is substantiated by objective clinical findings and is associated with demonstrable degenerative changes.

(1) Single vertebral level, 7 percent.

(2) Multiple vertebral levels, 10.5 percent.

2. Herniated intervertebral disc, single vertebral level:

a. Neck and specific radicular pain present with objective neurologic findings; and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc; and no surgery is performed for treatment, 14 percent.

b. Condition treated by surgery:

(1) Surgery with excellent results such as mild neck pain, no arm pain, and no neurologic deficit, 9 percent.

(2) Surgery with average results such as mild increase in symptoms with neck motion or lifting, and mild to moderate restriction of activities related to neck and arm pain, 11 percent.

(3) Surgery with poor surgical results such as persistent or increased symptoms with neck motion or lifting, and major restriction of activities because of neck and arm pain, 13 percent.

(4) Multiple operations on neck with poor surgical results such as persisting or increased symptoms of neck and arm pain. 15 percent.

c. Recurrent herniated intervertebral disc, occurring to same vertebral level previously treated with surgery, add five percent to b.(1)-(4).

d. Herniated intervertebral disc at a new vertebral level other than the previously treated herniated intervertebral disc, calculate rating the same as a. and b.

d. Spinal stenosis, proven by computerized axial tomography or myelogram.

a. With myelopathy verified by objective neurologic findings, no loss of function, 14 percent.

b. Loss of function. Rate as provided in 8 MCAR § 1.9006H.

4. Fusion surgery. Anterior or posterior. Fusion of a single vertebral level with or without a laminectomy, 11.5 percent. Add five percent for each additional vertebral level.

~~2.~~ 5. Fracture:

a. vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 14 percent;

b. vertebral compression with a decrease of more than 25 percent of vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, loss of motion in the neck in all planes, approximately 50 percent normal range of motion in neck with pain, 19 percent;

c. vertebral fracture with involvement of posterior elements with X-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent;

(2) with persistent pain, ~~with partial motor and sensory loss, 17.5~~ 12 percent;

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent;

d. severe dislocation~~, normal reduction with surgical fusion~~:

(1) ~~no residual motor or sensory changes, 17.5~~ normal reduction with surgical fusion, 12 percent;

(2) poor reduction with fusion, persistent radicular pain, ~~partial motor loss, only slight weakness and numbness, 21.5~~ 17.5 percent;

~~(3) same as (2) with partial paralysis as defined in 8 MCAR § 1.9006 [Temporary] H.1.b., 30 percent.~~

C. ~~Cervical intervertebral disc. For permanent partial disability of cervical intervertebral disc, the disability of the whole body is as follows:~~

~~1. successful surgical removal of disc, with relief of acute pain, no surgical fusion, no neurologic residual, 7 percent;~~

~~2. same as 1. with neurological manifestations such as persistent pain, numbness, weakness in fingers, 14 percent.~~ Thoracic spine. The spine rating is inclusive of all symptoms including radicular gross motor weakness and sensory loss, but excluding spinal cord injury. Permanent partial disability of the thoracic spine is a disability of the whole body as set forth below:

1. Healed sprain, strain, or contusion:

a. Subjective symptoms of pain not substantiated by objective clinical findings or demonstrable degenerative changes, 0 percent.

b. Pain associated with chronic muscle spasm. The chronic muscle spasm is substantiated by objective clinical findings and is associated with demonstrable degenerative changes, single or multiple level, 3.5 percent.

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2. Herniated intervertebral disc, symptomatic:

a. Specific radicular pain present with objective neurologic findings, and x-ray or computerized axial tomography or myelogram specifically positive for herniated disc, and no surgery is performed for treatment, 5 percent.

b. Condition treated by surgery:

(1) Surgery with excellent results such as mild thoracic pain, no radicular pain, and no neurological deficit, 5 percent:

(2) Surgery with poor surgical results such as persistence of increased symptoms with lifting, and major restriction of activities, 10 percent.

3. Fractures:

a. Vertebral compression with a decrease of 25 percent or less in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 10.5 percent.

b. Vertebral compression fracture, with a decrease of more than 25 percent in vertebral height, one or more vertebral segments, no fragmentation, no involvement posterior elements, no nerve root involvement, 15 percent.

c. Vertebral fracture with involvement of posterior elements with x-ray evidence of moderate partial dislocation:

(1) no nerve root involvement, healed, 10.5 percent:

(2) with persistent pain, with mild motor and sensory manifestations, 17.5 percent:

(3) with surgical fusion, healed, no permanent motor or sensory changes, 14 percent.

d. Severe dislocation, normal reduction with surgical fusion:

(1) No residual motor or sensory changes, 12 percent:

(2) Poor reduction with fusion, persistent radicular pain, motor involvement, 17.5 percent:

8 MCAR § 1.9008 [Temporary] Musculo-skeletal schedule; amputations of upper extremity.

A. Permanent partial disability due to amputation of upper extremities is a disability of the whole body as set forth below:

1. forequarter amputation, 70 percent:
2. disarticulation at shoulder joint, 60 percent:
3. amputation of arm above deltoid insertion, 60 percent:
4. amputation of arm between deltoid insertion and elbow joint, 57 percent:
5. disarticulation at elbow joint, 57 percent:
6. amputation of forearm below elbow joint proximal to insertion of biceps tendon, 57 percent:
7. amputation of forearm below elbow joint distal to insertion of biceps tendon, 54 percent:
8. disarticulation at wrist joint, 54 percent:
9. midcarpal or midmetacarpal amputation of hand, 54 percent:
10. amputation of all fingers except thumb at metacarpophalangeal joints, 32.5 percent:
11. amputation of thumb:
    a. at metacarpophalangeal joint or with resection of metacarpal bone, 21.5 percent:
    b. at interphalangeal joint or through proximal phalynx, 16 percent:
    c. from interphalangeal joint to midportion distal phalynx, 13 percent:
12. amputation of index finger:
    a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 13.5 percent:
    b. at proximal interphalangeal joint or through middle phalynx, 11 percent:
    c. at distal interphalangeal joint to middistal phalynx, 5 percent:

d. from middistal phalynx, distal, 2.5 percent;

13. amputation of middle finger:
    a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 11 percent;
    b. at proximal interphalangeal joint or through middle phalynx, 9 percent;
    c. at distal interphalangeal joint to middistal phalynx, 5 percent;
    d. from middistal phalynx, distal, 2.5 percent;
14. amputation of ring finger:
    a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 5.5 percent;
    b. at proximal interphalangeal joint or through middle phalynx, 4 percent;
    c. at distal interphalangeal joint to middistal phalynx, 3 percent;
    d. from middistal phalynx, distal, 1.5 percent;
15. amputation of little finger:
    a. at metacarpophalangeal joint or with resection of metacarpal bone or through proximal phalynx, 3 percent;
    b. at proximal interphalangeal joint or through middle phalynx, 2 percent;
    c. at distal interphalangeal joint to middistal phalynx, 1 percent;
    d. from middistal phalynx, distal, 0.5 percent.

8 MCAR § 1.9009 [Temporary] Musculo-skeletal schedule; sensory loss, upper extremities.

A. General. For sensory loss to the upper extremities resulting from ~~peripheral~~ nerve injury, the disability of the whole body is set forth in B.-D. For the portion of the body described in ~~the category~~ B., there must be a total loss of the sensory function.

B. Sensory loss, complete:
1. median function at wrist, ~~32.5~~ 22.5 percent;
2. ulnar function at wrist, 11 percent;
3. radial function at wrist, 5.5 percent;
4. medial antebrachial cutaneous, 3 percent;
5. medial brachial cutaneous, 3 percent;
6. loss of thumb, whole, 11 percent;
    a. radial digital nerve, 4 percent;
    b. ulnar digital nerve, 6.5 percent;
7. index finger, whole, 5.5 percent;
    a. radial digital nerve, whole, 3.5 percent;
    b. ulnar digital nerve, 2 percent;
8. long finger, whole, 5.5 percent;
    a. radial digital nerve, 3.5 percent;
    b. ulnar digital nerve, 2 percent;
9. ring finger, whole, 3 percent;
    a. radial digital nerve, 2 percent;
    b. ulnar digital nerve, 1 percent;
10. little finger, whole, 3 percent;

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a. radial digital nerve. 1 percent:

b. ulnar digital nerve. 2 percent:

11. sensory loss distal to proximal interphalangeal joint. 50 percent of the value of entire digital nerve as set forth in B., either radial or ulnar as applicable:

12. sensory loss distal to one-half distal phalanx. 25 percent of entire digital nerve as set forth in B.

C. Quality of sensory loss in the hand. The levels of sensory loss and the corresponding disabilities of the whole body are measured as follows:

1. minimal. 2-point discrimination at 6 millimeters or less. 0 percent;

2. moderate. 2-point discrimination greater than 6 millimeters. ½ of value in B.;

3. severe. 2-point discrimination at greater than 10 millimeters. ¾ of value in B.;

4. total. 2-point discrimination at greater than 15 millimeters. same value as in B.

D. Causalgia. When objective medical evidence shows persistent causalgia despite treatment, there is loss of sensory and motor function, loss of joint function, and inability to use the extremity in any useful manner. The permanent partial disability to the member, rating from the most proximal joint involved, and the percentage disability of the whole body is 50 percent of that set forth in 8 MCAR § 1.9008 [Temporary] A.1.-15.

8 MCAR § 1.9010 [Temporary] Musculo-skeletal schedule; motor loss or motor and sensory loss, upper extremities.

A. ~~General. Permanent partial disability due to motor loss of the upper extremities is a disability of the whole body as set forth in B. C.~~ Total or complete loss. Total or complete loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is:

~~B.~~ 1. Motor loss, complete:

~~1.~~ a. median nerve above mid forearm. 30 percent;

~~2.~~ b. median nerve below mid forearm. 19 percent;

~~3.~~ c. radial nerve. 19 percent;

~~4.~~ d. ulnar nerve above mid forearm. 19 percent;

~~5.~~ e. ulnar nerve below mid forearm. 13.5 percent.

~~C.~~ 2. Complete motor and sensory loss:

~~1.~~ a. median nerve above mid forearm. 40.5 percent;

~~2.~~ b. median nerve below mid forearm. 35 percent;

~~3.~~ c. radial nerve. 27 percent;

~~4.~~ d. ulnar nerve above mid forearm. 21.5 percent;

~~5.~~ e. ulnar nerve below mid forearm. 16 percent.

~~D.~~ 3. Complete loss of motor function:

~~1.~~ a. brachial plexus complete. 60 percent:

~~a.~~ (1) upper trunk C5-6. 47 percent:

~~b.~~ (2) mid trunk C7. 23 percent:

~~c.~~ (3) lower trunk C8-T1. 46 percent:

~~2.~~ b. anterior thoracic. 3 percent:

~~3.~~ c. axillary nerve. 23 percent:

~~4.~~ d. dorsal scapular. 3 percent:

~~5.~~ e. long thoracic. 9 percent:

~~6.~~ f. musculo cutaneous. 17.5 percent:

~~7.~~ g. subscapular. 3 percent:

~~8.~~ h. suprascapular. 11.5 percent:

~~9.~~ i. thoraco dorsal, 6 percent.

4. Complete loss of function, motor and sensory:

a. C-5 root, 11 percent;

b. C-6 root, 12 percent;

c. C-7 root, 11 percent;

d. C-8 root, 13 percent.

B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity, and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-4.

8 MCAR § 1.9011 [Temporary] Musculo-skeletal schedule; shoulder.

A. General. For permanent partial disability to the shoulder, disability of the whole body is as set forth in B.-C.:

B. Range of motion:

1. total ankylosis in optimum position, abduction 60 degrees, flexion ten degrees, rotation, neutral position, 30 percent;

2. total ankylosis in mal-position, grade upward to 50 percent;

3. mild limitation of motion: no abduction beyond 90 degrees, rotation no more than 40 degrees with full flexion and extension, 3 percent;

4. moderate limitation of motion: no abduction beyond 60 degrees, rotation no more than 20 degrees, with flexion and extension limited to 30 degrees, 12 percent;

5. severe limitation of motion: no abduction beyond 25 degrees, rotation no more than ten degrees, flexion and extension limited to 20 degrees, 30 percent;

C. Procedures or conditions:

1. acromio-clavicular separation of the following severity:

a. grade 1, 0 percent;

b. grade 2, 3 percent;

c. grade 3, 6 percent.

2. anterior or posterior shoulder dislocation, no surgery, single episode, 3 percent.

3. recurrent dislocation, at least three times in six months, 10 percent.

4. repair recurrent shoulder dislocation, no loss of motion, 6 percent.

5. resection distal end of clavicle, 3 percent.

6. humeral shaft fracture, normal range of motion both joints, 0 percent.

7. humeral shaft fracture, open reduction, mild restriction of shoulder and elbow motion, 6 percent.

8. surgical neck fracture, healed, mild loss of motion, 0 percent.

9. greater tuberosity fracture, mild loss of motion, mild pain on abduction, 2 percent.

8 MCAR § 1.9012 [Temporary] Musculo-skeletal schedule; elbow.

A. General. Permanent partial disability of the elbow is disability of the whole body as set forth in B.-C.

B. Range of motion. Flexion and extension of forearm is 85 percent of the arm. Rotation of the forearm is 15 percent of the arm.

1. Total ankylosis in optimum position approximating midway between 90 degrees flexion and 180 degrees extension, a 45-degree angle, 30 percent.

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2. Total ankylosis in mal-position. 40 percent.

3. Limitation of motion:

a. mild. motion limited from ten degrees flexion to 100 degrees of further flexion. 6 percent:

b. moderate. motion limited from 20 degrees flexion to 75 degrees of further flexion. 12 percent:

c. severe. motion limited from 45 degrees flexion to 90 degrees of further flexion. 21 percent:

4. Flail elbow. pseudarthrosis above joint line. wide motion but very unstable. 39 percent.

5. Resection head of radius. 9 percent.

C. Procedures or conditions:

1. radial or ulnar shaft fracture. full motion. 0 percent:

2. radial or ulnar fracture. open reduction. mild limitation of motion as defined in B.3. 9 percent:

3. olecranon fracture. no loss of motion. 0 percent:

4. olecranon fracture. open reduction internal fixation. mild limitation of motion as defined in B.3.. 6 percent:

5. epicondylar fracture. no loss of motion. 0 percent:

6. epicondylar fracture. mild loss of motion as defined in B.3.. 6 percent:

7. release medial or lateral epicondyle. 2 percent:

8. ulnar nerve transposition. 2 percent.

8 MCAR § 1.9013 [Temporary] Musculo-skeletal schedule; wrist.

A. General. Permanent partial disability of wrist is disability of the whole body as set in B.-C.

B. Range of motion:

1. excision distal end of ulna. flexion and extension credited with 75 percent of hand. and rotation 25 percent of hand. 5 percent:

2. total ankylosis in optimum position. 19 percent:

3. total ankylosis in mal-position of extreme flexion or extension. 25 percent:

4. limitation of motion:

a. mild. rotation normal. loss of 15 degrees palmar flexion and loss of 20 degrees dorsiflexion. 5 percent:

b. moderate. rotation limited to 60 degrees in pronation-supination. loss of 25 degrees palmar flexion. loss of 30 degrees dorsiflexion. 10 percent:

c. severe. rotation limited to 30 degrees in pronation-supination. palmer flexion less than 25 degrees. dorsi-flexion less than 30 degrees. 15 percent.

C. Procedure or conditions.

1. Colles/Smith. extraarticular:

a. no loss of motion. 0 percent:

b. mild loss of motion as defined in B.4.a.. 3 percent.

2. Colles/Smith/Barton. intraarticular.

a. no loss of motion. 0 percent:

b. mild loss of motion as defined in B.4.a.. 6 percent:

c. moderate loss of motion as defined in B.4.b.. 10 percent.

3. Carpal bone fracture. no loss of motion. 3 percent.

4. Carpal dislocation. mild loss of motion as defined in B.4.a.. 6 percent.

5. Carpal tunnel release. 0.5 percent.

6. Carpal tunnel release with moderate paresthesias. 3 percent.

7. DeQuervain's release. 0 percent.

8. Ganglion excision. 0 percent.

9. Scaphoid graft. 3 percent.

8 MCAR § 1.9014 [Temporary] Musculo-skeletal schedule, fingers.

A. General. Permanent partial disability of fingers is a disability of the whole body as set forth in B.-C.

B. Ankylosis of joints.

1. Any digit, excluding the thumb.

a. Total ankylosis of distal interphalangeal joint:

(1) optimum position, 4 percent;

(2) mal-position, flexed 35 degrees or more, 5 percent.

b. Total ankylosis of proximal interphalangeal joint:

(1) optimum position, flexed 25 to 40 degrees, 8 percent;

(2) mal-position, any position other than (1) above, 9 percent.

c. Total ankylosis of both distal and proximal interphalangeal joints. If total ankylosis of distal and proximal interphalangeal joints occurs, calculate disability according to a., and then add c. (1) or (2) as appropriate:

(1) optimum position, 1 percent;

(2) mal-position, 2 percent.

d. Total ankylosis metacarpophalangeal joint:

(1) optimum position, 35-50 degree flexion; 0.5 percent;

(2) mal-position, any position other than (1), 1 percent.

e. Total ankylosis both interphalangeal joints and metacarpophalangeal joint, add an additional 2 percent.

2. Thumb.

a. Total ankylosis interphalangeal joint:

(1) optimum position, 0 to 15 degrees, 1 percent;

(2) mal-position, flexion greater than 15 degrees, 2 percent.

b. Total ankylosis metacarpophalangeal joint:

(1) optimum position, up to 25 degree flexion, 1 percent;

(2) mal-position, flexion greater than 5 degrees, 2 percent.

c. Total ankylosis both interphalangeal and metacarpophalangeal joints:

(1) optimum position, 4 percent;

(2) mal-position, 5 percent.

d. Total ankylosis carpometacarpal joint alone:

(1) optimum position, 4 percent;

(2) mal-position, 8 percent.

e. Total ankylosis interphalangeal, metacarpophalangeal, and carpometacarpophalangeal joints:

(1) optimum position, 21 percent;

(2) mal-position, 23 percent.

3. Limitation of motion, fingers and thumb:

a. mild, total closing motion tip of digit, can flex to touch palm and thumb, and extend to 15 degrees flexion, strength of grip normal, 3 percent;

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b. moderate. total closing motion. tip of digit. lacks ½ inch of touching palm and can extend to 30 degrees flexion. 6 percent:

c. severe. total closing motion tip of digit lacks one inch of touching palm and can extend to 45 degrees flexion. 9 percent:

d. soft tissue loss. isolated soft tissue loss of the end of digit. 20 percent of the disability to the whole body for amputation of that digit as set forth at 8 MCAR § 1.9009 [Temporary] A.1.-19.

B. Procedures or conditions:

1. release of trigger finger or thumb. 0 percent:
2. release of Guyon's Canal. 0 percent:
3. Boutonniere repair. 3 percent:
4. extensor tendon repair. 0 percent.

8 MCAR § 1.9015 [Temporary] Musculo-skeletal schedule; amputations of lower extremities.

For permanent partial disability due to amputation of lower extremities the disability of the whole body is:

1. hemipelvectomy. 50 percent:
2. disarticulation at hip joint. 40 percent:
3. amputation above knee joint with short thigh stump. 3 inch or less below tuberosity of ischium. 40 percent:
4. amputation above knee joint with functional stump. 36 percent:
5. disarticulation at knee joint. 36 percent:
6. amputation below knee joint with short stump. 3 inch or less below intercondular notch. 36 percent:
7. amputation below knee joint with functional stump. 28 percent:
8. amputation at ankle. Syme type. 28 percent:
9. partial amputation of foot. Chopart's type. 21 percent:
10. mid-metatarsal amputation. 14 percent:
11. amputation of all toes at metatarsophalangeal joints. 8 percent:
12. amputation of great toe:
    a. with resection of metatarsal bone. 8 percent:
    b. at metatarsophalangeal joint. 5 percent:
    c. at interphalangeal joint. 4 percent:
13. amputation of lesser toe. 2nd-5th:
    a. with resection of metatarsal bone. 2 percent:
    b. at metatarsophalangeal joint. 1 percent:
    c. at proximal interphalangeal joint. 0 percent:
    d. at distal interphalangeal joint. 0 percent.

8 MCAR § 1.9016 [Temporary] Musculo-skeletal schedule; ~~sensory loss~~ nerve injury or motor and sensory loss, lower extremities.

~~For sensory loss to the lower extremeities resulting from nerve injury, and where there is total loss of the sensory function for those particular portions of the body, the disability of the whole body is~~

A. Total loss. Total loss means that motor function is less than anti-gravity and there is complete loss of sensation. For loss to the lower extremities resulting from nerve injury, and where there is total loss of function for those particular portions of the body, the disability of the whole body is:

1. femoral. anterior crural. 13 percent:
2. femoral. anterior crural. below iliacus nerve. 11 percent:
3. genitofemoral. genito crural. 2 percent:
4. inferior gluteal. 9 percent:

5. lateral femoral cutaneous. 3 percent:

6. ~~obturator. 3 percent:~~

~~7.~~ posterior cutaneous of thigh. 2 percent:

~~8.~~ 7. superior gluteal. 7 percent:

~~9.~~ 8. sciatic. above hamstring innervation. 31 percent:

~~10.~~ 9. common peroneal. lateral. or external popliteal. 13 percent:

~~11.~~ 10. deep peroneal. above midshin. 9 percent:

~~12.~~ 11. deep peroneal. below midshin. anterior tibial. 2 percent:

~~13.~~ 12. superficial peroneal. 5 percent:

~~14.~~ 13. tibial nerve. medial. or internal popliteal:

a. above knee. 15 percent:

b. posterior tibial. midcalf and knee. 11 percent:

c. below midcalf. 9 percent:

d. lateral plantar branch. 3 percent:

e. medial plantar branch. 3 percent:

~~15.~~ 14. sural. external saphenous. 1 percent:

15. L-4 nerve root. 11 percent:

16. L-5 nerve root. 13 percent:

17. S-1 nerve root. 15 percent:

18. Lumbosacral plexus. 40 percent.

B. Partial loss. Partial loss means that motor function is less than normal but greater than anti-gravity. and there is incomplete sensory loss. Partial loss is rated at 25 percent of the percentages assigned at A.1.-18.

8 MCAR § 1.9017 [Temporary] Musculo-skeletal schedule; joints.

A. General. For permanent partial disability of joints. disability of the whole body is set forth in B.-I.

B. Surgical or traumatic shortening of lower extremity.

1. ¼ inch to ¾ inch. 3 percent:

2. ¾ to 1¼ inches. 4.5 percent:

3. 1¼ to 1¾ inches. 6 percent:

4. 1¾ inches and above. 9 percent:

C. Hip.

1. range of motion.

a. limitation of motion:

(1) mild. anterior posterior movement from 0 degree to 120 degree flexion. rotation and lateral motion. abduction. adduction free to 50 percent of normal. 6 percent:

(2) moderate. anterior posterior motion from 15 degrees flexion deformity to 110 degrees further flexion. rotation. lateral motion. abduction. and adduction free to 25 percent normal. 12 percent:

(3) severe. anterior posterior motion from 30 degrees flexion deformity to 90 degrees further flexion. 22 percent.

2. Procedures or conditions:

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a. nonunion proximal femur fracture without reconstruction, 33 percent;

b. arthroplasty, able to stand at work and walk, motion 25 percent to 50 percent of normal, 18 percent;

c. total hip arthroplasty, normal result, 13 percent;

d. femoral endoprosthesis:

(1) minimal pain, near normal range of motion, able to walk unsupported, 15 percent;

(2) mild to moderate pain with weight bearing, motion 50 percent of normal, 20 percent;

e. hip pinning for fracture.

(1) minimal pain, near normal range of motion, able to walk unsupported, 5 percent;

(2) mild to moderate pain, motion 50 percent of normal, 10 percent.

D. Femur:

1. shaft fracture, closed, healed, 0 percent;

2. femoral shaft fracture, open reduction, loss of less than 20 degrees of movement of any one plane of either the hip or the knee, no malalignment, 2 percent.

E. Knee:

1. Range of motion.

a. ankylosis and limited motion, total ankylosis optimum position, 15 degrees flexion, 22 percent;

b. limitation of motion:

(1) mild, 0 degrees to at least 110 degrees flexion, 2 percent;

(2) moderate, 5 degrees to at least 80 degrees flexion, 7 percent;

(3) severe, 5 degrees to at least 60 degrees flexion, 15 percent;

(4) extremely severe, limited from 15 degrees flexion deformity with further flexion to 90 degree, 18 percent.

2. Procedures or conditions:

a. surgical removal of medial or lateral semilunar cartilage, no complications, 3 percent;

b. surgical removal both cartilages, 9 percent;

c. ruptured cruciate ligament, repaired or unrepaired:

(1) mild laxity, 3 percent;

(2) moderate laxity, 7 percent;

(3) severe laxity, 10 percent;

d. excision of patella, 9 percent;

e. plateau fracture, depressed bone elevated, semilunar excised, 9 percent;

f. plateau fracture, undisplaced, 2 percent;

g. supracondylar or intercondylar fracture, displaced, 7 percent;

h. supracondylar or intercondylar fracture, undisplaced, 2 percent;

i. patella fracture, open reduction or partial patellectomy, displaced, 5 percent;

j. patella fracture, open reduction or partial patellectomy, undisplaced, 2 percent;

k. arthroscopy, 0 percent;

l. repair collateral ligament, mild laxity, 2 percent;

m. repair collateral ligament, moderate laxity, 4 percent;

n. repair patellar dislocation, 5 percent;

o. total knee arthroplasty, flexion to 90 degrees, extension to 0 degrees, 13 percent;

p. total knee unicondylar, 7 percent;

q. lateral retinacular release, 1 percent;

n. proximal tibial osteotomy, flexion to 90 degrees, extension to 0 degrees, 5 percent.

F. Tibia:

1. tibial shaft fracture, undisplaced, healed, normal motion and alignment, 0 percent;

2. tibial shaft fracture, open reduction, loss of less than 20 degrees of movement in any one plane in either the knee or the ankle with full knee extension, no malalignment, 5 percent.

G. Ankle and foot.

1. Range of motion:

a. total ankylosis ankle and foot, pantalar arthrodesis:

(1) in 10 degrees plantgar flexion, 15 percent;

(2) mal-position 30 degrees plantar flexion, 20 percent;

b. ankylosis of foot, subtalar or triple arthrodesis tarsal bones, ankle, normal motion, 7.5 percent;

(1) decreased motion, subtalar joint, 3.5 percent;

(2) ankylosis in mal-position, 8 percent;

c. ankylosis of tibia and talus, subtalar joints free, optimum position 15 degrees plantar flexion, 12 percent;

d. limitation of motion in the ankle:

(1) mild, motion limited from position of 90 degrees right angle to 20 degrees plantar flexion, 3 percent;

(2) moderate, motion limited from position of 10 degrees flexion to 20 degrees plantar flexion, 6 percent;

(3) severe, motion limited from position of 20 degrees plantar flexion to 30 degrees plantar flexion, 12 percent.

2. Procedures or conditions:

a. achilles tendon rupture with treatment surgically or nonsurgically, able to stand on toes, 2 percent;

b. achilles tendon rupture with treatment surgically or nonsurgically, unable to sustain body weight on toes, 4 percent;

c. open reduction ankle:

(1) normal range of motion:

(a) medial malleolus only, 2 percent;

(b) lateral malleolus only, 2 percent;

(2) mild restriction on range of motion:

(a) medial and lateral malleolus, 4 percent;

(b) trimalleolar, 4 percent;

d. ankle, lateral ligament reconstruction, mild laxity, normal range of motion, 2 percent.

H. Foot.

1. Range of motion:

a. ankylosis of tarsal metatarsal or mild tarsal joints:

(1) normal position, 2.5 percent;

(2) mal-position, 5 percent;

b. limited motion in the foot:

(1) mild, limited motion with mild pain with weight bearing, no change in activities, 2.5 percent;

(2) moderate, limitation of motion with pain with weight bearing, no reduction in athletic or vigorous activities, 5 percent;

(3) severe, limitation of motion with pain with weight bearing, sedentary activities not affected, 10 percent;

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2. Procedures or conditions:

a. calcaneal fracture, extra articular, pain with weight bearing, 6 percent:

b. calcaneal fracture, intra articular:

(1) mild limitation of motion as in 1.b.(1), 6 percent:

(2) moderate limitation of motion as in 1.b.(2), 12 percent:

(3) severe limitation of motion as in 1.b.(3), 18 percent:

c. avascular necrosis talus:

(1) mild limitation of motion as in 1.b.(1), 6 percent:

(2) moderate limitation of motion as in 1.b.(2), 12 percent:

(3) severe limitation of motion as in 1.b.(3), 18 percent:

d. tarsal fractures, healed, mild pain, 3 percent:

e. metatarsal fractures, healed, 0 percent:

f. phalyngeal fractures, healed, 0 percent.

I. Toes.

1. complete ankylosis of metatarsophalangeal joint, any toe, 3 percent:

2. complete ankylosis any toe, interphalangeal joint, optimum position semi-flexion, 1 percent.

8 MCAR § 1.9018 [Temporary] Respiratory system.

A. Evaluation procedures. The procedures used in evaluating permanent partial disability of the respiratory system shall include the following:

1. complete history and physical examination with special reference to cardiopulmonary symptoms and signs;

2. chest roentgenography (posteroanterior in full inspiration, posteroanterior in full expiration timed, three seconds, lateral):

3. hematocrit or hemoglobin determination:

4. electrocardiogram:

5. performance of ~~not less than two of~~ the following tests of ventilation:

a. ~~one second forced expiratory volume:~~

~~b. forced vital capacity:~~

~~c. forced expiratory volume (FEV)/forced vital capacity (FVC) ratio expressed as a percentage: and~~ one second forced expiratory volume (FEV1), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 69 and 71;

b. forced vital capacity (FVC), expressed as a percentage of the normal values set forth in the A.M.A. Guides, pages 70 and 72.

6. ~~at least one pulmonary function test, such as a diffusing capacity study~~ diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits.

B. Measurement of respiratory loss of function. Table I shall be used to calculate the percentage of disability of the whole body due to permanent partial disability of the respiratory system.

TABLE I

	Forced Spirometry Measurements ~~$FEV_{1.0}$ FVC FEV_1/FVC%~~ ½(FEV1 + FVC) (Test three times)	Diffusing Capacity*	Percent Disability of Whole Body
Symptoms			
When dyspnea occurs, is consistent with the circumstances of activity.	Not less than 85 percent of normal	Not Applicable	0

Dyspnea does not occur at rest and seldom occurs during the performance of the usual activities of daily living.	70 to 85 percent of normal	Not Applicable	15
Dyspnea does not occur at rest but does occur during the usual activities of daily living.	50 to 70 percent of normal	Usually Not Applicable	30
Dyspnea occurs during activities such as climbing one flight of stairs or walking one block on the level.	25 to 50 percent of ~~predicted~~ normal	40 percent or less of normal	60
Confined to bed and oxygen dependent.	Less than 25 percent of normal	20 percent or less of normal	85

*The diffusing capacity studies must be performed when complaints of dyspnea continue unabated in spite of forced spirometric measurement results above the cut-off limits set forth in Table 1.

C. Asthma. Asthma which is not medically controllable and which requires at least six hospitalizations in 12 months. 25 percent.

8 MCAR § 1.9019 [Temporary] Organic heart disease.

A. General. For permanent partial disability due to organic heart disease, the disability of the whole body is set forth in B.

B. Heart ratings. The following ratings may be applied only after a compilation of a patient's complete history and a physical examination. Testing must include chest X-ray and electrocardiogram. The testing may include echocardiography, exercise testing, and radionuclide studies.

The following table sets forth symptoms of organic heart disease. The percentage of disability of the whole body is determined by the symptoms present.

Organic Heart Disease Schedule

Percentage Disability of Whole Body	10 percent	30 percent	60 percent	85 percent
Organic Heart Disease	Present	Present	Present	Present
Symptoms	Not present	Not present at rest	Not present at rest	Present at rest
Level of activity causing symptoms	No symptoms from usual activities of daily living, including such activities as stair- or hill-climbing, and walking	No symptoms from usual activities of daily living	Symptoms from a one or more block walk or from climbing stairs. Symptoms also from activities of daily living	Worsening of symptoms with any activity

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Level of unusual activity causing symptoms	No symptoms from walking quickly, recreation, hill- or stair-climbing, arm-work, and similar activities	Symptoms from hill- or stair-climbing, walking quickly, arm-work, or recreation	Symptoms from emotional stress, walking quickly, and similar activities	May be present at rest or may awaken patient
Signs of heart failure	No	No	Relieved by therapy	Not usually relieved by therapy
Signs of symptoms of angina	No	With prolonged or severe exertion	With mild exertion	Rest or nocturnal symptoms

8 MCAR § 1.9020 [Temporary] Vascular disease affecting the extremities.

The following schedule shall be used to determine the percentage of disability of the whole body for permanent partial disability due to vascular disease. Permanent partial disability from vascular disease affecting the extremities must be rated according to the following classifications. The system shall be used only after a complete history and physical examination. The full evaluation shall include imaging examination (X-ray with and without contrast, computer axial tomography scanning, sonography, radionuclide studies) volume studies, or flow studies.

Vascular Disease Schedule

Percentage of disability of whole body	0 percent	10 percent	30 percent	60 percent	90 percent
Intermittant claudication distance	No	Approx. one city block	Approx. ¼ city block	Less than ¼ city block	Constant pain
Pain at rest	No	No	No	Sometimes	Constant
Physical signs of diagnosis	None No ulceration	Healed, painless stump, or healed ulcer	Healed stump but persistent signs of activity, or persistent superficial ulcer	Amputation above wrist or ankle with continued sign of disease, or widespread deep ulcer	Amputation above wrist or ankle in more than one limb, or wide, deep ulceration of more than one limb
Edema	Rare and transient	Persistent, incompletely controlled	Very severe and only partially controlled	Marked and uncontrollable	Marked and uncontrollable

8 MCAR § 1.9021 [Temporary] Gastrointestinal tract.

A. General. The following schedule is for the evaluation of permanent partial disability of the gastrointestinal tract. The evaluation must include a thorough history and physical examination. Additional studies, such as radiographic, metabolic, absorptive, endoscopic, and biopsy may be necessary to determine the functioning of these organs. Disability shall not be determined until after completion of all medically accepted diagnostic and therapeutic efforts. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

For evaluative purposes, the digestive tract has been divided into (1) the esophagus, stomach, duodenum, small intestine, and pancreas, (2) the colon and rectum, (3) the anus, and (4) the liver and biliary tract.

B. Upper digestive tract (esophagus, stomach, duodenum, small intestine, and pancreas).

1. Class 1, 2 percent.

a. Symptoms or signs of upper digestive tract disease are present or there is anatomic loss or alteration; continuous treatment is not required; and weight can be maintained at the desirable level; or

b. There are no complications after surgical procedures.

2. Class 2, 15 percent. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; dietary restriction and drugs are required for control of symptoms, signs, or nutritional deficiency; and loss of weight below the desirable weight does not exceed 10 percent.

3. Class 3. 35 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and dietary restrictions and drugs do not completely control symptoms, signs, or nutritional state; or

b. There is 10 to 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder of the upper digestive tract.

4. Class 4. 65 percent.

a. Symptoms and signs of organic upper digestive tract disease are present or there is anatomic loss or alteration; and symptoms are not controlled by treatment; or

b. There is greater than a 20 percent loss of weight below the desirable weight and the weight loss is ascribable to a disorder of the upper digestive tract.

C. Colon and rectum.

1. Class 1. 2 percent:

a. signs and symptoms of chronic or rectal disease are infrequent;

b. limitation of activities, special diet, or medication is not required; no systemic manifestations are present and weight and nutritional state can be maintained at a desirable level; or

c. there are no complications after surgical procedures.

2. Class 2. 15 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration. There are mild gastrointestinal symptoms with intermittent disturbance of bowel function, accompanied by periodic or continual pain. Minimal restriction of diet or mild symptomatic therapy may be necessary. No impairment of nutrition results.

3. Class 3. 30 percent. There is objective evidence of colonic or rectal disease or anatomic loss or alteration; there are moderate to severe exacerbations with disturbance of bowel habit, accompanied by periodic or continual pain; restriction of activity, special diet and drugs are required during attacks; and there are constitutional manifestations such as fever, anemia, or weight loss.

4. Class 4. 50 percent. There is objective evidence of colonic and rectal disease or anatomic loss or alteration; there are persistent disturbances of bowel function present at rest with severe persistent pain; complete limitation of activity, continued restriction of diet, and medication do not entirely control the symptoms; there are constitutional manifestations such as fever, weight loss, or anemia present; and there is no prolonged remission.

D. Anus.

1. Class 1. 2 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; or there is mild incontinence involving gas or liquid stool; or anal symptoms are mild, intermittent, and controlled by treatment.

2. Class 2. 12 percent. Signs of organic anal disease are present or there is anatomic loss or alteration; and moderate but partial fecal incontinence is present requiring continual treatment; or continual anal symptoms are present and incompletely controlled by treatment.

3. Class 3. 22 percent.

a. Signs of organic anal diseases are present and there is anatomic loss or alteration; and complete fecal incontinence is present; or

b. Signs of organic anal disease are present and severe anal symptoms are unresponsive or not amenable to therapy.

E. Liver and biliary tract.

1. Class 1. 5 percent.

a. There is objective evidence of persistent liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate minimal disturbance of the liver function; or

b. Primary disorders of bilirubin metabolism are present.

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2. Class 2. 20 percent. There is objective evidence of chronic liver disease even though no symptoms of liver disease are present; and no history of ascites, jaundice, or bleeding esophageal varices within five years; nutrition and strength are normal; and biochemical studies indicate more severe liver damage than Class 1.

3. Class 3. 40 percent. There is objective evidence of progressive chronic liver disease, or history of jaundice, ascites, or bleeding esophageal or gastric varices within the past year; nutrition and strength may be affected; and there is intermittent ammonia and meat intoxication.

4. Class 4. 75 percent. There is objective evidence of progressive chronic liver disease, or persistent ascites or persistent jaundice or bleeding esophageal or gastric varices, with central nervous system manifestations or hepatic insufficiency; and nutrition state is below normal.

F. Biliary tract.

1. Class 1. 5 percent. There is an occasional episode of biliary tract dysfunction.

2. Class 2. 20 percent. There is recurrent biliary tract impairment irrespective of treatment.

3. Class 3. 40 percent. There is irreparable obstruction of the bile tract with recurrent cholangitis.

4. Class 4. 75 percent. There is persistent jaundice and progressive liver disease due to obstruction of the common bile duct.

8 MCAR § 1.9022 [Temporary] Reproductive and urinary tract schedule.

A. General. This rule sets forth the percentage of disability of the whole body for permanent partial disability of the reproductive and urinary systems. The percentages indicated in this schedule are the disability of the whole body for the corresponding class.

B. Evaluative procedures. For evaluative purposes the reproductive and urinary systems are divided into the: (1) upper urinary tract, (2) bladder, (3) urethra, (4) male reproductive organs, and (5) female reproductive organs.

Procedures for evaluating permanent partial disability of the genitourinary and reproductive systems shall include:

1. a complete history and physical examination with special reference to genitourinary/reproductive symptoms and signs, including psychological evaluation when indicated by the symptoms;

2. laboratory tests to identify the presence or absence of associated disease. The tests may include multi-channel chemistry profile, complete blood count, complete urinalysis, including microscopic examination of centrifuged sediment, chest X-ray, both posterior/anterior and left lateral views, electrocardiogram, performance of a measurement of total renal functions—endogenous creatinine clearance corrected for total body surface area. Other tests may include:

a. kidney function tests, such as arterial blood gases and determinations of other chemistries that would reflect the metabolic effects of decreased kidney function;

b. special examinations such as cystocopy, voiding cystograms, cystometrograms; and

c. a description of the anatomy of the reproduction or urinary system.

~~B.~~ C. Upper urinary tract.

1. Solitary kidney, 10 percent. This category shall apply only when a solitary kidney is the only upper urinary tract permanent partial disability. When a solitary kidney occurs in combination with any one of the following four classes, the disability rating for that class shall be increased by 10 percent.

2. Class 1. 5 percent. Diminution of kidney function as evidenced by a creatinine clearance of 50 to 70 percent of age and sex adjusted normal values, other underlying causes absent.

3. Class 2. 22 percent. Diminution of the upper urinary tract function as evidenced by a creatinine clearance of 40 to 50 percent of age and sex adjusted normal values, no other underlying disease.

4. Class 3. 47 percent. Diminution of upper urinary tract function, as evidenced by creatinine clearance of 25 to 40 percent of age and sex adjusted normal values.

5. Class 4. 77 percent. diminution of upper urinary tract function as evidenced by creatinine clearance below 25 percent of age and sex adjusted normal values.

~~C.~~ D. Bladder.

1. Class 1. 5 percent. Symptoms and signs of bladder disorder requiring intermittent treatment, but without evidence of intervening malfunction between periods of treatments or symptomatology.

2. Class 2. 15 percent. Symptoms and signs of bladder disorder requiring continuous treatment, or there is bladder reflex activity but loss of voluntary control.

3. Class 3. 20 percent. Poor reflex activity evidenced by intermittent dribbling, and no voluntary control.

4. Class 4. 30 percent. Continuous dribbling.

~~D.~~ E. Urethra.

1. Class 1. 2 percent. Symptoms and signs of urethral disorder are present which require intermittent therapy for control.

2. Class 2. 15 percent. Symptoms and signs of urethral disorder that cannot be effectively controlled by treatment.

~~E.~~ F. Penis.

1. Class 1. 10 percent. Impaired sexual function but vaginal penetration is possible.

2. Class 2. 20 percent. Impaired sexual function and vaginal penetration is not possible.

~~F.~~ G. Testes, epididymides, and spermatic cords.

1. Class 1. 5 percent.

a. Symptoms and signs of testicular, epididymal, or spermatic cord disease are present and there is anatomic alteration; and

b. Continuous treatment is not required; and

c. There are no abnormalities of seminal or hormonal functions; or

d. Solitary teste is present.

2. Class 2. 10 percent.

a. Symptoms and signs of testicular, epididymal or spermatic cord disease are present and there is anatomic alteration; and

b. Frequent or continuous treatment is required; and

c. There are detectable seminal or hormonal abnormalities.

3. Class 3. 20 percent. Trauma or disease produces bilateral anatomical loss or there is no detectable seminal or hormonal function of testes, epididymides, or spermatic cords.

~~G.~~ H. Prostate and seminal vesicles.

1. Class 1. 5 percent. ~~A patient belongs in Class 1 when:~~

a. there are symptoms and signs of prostatic or seminal vesicular dysfunction or disease;

b. anatomic alteration is present; and

c. continuous treatment is not required.

2. Class 2. 10 percent.

a. frequent severe symptoms and signs of prostatic or seminal vesicular dysfunction or disease are present; and

b. anatomic alteration is present; and

c. continuous treatment is required.

3. Class 3. 20 percent. There has been ablation of the prostate or seminal vesicles.

~~H.~~ I. Vulva and vagina.

1. Class 1. 10 percent. Impaired sexual function but penile containment is possible.

2. Class 2. 20 percent. Impaired sexual function and penile containment is not possible.

J. Cervix and uterus.

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1. Class 1. 5 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which do not require continuous treatment: or

b. Cervical stenosis, if present, requires no treatment: or

c. There is anatomic loss of the cervix or uterus in the postmenopausal years.

2. Class 2. 10 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which require continuous treatment: or

b. Cervical stenosis, if present, requires periodic treatment.

3. Class 3. 20 percent.

a. Symptoms and signs of disease or deformity of the cervix or uterus are present which are not controlled by treatment: or

b. Cervical stenosis is complete: or

c. Anatomic or complete functional loss of the cervix or uterus occurs in premenopausal years.

K. Fallopian tubes and ovaries.

1. Class 1. 5 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which do not require continuous treatment: or

b. Only one fallopian tube or ovary is functioning in the premenopausal years.

2. Class 2. 10 percent. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present which require continuous treatment, but tubal patency persists and ovulation is possible.

3. Class 3. 20 percent.

a. Symptoms and signs of disease or deformity of the fallopian tubes or ovaries are present and there is total loss of tubal patency or total failure to produce ova in the premenopausal years: or

b. Bilateral loss of the fallopian tubes or ovaries occurs in the premenopausal years.

8 MCAR § 1.9023 [Temporary] Skin disorders.

Permanent partial disability resulting from skin disorders are a disability of the whole body as set forth in this rule. This schedule is based upon the effect of the disorder on the ability to function and perform activities of daily living and the degree of treatment required for the disorder. The schedule is not based upon the location or the percentage of the body affected by a specific skin disorder. Impairment due to burns shall be rated under 8 MCAR § 1.9024 and not under this schedule.

1. Class 1. 2 percent. Signs or symptoms of skin disorder are present and supported by objective skin findings. With treatment there is no or minimal limitation in the performance of the activities of daily living, although certain physical or chemical agents might temporarily increase the extent of limitation.

2. Class 2. 10 percent. Signs and symptoms of skin disorder are present and intermittent treatment is required. There is limitation in the performance of some of the activities of daily living.

3. Class 3. 20 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required. There is limitation in the performance of many of the activities of daily living.

4. Class 4. 45 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which may include periodic confinement at home or other domicile. There is limitation in the performance of many of the activities of daily living.

5. Class 5. 70 percent. Signs and symptoms of skin disorder are present. Continuous treatment is required which necessitates confinement at home or other domicile. There is severe limitation in the performance of nearly all of the activities of daily living.

8 MCAR § 1.9024 [Temporary] Burns.

A. General. The whole body disability due to burns is not equal to the percent of body surface area which is burned. The percentage of body surface area affected must be determined according to Lund and Browder. The ratings determined under A.-D. must be combined as set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c), provided that the

maximum disability to the whole body under this schedule must not exceed 70 percent. Loss of motion or body parts except the face must be rated under the musculoskeletal schedules and must not be considered as included in a rating under this rule unless specifically provided otherwise.

B. Burns other than electrical conduction. A rating under this section is the ratings assigned by the following paragraphs combined as provided in Minnesota Statutes, section 176.105, subdivision 4, clause (c):

1. Any burn that heals within one month and leaves no hypertrophic scar, 0 percent.

2. Cold intolerance of the hands, face, or head as evidenced by the wearing of heavy gloves or additional scarves at 35 degrees Fahrenheit, 10 percent.

3. Heat intolerance is evidenced by fatigue, malaise, nausea, and an oral temperature of at least 100 degrees Fahrenheit upon exposure to an environmental temperature of 90 degrees Fahrenheit at 60 percent relative humidity, 5 percent.

4. Sensitivity to sun exposure as evidenced by the need to cover the skin or use sun screen to prevent sunburn, 10 percent.

5. Sensitivity to dust, chemical, or petroleum exposure; altered sweating; or apocrine gland dysfunction. For one or any combination of these conditions, the whole body disability is:

a. If the sensitivity affects less than 5 percent of the body surface area, 0 percent.

b. If the sensitivity affects 5 to 20 percent of the body surface area, 2 percent.

c. If the sensitivity affects 20 percent or more of the body surface area, 3 percent.

6. Sensory loss due to burns:

a. Loss of sensation on palmar surface of hands shall be rated as provided by 8 MCAR § 1.9009 C.

b. Sensory loss in less than 5 percent of the body surface area, 0 percent.

c. Sensory loss in 5 to 20 percent of the body surface area, 2 percent.

d. Sensory loss in more than 20 percent of the body surface area, 5 percent.

C. Electrical conduction injuries.

1. Associated sensory loss and concommitant thermal injuries must be rated as provided in A.

2. Peripheral nerve deficits must be rated as provided in the musculoskeletal schedule.

The ratings under 1. and 2. must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

D. Cosmetic disfigurement. This section applies to disfigurement on the face, the head, the neck, or the hands due to burns. Where there is surgery, this rating is done after correction by plastic surgery. The final rating under this schedule shall not be done until hypertrophic scarring is matured or more than 24 months after the injury. The ratings under the paragraphs of this section must be combined in the manner set forth at Minnesota Statutes, section 176.105, subdivision 4, clause (c).

1. Face. The face is the anterior head from the forehead, to and including the chin.

a. Loss of facial features:

(1) Deformity of nasal tip or deformity, thinning, or eversion of ala nasi, 5 percent.

(2) Loss of more than 50 percent of nasal cartilage or of both ala nasi, 25 percent.

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b. Eyes:

(1) Loss of one eyebrow, 2.5 percent.

(2) Loss of two eyebrows, 5 percent.

(3) Ectropian unaccompanied by visual impairment:

(a) Lower lid pulled from eye when mouth is opened and neck extended, 5 percent.

(b) Lower lid pulled away with no movement of face or neck, 10 percent.

(c) Cornea unprotected when sleeping, 15 percent.

(4) Epiphora unaccompanied by visual impairment, 10 percent.

c. Mouth. A rating under this paragraph is the arithmetic sum of (1)-(4).

(1) Noncongenital microstomia or distortion affecting eating and dental hygiene, 10 percent.

(2) Eversion of the upper lip, 7.5 percent.

(3) Eversion of the lower lip, 7.5 percent.

(4) Distortion of vermillion border, 10 percent.

d. Ear. Loss of 75 percent or more of one external ear, 5 percent.

e. Hypertrophic scarring of face in areas other than those covered in a.-d.:

(1) Affecting only forehead above the eyebrows, 10 percent.

(2) Affecting the lower face from eyebrows to chin, 25 percent.

(3) Affecting both the forehead above the eyebrows and the lower face from the eyebrows to chin, 35 percent.

f. Wrinkling of face in areas other than those covered in a.-e., one-third of percentages in e.

2. Head, Alopecia:

a. Anterior hairline:

(1) Loss of less than 20 percent of hair on anterior hairline, 0 percent.

(2) Loss of 20 to 50 percent of hair on anterior hairline, 2 percent.

(3) Loss of more than 50 percent of hair on anterior hairline, 3 percent.

b. Elsewhere on head and not affecting anterior hairline:

(1) Loss of 0 to 15 percent of hair, 0 percent.

(2) Loss of 15 to 30 percent of hair, 1 percent.

(3) Loss of 20 to 50 percent of hair, 2 percent.

(4) Loss of more than 50 percent of hair, 3 percent.

The ratings under a. and b. must be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

3. Anterior neck. The anterior neck extends from the ear lobule anteriorally to the ear lobule and downward to mid clavicle. Disfigurement on the posterior neck from the ear lobule posteriorally to the ear lobule shall not be rated under this rule. Ratings under a. and b. shall be combined as set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

a. Hypertrophic scarring or banding:

(1) Affecting less than 10 percent of the anterior neck, 0 percent.

(2) Affecting 10 to 30 percent of the anterior neck. 10 percent.

(3) Affecting 30 to 50 percent of the anterior neck. 12 percent.

(4) Affecting more than 50 percent of the anterior neck. 15 percent.

b. Chin shelf. The chin shelf is the area from the chin backwards to the neck.

(1) Chin shelf extends less than 2 inches. 3 percent.

(2) Chin shelf extends less than 1 inch. 10 percent.

4. Hands. The hand extends from the carpus outward. Loss of body parts and loss of motion are rated in the musculoskeletal schedule.

a. Hypertrophic scarring affecting less than 30 percent of dorsum of one hand. 0 percent.

b. Hypertrophic scarring affecting 30 to 50 percent of dorsum of one hand. 3 percent.

c. Hypertrophic scarring affecting 50 percent or more of dorsum of one hand. 7 percent.

8 MCAR § 1.9025 [Temporary] Pre-existing impairments.

Where a disability is subject to apportionment under Minnesota Statutes, section 176.101, subdivision 4a, the rating for the disabled condition under a category of the schedules of these rules must be reduced as provided in this rule. As used in this rule, the term disabled condition includes the pre-existing disability.

A. This section applies where the pre-existing disability has not been rated and neither B. nor C. is applicable.

1. The pre-existing disability must be rated under a category of the schedules of these rules.

2. The whole body disability rating assigned to the disabled condition of the member by the schedules of these rules must be reduced by the rating assigned to the pre-existing disability of the member in 1.

3. For example, the medical report establishes a pre-existing impairment of amputation of the index finger at the metacarpophalangeal joint. This injury is a 13.5 percent pre-existing disability to the body as a whole under 8 MCAR § 1.9008 [Temporary] A.12.a. The disabled condition is amputation of all fingers except the thumb at the metacarpophalangeal joint, a 32.5 percent disability under 8 MCAR § 1.9008 A.10. 32.5 percent less 13.5 percent gives the disability (adjusted for the pre-existing impairment) of 19 percent. Payment is made for the 19 percent disability at the rate appropriate for a 32.5 percent disability. Thus, if economic recovery benefits are paid, 19 percent is multiplied by 680 weeks; for impairment benefits, 19 percent is multiplied by $85,000.

B. This section applies where the pre-existing disability of a member has been rated in another proceeding or state and the rating represents a percentage of disability to the whole body. The rating of the disabled condition under a category of these schedules shall be reduced by the rating assigned to the pre-existing disability of the member.

C. This section applies where the injury producing the pre-existing disability occurred prior to January 1, 1984, and the pre-existing disability has been rated under Minnesota Statutes, section 176.101, subdivision 3; or where Minnesota Statutes, chapter 176 is inapplicable and the rating represents a percentage of disability of a member.

1. From Table 1, determine the maximum whole body disability assignable to the pre-existing disability. Use Table 2 where disability to an internal organ is rated as a percentage of disability to the particular organ rather than a percentage of disability to internal organs. Where the pre-existing disability is not listed in Table 1 or Table 2, the maximum whole body disability is the maximum disability assigned to the affected member by the schedules of 8 MCAR §§ 1.9001-1.9024 [Temporary].

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TABLE 1

Member	Maximum Whole Body Disability (Percent)
Thumb	16
Index finger	11
Middle finger	9
Ring finger	4
Little finger	2
Great toe	5
Lesser toe	1
Hand	54
Hand and wrist	54
Arm	60
Foot	21
Foot and ankle	28
Leg	40
Eye	24
Eyes (both)	85
Hearing loss (both ears)	35
Back	71
Voice	70
Burns and skin impairments, including disfigurement	70
Internal organs, excluding brain	85
Brain	100
Head	20

TABLE 2

Member	Maximum Whole Body Disability (Percent)
Stomach	65
Pancreas	65
Colon	50
Spleen	0
Bladder	30
Sexual organs or function	20
Circulatory system	90
Heart	85
Lungs	85
Liver	75
Solitary kidney	10
Kidney, excluding solitary kidney	77

2. Multiply the prior rating of the member's pre-existing disability by the maximum whole body disability determined in 1. Where a disputed rating has been closed out to a stipulated rating but payments were made on a different rating, the rating for purposes of this rule is the closed-out rating.

3. Subtract the percentage amount determined in 2. from the whole body disability rating assigned to the disabled condition of the member by the schedules of these rules. The remainder is the amount due for the disabled condition after apportionment for the pre-existing disability.

4. For example, a pre-1984 back injury was rated at 25 percent of the back. The whole body disability attributable to this injury is 25 percent by 71 percent equals 17.75 percent. After 1984, a second back injury is rated at 24.5 percent under these

rules (24.5 percent minus 17.75 percent equals 6.75 percent). Six and three-fourths (6.75) percent is the amount assigned to the disabled condition after apportionment.

D. Where the pre-existing disability and the subsequent permanent partial disability affect more than one member, apportionment must be determined as follows:

1. For each member, determine the percentage of whole body disability under A.-C., as appropriate.

2. Combine the percentages obtained in 1. in the manner set forth in Minnesota Statutes, section 176.105, subdivision 4, clause (c).

Effective Date. Rulel 8 MCAR §§ 1.9001~~-1.9023~~ 1.9025 [Temporary] are effective January 1, 1984.

Board of Peace Officer Standards and Training

Proposed Adoption of Rules Governing Investigation and Resolution of Misconduct Allegations

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Minnesota Board of Peace Officer Standards and Training proposes to adopt the above-entitled rule without a public hearing. The Board has determined that the proposed adoption of this rule will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes sections 14.21-14.28 (1982).

Persons interested in this rule shall have 30 days to submit comments on the proposed rule. The proposed rule may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language.

Unless seven or more persons submit written requests for a public hearing on the proposed rule within the 30-day comment period, a public hearing will not be held. In the event a public hearing is required the agency will proceed according to the provisions of Minnesota Statutes sections 14.13-14.20 (1982).

Persons who wish to submit comments or a written request for a public hearing should submit such comments or request to:

Mark K. Shields
Board of Peace Officer Standards and Training
333 Sibley Street, Suite 495
St. Paul, Minnesota 55101
(612) 296-2620

Authority for the adoption of this rule is contained in Laws of 1983, Chapter 269, sections 3-6, Minn. Stat. sections 626.843, Subd. 3(d) (1982), and 626.845 (i) (1982). Additionally, a Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from the Board upon request.

Upon adoption of the final rule without a public hearing, the proposed rule, this Notice, the Statement of Need and Reasonableness, all written comments received, and the final Rules as Adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the final rule as proposed for adoption, should submit a written statement of such request to the above address.

A copy of the proposed rule is attached to this Notice.

Free copies of this Notice and the proposed rule are available and may be obtained by contacting the Board of Peace Officer Standards and Training.

State of Minnesota
Mark K. Shields, Executive Director

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STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry Governing Workers' Compensation Permanent Partial Disability Schedule

FINDINGS OF FACT AND CONCLUSIONS

As required by Minn. Stat. § 176.105, subd. 4, (1983), the above-captioned matter was the subject of a public hearing on November 4, 1983, at 8:30 a.m. at Room 83, State Office Building, St. Paul, Minnesota. Notice of this public hearing and the proposed rules was published in the October 3, 1983 State Register. All other procedures for the adoption of temporary rules, as governed by Minn. Stat. § 14.29-.36 and 176.105, subd. 4, (1983), have been fulfilled.

Also, proposed amendments to the temporary rules as proposed were published in the December 5, 1983 issue of the State Register. These proposed amendments were published to afford the public and all interested parties maximum participation in commenting on the rules.

Therefore, after affording all interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced upon the records, files, and proceedings herein, I find the following:

1. The deletion and addition of language at 8 MCAR § 1.9001 A., line 15 was done for form reasons. Because the amendments of the rule as proposed included two new sections, the numbering of the rule had to be amended. This form change occurs throughout the rule and will not be specifically referenced or explained again.

2. The added language at 8 MCAR § 1.9001 B., lines 31-34 was needed to further clarify the appropriate procedure in combining impairment ratings. The specific statute cited in the amendment directs the public to the provision in the new workers' compensation law which governs this procedure.

3. A sentence was added to 8 MCAR § 1.9001 D., lines 8-10 to further clarify the rules of construction. Prior to the addition of this language, it was possible a person could mistakenly believe the documents were incorporated by reference in their entirety. All technical terms are defined either in the rule or in the documents incorporated by reference. This clarification reasonably limits the incorporation by reference as intended by the rule.

4. The amendment at 8 MCAR § 1.9001 D.1., line 14 is a correction of a typographical error.

5. The amendment at 8 MCAR § 1.9001 D.3., line 22 is a correction of a typographical error.

6. The amendment at 8 MCAR § 1.9001 D.4., line 26 was found to be a more accurate citation of the document reference.

This revised citation is to a more recent edition of the same source document.

7. The amendment at 8 MCAR § 1.9001 D.5., line 27 was language added to more accurately describe the source document referenced in the rule.

8. The language added at 8 MCAR § 1.9001 D.10., lines 4 and 5 was for stylistic reasons suggested by the Revisor of Statutes.

9. The new language in the amendment at 8 MCAR § 1.9001 D.11., lines 6-9 was needed because of a new section added to the rule at 8 MCAR § 1.9024 dealing with burns. The source document referenced by the new language contains procedures and formulas vital to implementing the new section of the rule.

10. The new language in the amendment at 8 MCAR § 1.9001 E., lines 10-17 was added to clarify the agency's intent that the provisions of the rule be severable. This amendment is needed to avoid attempts at declaring the entire rule invalid, if some authority holds a portion of the rule invalid.

11. The amendment at 8 MCAR § 1.9002 H., lines 7-8 was needed to define a term included in the new section added at 8 MCAR § 1.9024.

12. The re-lettering of 8 MCAR § 1.9002 commencing with I. is needed and reasonable for form purposes because of the insertion of several new definitions.

13. The new language added at 8 MCAR § 1.9002 K., lines 15-20 was suggested in oral comment by the Minnesota Medical Association Ad Hoc Committee on Workers' Compensation (hereafter "MMA Committee") after the rule as proposed was first published on October 3, 1983. This definition was added because the documents incorporated by reference contained numerous definitions of the term "degenerative changes." Therefore, the MMA Committee suggested this definition as best reflecting the specific needs of the rules. This amendment is needed and reasonable.

14. The amendment at 8 MCAR § 1.9002 T., lines 9-10 is added for consistency and clarification. The term used in the definition is already defined in the rule at 8 MCAR § 1.9016 A. and B. Therefore, a member of the public would more easily find the term and its definition by inserting it in the definitions portion of the rule.

15. The language added in the amendment at 8 MCAR § 1.9002 U., lines 11-12 was needed to define a term included in the new burn section added at 8 MCAR § 1.9024.

16. The language added in the amendment at 8 MCAR § 1.9002 UU., lines 26-27 was needed to define a term included in the new burn section added at 8 MCAR § 1.9024.

17. The language deleted and added in the amendments at 8 MCAR § 1.9003 C.1.b., p. 8, lines 34-36, p. 9, lines 1-11, was suggested in written comments, dated October 11, 1983, by Dr. Martin G. Bruhl. This letter is, of course, part of the record.

This amendment provides needed clarification for physicians applying the schedule. Dr. Bruhl's suggested language is needed because it describes the visual field at the beginning of the eye schedule rather than later in the rule.

18. The deletion of language at 8 MCAR § 1.9003 D.3.b., line 36 was needed for clarification. In the October 11, 1983 letter from Dr. Bruhl, this amendment was suggested because the language deleted was unnecessary. Because the method of determining the percentage loss of visual efficiency requires only one ocular motility reading, it is reasonable that this language be deleted.

19. The language added in the amendment at 8 MCAR § 1.9003 D.3.c., lines 3-10 was also suggested in Dr. Bruhl's October 11, 1983 letter. The language explains the steps one must follow to determine the loss of ocular motility. Although these steps are outlined in the American Medical Association's Guides to the Evaluation of Permanent Impairment (hereinafter "AMA Guides"), it is needed and reasonable to set them forth in the rule itself.

20. The language added in the amendment at 8 MCAR § 1.9003 E.2.b., lines 4-5 was the final suggestion contained in Dr. Bruhl's October 11, 1983 letter. The suggested language in his letter was to clarify the reference to "glasses." This added clarification is needed to assist physicians implementing the schedule.

21. The deletion of language at 8 MCAR § 1.9003 E.2.d., lines 11-13 occurred because of the new section of the rule added at 8 MCAR § 1.9025. The new section provides a practical working guide for a person using the schedule to calculate an apportionment for a pre-existing impairment. Therefore, it was reasonable to delete this language because the subject matter is now addressed elsewhere in the rule.

22. The amendment at 8 MCAR § 1.9004 C.1., line 7 is needed for the same reasons set forth above in #6. The citation now references the current revised edition of the source document.

23. The new language at 8 MCAR § 1.9005 A., line 31 is needed as a form revision for clarification.

24. The new language at 8 MCAR § 1.9005 B.1. and 2., lines 41-45 was added because of oral comments by members of the MMA Committee. Upon a final review, the MMA Committee members agreed that this rare condition should be included to make the rule more comprehensive.

25. Members of the MMA Committee after review of the entire schedule, suggested that the percentages at 8 MCAR § 1.9006 C.3.-5., lines 21-26 should be amended. The MMA Committee recommended that these three percentages had to be lowered in light of a review of the entire schedule. These amendments are needed and reasonable in light of a desire for consistency throughout the entire rule.

26. The amendments at 8 MCAR § 1.9006 D.1.-4., lines 29-36 are needed because they more accurately reflect the intent of the agency in describing and implementing the Kenny scale. Dr. Herbert A. Schoening, a member of the MMA Committee, suggested in an October 13, 1983 letter, that a clarification was necessary regarding the Kenny scale. Specifically, the numbers used in the rule had ranged from zero through four. However, Dr. Schoening, who is one of the authors of the Kenny scale, indicated the scale should range from zero to twenty-eight. This finding applies to all of the references to the Kenny's scale and amendments thereto throughout the remainder of this rule.

27. The language deleted and inserted at 8 MCAR § 1.9006 H., lines 12-20 was needed to reflect a reorganization based on several of the amendments to the rule. The section of this portion of the schedule dealing with brain injuries was deleted. Now this section of the schedule refers only to spinal cord injuries. Injuries to the brain are dealt with separately at 8 MCAR § 1.9006 I. This new language was found to be needed to provide further clarification for a user of the schedule seeking to calculate specific percentages of disability within this portion of the schedule.

28. The language deleted and inserted at 8 MCAR § 1.9006 H.3.b., lines 18-19 was a needed stylistic change for clarification.

29. The language deleted in the amendment at 8 MCAR § 1.9006 I.4., line 32 was suggested in a letter by Mr. Tim McCoy

dated November 3, 1983. Mr. McCoy, a member of the law firm of Grose, Von Holtum, Sieben and Schmidt, Ltd., suggested that deleting this language was necessary to provide a more practical measure of the nature of emotional disturbances and personality changes. This amendment is needed to provide more flexibility in calculating a degree of impairment under this category.

30. The language added and deleted at 8 MCAR § 1.9006 I.5., lines 12-15 were also suggested in the letter from Mr. Tim McCoy dated November 3, 1983. The language changes here are for the same rationale as set forth above in #29.

31. The language added and deleted at 8 MCAR § 1.9006 I.6.d., lines 4-6 was a stylistic change for clarification. The rule now more accurately reflects the intent of the physicians who assisted in drafting this portion of the rules. The MMA Committee specifically believe that restructuring the sentence was important to enable physicians to understand the intent of the rule. This change was found to be needed to more adequately express the intent of the department.

32. The amendments at 8 MCAR § 1.9006 I.7., lines 7-24 were part of a re-organization of this portion of the schedule. The MMA Committee recommended the deletion of this language. It also recommended that the language added more appropriately describes the calculations that should occur. In other words, it was needed to have the impairments listed in this section calculated by the earlier portion of the rule dealing specifically with spinal cord injuries. This change was

appropriate because it avoided duplicative ratings of injuries in various portions of the rule. It also consolidated the portions of the rule where the ratings should occur and ensures that ratings for similar disabilities will be consistent.

33. The language added at 8 MCAR § 1.9006 I.8., lines 25-27 was based on the same rationale as the changes set forth in #32. Specifically, it was needed to reference the other portions of the schedule where a specific procedure for rating a permanent partial disability already exists. This language clarifies that there will not be duplication of ratings in various parts of the schedule. This consolidation is helpful and avoids further confusion on where and how to rate such disabilities.

34. There were numerous changes at 8 MCAR § 1.9007 of the rule. Specifically, at 8 MCAR § 1.9007 A.1., p. 29, lines 18-36, p. 30, lines 1-30, a substantial portion of the language was deleted and new language was put in its place. However, the nature of the rule is substantially the same. Several comments from the public suggested that this portion of the schedule was too restrictive. Therefore, this portion of the schedule was revised to better reflect the current experience in work-related injuries. The original rule as proposed had required four elements to be present to be rated by the schedule: muscle spasm, rigidity (loss of motion or postural abnormality), pain and x-ray findings. In the new language at 8 MCAR § 1.9007 A.1.a.-b., lines 7-14 the requirements are only pain and rigidity (loss of motion or postural abnormality) or pain and chronic

muscle spasm. This change reflects the more common experience by physicians treating these types of injuries. The new language at 8 MCAR § 1.9007 A.1.c.-d., lines 15-30 is essentially the same as the original rule. These deletions and insertions are needed to more adequately represent the current common practice in evaluating workers' compensation injuries. These amendments also are needed because they reflect beneficial organizational changes for the practitioner in applying and reviewing the rules.

35. The amendments inserted and language deleted at 8 MCAR § 1.9007 A.2.a., lines 32-36 are stylistic and typographical changes to more accurately reflect the intent of the agency. These amendments were suggested by the MMA Committee in comments subsequent to the rules as proposed being published. These changes are deemed reasonable for form and stylistic reasons to assist a member of the public in understanding and implementing the schedule.

36. The added language at 8 MCAR § 1.9007 A.2.b.(3), line 9 was suggested by Mr. Tim McCoy in his November 5, 1983 letter. This added language was needed for parallel construction and consistency with other portions of the schedule as to certain treatments for back injuries.

37. The numbers deleted and inserted at 8 MCAR § 1.9007 A.2.b.(3)-(4), lines 8, 12 and 15 were part of an organizational change within the schedule. The numbers were redefined because the rating of gross motor weaknesses was removed from the lumbar and cervical spine sections and placed

elsewhere in the amended schedule. Therefore, it was reasonable to lower these percentages because an individual would be able to rate his gross motor weakness elsewhere in the schedule. This process would increase injured workers' total percentage disability to the same level as in the original rules as proposed.

38. The language deleted and inserted at 8 MCAR § 1.9007 A.4., lines 32-36 was for clarification reasons suggested by the MMA Committee. These amendments are needed for members of the public to understand the intent of the department.

39. The language deleted and inserted at 8 MCAR § 1.9007 A.5., lines 1-5 was for clarification and stylistic reasons. The MMA Committee suggested that the language in 8 MCAR § 1.9007 A.5.a.-b. was redundant with c.-d. Therefore, a. and b. were deleted. However, the percentages assigned to a. and b. were found by the MMA Committee to be more appropriate. These percentages are needed and reasonable as amended based upon the suggestions of the MMA Committee. The other changes in the remaining portion of 8 MCAR § 1.9007 A.5.c.-d. were for stylistic and form purposes. These changes were needed to more accurately reflect the injuries compensated by the schedule as indicated by the MMA Committee. Percentages in c. and d., lines 18 and 24, changed because gross motor weakness was rated elsewhere similar to #37 above.

40. There were substantial language changes to 8 MCAR § 1.9007 B. regarding the cervical spine. The language at 8 MCAR

§ 1.9007 B., p. 33, lines 9-15 clarified what portion of the schedule one uses to rate certain types of diabilities. This new language will prevent duplication of ratings. The new language set forth at 8 MCAR § 1.9007 B.1.-4. parallels the schedule for the lumbar spine at 8 MCAR § 1.9007 A.1.-4. Several of these changes were also suggested in Mr. Tim McCoy's letter of November 5, 1983. Overall, the revisions to the cervical spine portion of the schedule were reviewed by the MMA Committee and found to be needed. Portions of the cervical spine ratings had a lower percentage than in the original language because gross motor weakness is now rated elsewhere. However, in the earlier rules as proposed, it was envisioned that it would be included in this portion of the ratings. Therefore, the percentages have been lowered accordingly. This is needed to allow for an accurate recovery by going to the appropriate sections of the schedule.

41. The language added and deleted at 8 MCAR § 1.9007 B.5.a.-d., p. 35, lines 1-22 reflect percentage changes for the same reasons as set forth above in #40. Specifically, by rating motor and sensory loss separately and moving them to a separate portion of the schedule, the percentage recovery under the cervical spine is correspondingly lower. This amendment is needed to prevent duplication of ratings within the schedule.

42. The language added at 8 MCAR § 1.9007 C.1.-3. was suggested by oral testimony at the public hearing on November 4, 1983, by Dr. Gordon Miller of the Minnesota Chiropractic Association. The thoracic spine was omitted from the original

rules as proposed. Based on comments by Dr. Miller and by review of the MMA Committee, inclusion of the thoracic spine was recommended. It is found that it is needed to include this portion of the spine and rankings to insure a comprehensive schedule of permanent partial disabilities. The structure and ratings for this portion of the schedule are organized in a parallel construction with the lumbar and cervical spine.

43. The language deleted at 8 MCAR § 1.9009 A., lines 30 and 32 was recommended by the MMA Committee as a correction for a typographical error. This change was found to be needed to more accurately reflect the intent of the department.

44. The amendment of the numbers at 8 MCAR § 1.9009 B.1., line 35 is the correction of a typographical error. This change is needed to more accurately reflect the department's intent.

45. The insertion of language at 8 MCAR § 1.9009 C., line 24 was suggested by the MMA Committee. The reference to the hand is important because it clarifies what was intended by the department. This change will assist a member of the public in interpreting the schedule. This change is needed because it more accurately reflects the intent of the agency.

46. The language added and deleted at 8 MCAR § 1.9010, lines 6-15 was recommended by the MMA Committee. The language inserted more accurately defines what is a total or complete motor and sensory loss. This insertion is important for the a

member of the public to understand the application of this portion of the schedule. Therefore, it is needed and reasonable.

47. The re-numbering and re-lettering commencing at 8 MCAR § 1.9010 A.1., lines 16-36 and p. 41, lines 1-4 is needed for form purposes because of the insertion of language in the immediate preceding section.

48. The language added at 8 MCAR § 1.9010 A.4.a.-d. was recommended by the MMA Committee to make the schedule more comprehensive. This addition is found to be needed to improve and make the rule more complete.

49. The additional language at 8 MCAR § 1.9010 B., lines 10-13 is necessary to define the term partial loss. This definition is important for purposes of implementing the schedule where disability is less than a complete or total loss. Therefore, it is found to be needed as clarification.

50. The language added and deleted at 8 MCAR § 1.9016, lines 2-7 was for further clarification to a member of the public reading the schedule. The revised language more adequately reflects the agency's intent.

51. The new language added at 8 MCAR § 1.9016 A. is a definition of the term as referenced in the definition section of a total loss earlier in the rule at 8 MCAR § 1.9010 A. It is needed for clarification and form purposes.

52. The language deleted at 8 MCAR § 1.9016 A.6., line 19 was a change recommended by the MMA Committee upon review of the rule as proposed. It was found reasonable to delete this

particular provision since this category was already compensated by another portion of the schedule.

53. The re-lettering and re-numbering which occurred commencing at 8 MCAR § 1.9016 A.7., lines 20-36 was necessary for form purposes and because of deletions and additions.

54. Several categories of disabilities were added commencing at 8 MCAR § 1.9016 A.15., p. 47, line 36 and p. 48, lines 1-3. Again, the MMA Committee recommended these additions upon review of the rule as proposed in its entirety. These particular injuries should have been included in the rule as proposed and their insertion at this time is a correction needed for the rule to be comprehensive.

55. The language inserted at 8 MCAR § 1.9016 B., lines 4 was included for form purposes and parallel construction based upon the earlier definition of partial loss above at #49. The rule as originally proposed did not have this term defined. Therefore, the MMA Committee recommended that it be included in the amendments to keep the rule comprehensive.

56. The language inserted and deleted at 8 MCAR § 1.9018 A.5. and 6., lines 7-23 and 8 MCAR § 1.9018 B., line 32 was suggested by Dr. James L. Craig in a letter dated October 17, 1983 and part of the record. Dr. Craig suggested that the rule as proposed needed further clarification by a different expression of the formula used for forced spirometry measurements. It was found to be needed to amend the formula to

represent what physicians would recognize as a more appropriate measure for respiratory loss of function.

57. A deletion and insertion of language at 8 MCAR § 1.9018 B., p. 54, line 25 was also suggested by Dr. Craig in his October 17, 1983 letter. The change was merely for consistency and was a typographical error in the first draft of the rules.

58. The language added at 8 MCAR § 1.9018 C., lines 7-9 were suggested in a letter by Dr. Paul B. Johnson dated November 7, 1983 and part of the record. Dr. Johnson suggested that asthma, although not common, should also be included under this portion of the disability schedule. His suggested language is found to be needed to make the schedule more comprehensive.

59. The language added at 8 MCAR § 1.9022, line 28 was for clarification of this portion of the schedule. It was found to be needed to include the words "and urinary" in this section heading to more appropriately express the intent of the department. This section of the rule had already explicitly dealt with the urinary tract; however, this was not set forth in the title.

60. The re-lettering, which occurs commencing at 8 MCAR § 1.9022 C., line 24 continuing to the end of the rule, was necessary because of a typographical error in the original rule as proposed. This change is needed to clarify the sequence of this portion of the rule.

61. The deletion of 8 MCAR § 1.9022 H.1., line 14 was for form purposes and parallel construction.

62. The language inserted at 8 MCAR § 1.9023, p. 66, line 6-7 was added for explanatory purposes. Because an entirely new section was added in the amendments to the rule dealing with burn disabilities, it was necessary to clarify that the section of the rule dealing with skin disorders did not include burns. This clarification was found to be needed to inform a physician or member of the public what portion of the schedule applies to burn disabilities.

63. An entirely new section of the rules was added at 8 MCAR § 1.9024. These amendments were suggested by members of the MMA Committee upon review of the adequacy of the skin disorder portion of the schedule. Specifically, Dr. Steven V. Fisher and Dr. Lynn D. Solem, both specialists dealing with burns, suggested the need for a portion of the schedule dealing specifically with disabilities relating to burns. Drs. Fisher and Solem in turn suggested the language which currently makes up the portion of the schedule dealing with burns. The burns schedule is a unique attempt at providing compensation for the unique disabilities which can be created by burn injuries. This portion of the schedule is found to be needed to deal with this very difficult type of disability which was not adequately compensated under the skin disorder portion of the schedule in the original rules as proposed.

64. The amendments commencing at 8 MCAR § 1.9025 is another entirely new section of the rule. Because of numerous questions regarding how to calculate the apportionment of pre-existing impairments together with impairments compensated by this schedule, the agency found it was needed to provide a practical guide for one calculating such a rating. This portion of the rule, 8 MCAR § 1.9025, clarifies the application of the schedule when there is a pre-existing impairment. This portion of the schedule is needed to assist an individual in applying a schedule given a certain fact situation. Also, at 8 MCAR § 1.9025 C.1. there is a table which lists the maximum whole-body disability for certain types of injuries to various members or functions of the body. This is an important summary of the level of compensation that the new schedule will provide for various permanent partial disabilities. Again, it is found that this new section is needed to provide a simplified guide for understanding and applying this schedule.

65. The language added at 8 MCAR § 1.9025, pg. 74, line 11 was not published in either the Rule as Proposed or Amendments to the Rules as Proposed. However, agency staff reviewing the rule suggested that a provision specifically setting forth a procedure for rounding percentages in the rule would be a needed clarification. This amendment is reasonable and needed because of the many formulas and percentages set forth in the rule. Such a modification will assist all those using the schedule. Therefore, this amendment is an appropriate

modification as allowed under Minn. Stat. § 14.31 (1983) from the rule as originally noticed in the State Register.

THEREFORE, based on all of the evidence as part of the record, I stated that these are my findings of facts and conclusions In the Matter of the Proposed Adoption of Temporary Rates of the State Department of Labor and Industry Governing Workers' Compensation Permanent Partial Disability Schedule.

STATE OF MINNESOTA

Steve Keefe
Commissioner of Labor and Industry
Date: 12/28/83

STATEMENT OF NEED AND REASONABLENESS
FOR
8 MCAR §§ 1.9001 - 1.9023 [Temporary]

These rules for the rating of permanent partial disability are required by Laws of Minnesota 1983, ch. 290, section 86, codified as Minn. Stat. § 176.105, subd. 4. Section (a) of Minn. Stat. 176.105, subd. 4 requires that the schedules established by these rules shall in the aggregrate provide benefits approximately equal to those currently payable. Written actuarial testimony will be provided at the November 4 hearing to establish that this requirement is fulfilled by the proposed rules.

Minn. Stat. 176.105, subd. 4 (b) requires the commissioner to conduct an analysis of the current permanent partial disability schedule for the purpose of determining the number and distribution of permanent partial disabilities and the average compensation for various permanent partial disabilities. Written actuarial testimony will be introduced at the hearing to establish that the commissioner has complied with this legislative directive.

Minn. Stat. 176.105, subd. 4 (b) (1) - (7) list factors which the commissioner may consider in the promulgation of the disability schedules. The discussion of the rules in the balance of this statement of need and reasonableness indicates that these factors were considered in developing the schedules. In addition, the commissioner's written analysis of the disability schedules of other states will be made part of the hearing record on November 4.

On January 1, 1984, the current permanent partial disability schedule of Minn. Stat. § 176.101, subd. 3 is repealed. Laws of Minnesota 1983, ch. 290, section 173. The schedules set forth in these rules replace the current statutory schedule and are thus effective January 1, 1984.

8 MCAR § 1.9001 - General

The basic purpose of specifying disability for categories of impairment is to promote consistency and objectivity in the rating of permanent impairments, thereby reducing litigation regarding the rating of disabilities.

Section B provides rules for interpreting the schedules. One of the purposes of the interpretation rules is to ensure selection of the smallest number of categories necessary to fairly represent the disabling condition. Thus, cumulation and duplication are prohibited. A specific restriction on cumulation is included for the musculoskeleletal schedule. To avoid rating on a basis other than the categories of the schedules, averaging or prorating is prohibited.

That the schedules are the exclusive rating basis is stated in Section C. The disability rating assigned to each category includes a consideration of loss of function.

Section D lists the documents incorporated by reference. These documents are standard medical references which are in common use. The documents are incorporated only to the extent that they are specifically referenced or are necessary for definition.

8 MCAR § 1.9002 - Definitions

Most of the sections of this rule define medical terms. Although these terms are defined in Dorland's or other documents incorporated by reference, the definitions in those documents were not sufficiently specific for the purpose of these rules. These terms are thus defined in the context of their use in the rules.

8 MCAR § 1.9003 - Eye Schedule

The Minnesota Medical Association adapted the eye schedule from the Wisconsin schedule and from the A.M.A. Guides. The eye schedule of this rule is a significant improvement over the out-dated method used under the current schedule. With the current statutory schedule, only distance vision is used as a measure of impairment. Thus, there is no compensation for impairment of near vision, of field vision, or of ocular motility. The schedule set forth in this rule corrects these inadequacies and provides a method for determining visual impairment which is consistent with present medical practice.

The examination requirements of section B follow generally accepted ophthalmological practices.

Section C describes the three factors (central visual acuity, field vision, and ocular motility) used to measure vision and the possible range within which the measurement of each factor may fall. For central visual acuity, the maximum at C.1.a. and the minimum for distance vision at C.2.a.(1) are those of both the A.M.A. and Wisconsin schedules. The minimum for near vision at C.2.A.(2) follows the Wisconsin schedule. The A.M.A. Guides measure near vision to only 14/140. The use of the Wisconsin limit permits greater distinctions at the higher levels of impairment.

For the visual field, the A.M.A. Guides were followed in choosing the maximum limit of 500 degrees at C.1.b. This maximum differs from the Wisconsin limit of 420 degrees. The availability and general professional acceptance of the A.M.A. visual field charts supported the selection of the A.M.A. method. The effect of increasing the normative visual field is to slightly increase the disability rating, and thus

compensation. A visual field of 420 degrees is measured as unimpaired under the Wisconsin system, while the same visual field is impaired when measured against a 500 degree standard.

For ocular motility, the maximum limit at C.1.c. is consistent with that of Wisconsin and the A.M.A. Guides. The minimum limit at C.2.c. is adopted from the Wisconsin schedule.

The 50 percent minimum at C.2.c.prevents overcompensation of ocular motility impairment. The worst case of double vision should not be compensated to the same extent that total blindness is compensated. Without the 50 percent minimum, this could occur because of the calculation method employed.

Section D prescribes the methods for measuring the three factors of vision. D.1.a.-d. set forth standard testing and calculation procedures. Table 1 is taken from the Wisconsin schedule and its use is consistent with the selection of the Wisconsin standards for maximum and minimum central visual acuity efficiency.

D.1.e. and f. permit downward adjustments of the efficiency measurement for aphakia and pseudophakia, conditions resulting from the development of cataracts. These adjustments are intended to compensate for the increased fragility of the eye and the need for corrective lenses. In cases of severe impairment, the adjustment under these provisions may result in less compensation than an adjustment for glasses under E.2.b. or c. In order to permit a higher compensation for the injury, the adjustment is not made where an adjustment under Section E permits more compensation.

D.2. and D.2.a. describe standard procedures for measuring visual field efficiency. D.2.b. sets forth the standard procedure to be followed in cases of irregular impairment of field. The number of radii selected will depend on the nature and extent of the particular impairment. The divisor for calculating efficiency will vary from case to case, depending on the number of radii selected.

D.2.c. is also the standard procedure followed by ophthalmologists where field vision is severely impaired.

D.3., the measurement of ocular motility, follows the method set forth in the A.M.A. Guides. The A.M.A. ocular motility chart was selected because of its availability and general acceptance in the ophthalmological profession.

Section E prescribes the method for combining the three factors (central visual acuity, field vision and ocular motility) to determine the visual efficiency of one eye. The factors are simply multiplied together. The method chosen is that used by Wisconsin and is relatively uncomplicated. The A.M.A. method is considerably more complex and requires the use of comparative value tables.

Section E.2. permits adjustments to the efficiency calculation in certain cases. For most eye conditions, visual impairment is the most objective and significant aspect of symptomatology. In some cases, vision is not affected by the condition or visual impairment is not a fair measure of the disability. E.2.a. provides additional compensation for conditions of the eye where visual impairment due to the condition was considered an inadequate basis for compensation.

E.2.b. and c. permit additional compensation where corrective lenses are required as a result of the injury. The rationale for this adjustment is that dependence or increased dependence on corrective lenses is in itself an impairment, even where the correction gives 100 percent visual efficiency.

E.2.d. specifies the point in the calculation at which adjustments for pre-existing impairments are to be made.

Section F follows the A.M.A. Guides in prescribing the method for calculating visual system impairment from the impairment to each eye. Both the Wisconsin and A.M.A. systems use this method. Table 2 is taken from the A.M.A. Guides.

8 MCAR § 1.9004. - Ear Schedule

The ear schedule was promulgated by a Minnesota Medical Association's Otolaryngology Committee. Consistent with the A.M.A. Guides, the schedule is based on binaural rather than monaural hearing loss. Use of the binaural standard is premissed on the belief that hearing impairment should be compensated on impairment to the audiological system rather than to one ear in isolation. Thus, the effect on overall hearing determines the extent of compensable loss.

Sections B-D of the rule describe the medical and testing procedures which precede the calculation of disability. Generally accepted medical procedures are required in Sections B and D. For audiological testing, calibration at regular intervals is required in Section C to ensure accurate measurement of hearing loss. Equipment calibration requirements are the ANSI standards which are generally used in the profession. The requirement to keep records is included so that a reliable method is available to substantiate a claim of proper calibration.

Section E of the rule prescribes the methods for calculating disability. At E.1.a., four test readings are required. Some procedures delete the 3,000 hertz reading and require only three test readings. By including the fourth reading at 3,000 hertz, the rule permits compensation for hearing loss in the higher ranges.

The 25 decibel "fence" of E.1.c. is the level at which there is usually no impairment in the ability to hear normal speech under normal

conditions. The effect of the fence is that hearing in an ear is considered unimpaired if the average hearing level for that ear is 25 decibels or less.

The calculation procedure in E.1.d.-f. is consistent with that used in the A.M.A. Guides and is in common use among practicing otolaryngologists.

The ear schedule of E.3, translating binaural hearing loss to whole body disability, is taken from the A.M.A. Guides.

Section F of the rule disallows an adjustment for presbycusis. Some schedules from other states decrease the whole body disability rating where presbycusis is diagnosed. Because presbycusis generally affects the higher ranges of hearing, some compensation for presbycusis may occur through the inclusion of the 3,000 hertz testing level. The difficulties of diagnosis and the desire to maintain simplicity in the calculations support the reasonableness of the prohibition against adjusting disability for presbycusis. To the extent that presbycusis is documented as a pre-existing impairment, an adjustment pursuant to Minn. Stat. § 176.101, subd. 4 (a) may be made.

Section G of the rule disallows an adjustment for tinnitus. The disallowance is based on the subjective nature of the complaint. In most cases of complaints objectively substantiated, the tinnitus impairs hearing and is thus indirectly compensated by increased impairment readings.

8 MCAR § 1.9005 - Skull Defects

The skull defects schedule was developed by the Minnesota Medical Association's Neurology Task Force to standardize the disability ratings for damage to the cranial bones of the head. In considering skull defects, the Task Force concluded that skull fractures, when not associated with skull defects, are usually not a permanent partial disability and thus did not include fractures under this rule. The rule distinguishes between filled defects, in which bone or artificial substances are used to replace the damaged skull, and unfilled defects. With unfilled defects, the brain remains unprotected by a rigid covering and the compensation for these defects is therefore higher.

8 MCAR § 1.9006 - Central Nervous System

The organization of the central nervous system schedule follows that of the A.M.A. Guides in addressing central nervous system impairments in terms of disorders of the cranial nerves, the spinal cord, and the brain.

Sections B through G of the rule categorize disabilities due to impairment of the cranial nerves. The percentages of disability generally follow the A.M.A. Guides, but provide greater detail and specificity. No compensation is provided for olfactory nerve impairments because of the negligible impact of these impairments on whole body functioning. To the extent that hearing is affected, impairments of the cochlear nerve are compensated under the Ear Schedule, 8 MCAR § 1.9004. Impairments of the oculomotor, trochlear and abducens nerves, which are responsible for eyeball motility and regulation of pupil size, are compensated by the Eye Schedule, 8 MCAR § 1.9003.

Section H categorizes disorders due to spinal cord impairment. For upper extremity impairments at H. 2, the disability rating for relatively minor impairments varies depending on whether the preferred or nonpreferred extremity is affected. The distinction between preferred and nonpreferred is not made for the more severe impairments. This is because with severe impairments the ability to perform self cares is minimal, and the distinction between preferred and nonpreferred extremities becomes meaningless.

Urinary bladder and anorectal impairments due to spinal cord injury are categorized at paragraphs 4 and 5 of Section H. The distinction among categories is based on degree of continence and voluntary control.

Sexual function impairment due to spinal cord injury is categorized at Section H. 6, using the same categories as are used in 8 MCAR § 1.9022 E. and H.

Impairments due to brain injury are categorized in Section I. The categories generally follow the A.M.A. Guides in classifying the impairments under communication disturbances, cerebral function disturbances, emotional disturbances, consciousness disturbances, and epilepsy. The rule goes beyond the A.M.A. Guides in distinguishing expressive and receptive communication disturbances and in providing categories for psychotic disorders, paralysis, and headaches.

A major contribution to objectivity in rating under this rule is the incorporation of the Kenny scale for self cares. The Kenny scale provides an objective procedure for rating independence in self cares. Each of the self care factors is rated on a 0 to 4 scale. The numbers translate to medical judgment terminology as follows:

A composite score of 24 to 28 or a single factor score of 4 means totally independent.

A composite score of 16 to 24 or a single factor score of 3 means minimally or mildly dependent.

A composite score of 10 to 16 or a single factor score of 2 means moderately or markedly dependent.

A composite score of 0 to 10 or a single factor score of 1 or 0 means severely or totally dependent.

In most cases, the subjective medical judgment should suffice for a rating; a formal evaluation pursuant to the Kenny system will be unnecessary. In questionable cases, however, the use of the Kenny evaluation procedure should practically eliminate dispute regarding the degree of dependence in self cares. Incorporation of the Kenny rating system thus significantly contributes to objectivity and the reduction of litigation in the application of this rule.

8 MCAR § 1.9007 - 1.9017 - Musculo-Skeletal Schedule

The musculo-skeletal schedule of 8 MCAR §§ 1.9007 -1.9017 follows the A.M.A. Guides in dividing impairments into those of the back (8 MCAR § 1.9007), the upper extremities (8 MCAR § 1.9008 -1.914), and the lower extremities (8 MCAR § 1.915 -1.917). In addition to the A.M.A. Guides, the Manual for Orthopaedic Surgeons in Evaluating Permanent Physical Impairment was also used in the development of the musculo-skeletal schedule.

8 MCAR § 1.9007 - Back Schedule

Disorders of the back are divided generally into those of the lumbar spine, Section A, and those of the cervical spine, Sections B and C. While the back schedule is consistent with the Orthopaedic Manual, the departures from the manual improve the objectivity and workability of the rule. Sections A - C clarify the various levels of disability while remaining consistent with the Orthopaedic Manual.

8 MCAR § 1.9008 - Upper Extremity Amputation Schedule

This rule is adopted from the A.M.A. Guides. Some categories were added to increase the specificity of the rule. The rating for amputation includes a consideration of motor and sensory loss. Pursuant to 8 MCAR § 1.9001.B., there cannot be an additional rating under 8 MCAR § 1.909 or 1.9010 for motor or sensory loss where this amputation schedule is used.

8 MCAR § 1.9009 - Sensory Loss - Upper Extremities

The A.M.A. Guides are used as the basis for this rule. The schedule departs from the Guides to simplify the levels of impairment, and to provide objectivity to the specific percentages applied. Pursuant to 8 MCAR § 1.9001 B., this schedule is not to be used where either the motor loss schedule or the amputation schedule is used.

8 MCAR § 1.9010 Motor Loss - Upper Extremities

The A.M.A. Guides are used as the basis for this rule. The schedule departs from the Guides to simplify the levels of impairment, and to provide objectivity to the specific percentages applied. Pursuant to 8 MCAR § 1.9001 B., this schedule should not be used where either the sensory loss or the amputation schedule is used.

8 MCAR § 1.9011 - Shoulder Schedule

8 MCAR § 1.9012 - Elbow Schedule

8 MCAR § 1.9013 - Wrist Schedule

8 MCAR § 1.9014 - Fingers Schedule

These schedules are adopted from the Orthopaedic Manual. Each schedule is broken into two basic sections: range of motion and other conditions. The section entitled "Procedures and Conditions" provides workable evaluation procedures and is an improvement on the Orthopaedic Manual. Pursuant to 8 MCAR § 1.9001.B., a disability should be rated under either the range of motion section or the procedures section; it should not be rated under both sections.

8 MCAR § 1.9015 - Amputations of Lower Extremities

The amputation of lower extremities schedule is adopted from the A.M.A. Guides. The schedule is specific and provides objectivity in its application. Pursuant to 8 MCAR § 1.9001.B., an injury cannot be rated under both this rule and 8 MCAR § 1.9016.

8 MCAR § 1.9016 - Sensory Loss - Lower Extremities

This rule was adopted from the A.M.A. Guides. The percentages of disability are within the ranges provided by the Guides. Pursuant to 8 MCAR § 1.9001 B., this schedule does not apply where the amputation schedule is used.

8 MCAR § 1.9017 - Joints Schedule

This schedule is adapted from the Orthopaedics Manual and the A.M.A. Guides. As with the upper extremities schedule, the body part is rated in one of two sections: range of motion or conditions and procedures. As provided by 8 MCAR § 1.9001 B., it is the intent of this rule to rate under only one of these sections. Thus, where a procedure or condition results in a loss of range of motion, the disability should be rated under the procedures or condition section only.

8 MCAR § 1.9018 - Respiratory System

The respiratory system schedule is a modification of the A.M.A. Guides. The classification of impairment is based primarily on the degree of dyspnea and the degree of impairment of ventilatory function. These factors are more easily evaluated than general characteristics such as malaise, fatigability, and excessive cough. Diffusing capacity studies are necessary when the patient's statement about the severity of dyspnea is inconsistent with forced spirometric measurement results. Diffusing capacity studies do not require subject cooperation, and are therefore useful as objective diagnostic tools.

The evaluation procedures listed in Section A are the accepted medical procedures applicable to respiratory system dysfunction.

The 0, 15 and 30 percent classes of Table 1 in Section B correspond to classes 1 through 3 of the A.M.A. Guides. The roentgenogram appearance factor is eliminated. The roentgenogram test result for each class in the A.M.A. Guides is equivocal, and thus not as definitive as the other criteria.

A zero percent class is included to clarify the fact that not all normal individuals will score one hundred percent on the forced spirometry measurement. Since there is a wide variation among normal individuals, no impairment is recognized until the test shows 85 percent of normal or less. The forced spirometry tests are administered three times to eliminate misleading results, with the highest test result determined as most representative of the subject's ability.

A new 85 percent class of severe impairment is added to the A.M.A. Guide's four classes. The diffusing capacity and forced spirometry measurement ranges in the 60 percent class are thus reduced to smaller, more specific categories. The individual confined to bed and requiring oxygen in the 85 percent class is clearly more disabled than the 60 percent person who is ambulatory, even if only for short distances. The severe loss of organ function and restriction of almost all normal daily activities justify the creation of this class.

8 MCAR § 1.9019 - Organic Heart Disease

The organic heart disease schedule is a simplification of the classifications used in the A.M.A. Guides. Permanent impairment due to heart disease most commonly results from failure of myocardial function, or impairment of coronary circulatory function, or both. A definite percentage of disability, within the range given by the A.M.A. Guides, is assigned to each class. The specificity of this schedule is superior to Minn. Stat. § 176.101, subd. 3 (40), which offered no guidelines for setting the percent of disability suffered from injury to internal organs.

Section B prescribes procedures to be followed in the diagnostic analysis. A detailed history is an established medical practice and is important in heart disease cases. Psychological responses to physical processes and physical responses to psychological processes are not uncommon in heart disease patients. Hence, it is essential that objective tests including x-rays and electrocardiograms be performed. Other standard tests, including echo-cardiography, exercise testing, and radionuclide studies, may be indicated by the symptoms present. Categorization is appropriate only after maximum medical and surgical therapy and rehabilitation, plus a reasonable period of time to permit maximum circulation and other adjustments.

Each category of disability in Section B requires a diagnosis of organic heart disease. In the category of least impairment, organic heart disease is present according to diagnostic tests, but is asymptomatic. The remaining categories are distinguished by the effects of the activities of daily living, as defined in 8 MCAR § 1.9002 E., and other specified activities.

8 MCAR § 1.9020 - Vascular Disease

No separate schedule for vascular disease affecting the extremities previously existed, although Minn. Stat. § 176.101, subd. 3 contained values assigned for loss of limbs. The vascular disease schedule is a simplification of the A.M.A. Guides. These impairments are most commonly the result of diseases of the arteries, veins, or lymphatics.

Prior to classification by this schedule, a diagnosis of vascular disease, using accepted medical standards, is necessary. A complete history and physical exam, as well as imaging examination, volume studies, or flow studies are required to establish the diagnosis.

Classification in this schedule depends upon the severity and extent of lesions on the extremities. When amputation due to peripheral vascular disease is present, evaluation using the amputation of lower extremities schedule in 8 MCAR § 1.9015 is proper.

The categories of the vascular disease schedule are based upon the physical symptoms present and the resulting effect upon the activity of walking. An individual with a zero percent disability experiences rare and transient edema, but no other physical symptoms or pain upon walking. This minor condition is uncompensated.

A ten percent disability is characterized by intermittent pain upon walking approximately one city block at an average pace and persistent, incompletely controlled edema. No active ulcers or stumps are present.

The 30, 60 and 90 percent categories each require either an active ulcer or signs of activity in a stump; pain upon walking short distances; and severe or marked edema. Choice of class is based upon the

physician's observance of signs of ulceration, diseased limbs, and degree of edema present. The pain reported by the patient is also considered. The 60 and 90 percent classifications both include advanced signs of disease, but are easily distinguished by the number of limbs affected.

8 MCAR § 1.9021 - Gastrointestinal Tract

The gastrointestinal tract schedule parallels the A.M.A. Guides and assigns percentages within the ranges given in the Guides. This schedule replaces the very indefinite rule of Minn. Stat. § 176.101 subd. 3 (40), which gave no guidelines for assigning percentages of disability. The specificity of the schedule promotes objectivity, consistency, and workability in the rating of disability.

Section A follows the accepted medical practice of requiring a thorough history and physical exam, and recommends basic diagnostic tests.

Section B classifies disorders of the upper digestive tract according to symptoms or signs of disease, anatomic loss or alteration, and weight variations. These factors may be objectively evaluated by the examining physician.

A class 1 symptom may be premissed on purely subjective complaints of the patient. A rating in this category thus relies on the physician to judge the reliability of the complaints.

Classes 2 through 4 describe impairments resulting in increasing weight loss and decreasing responsiveness to treatment by drugs and dietary restrictions. The divisions among classes are based upon evidence of disease and loss of function of the upper digestive tract organs.

Colonic and rectal impairments are classified in Section C. The basis for the division into classes of impairment is objective evidence of disease or anatomic loss or alteration. The physician notes the presence or absence of constitutional manifestations such as fever, anemia, and weight loss. The level of restriction in normal activities and diet is similarly graduated by class. These categories are specifically delineated, thereby reducing the likelihood of litigation.

Section D contains classes of anal impairment due to disease or local injury. Classification of disturbances in fecal continence resulting from neurological disorders are found in Rule 1.9006 H.5.

Classes 1 through 3 each require objective signs of organic anal disease. The evaluator rates the degree of incontinence, frequency of symptoms, and amenability of the symptoms to treatment. There should be little difficulty quantifying the required treatment and the patient's response to treatment. Each class is distinguished by the response to and results of treatment.

The five percent impairment classification of Section E.1. is based upon objective evidence of persistent liver disease when no symptoms of liver disease are present. It is an accepted medical fact that liver disease may be present in the absence of symptoms or physical findings. The requirement that biochemical studies indicate at least a minimal disturbance in liver function avoids reliance on complaints which are not objectively substantiated. The remaining classifications detail the physical manifestations of progressive liver disease.

Biliary tract impairments are rated in Section F according to the frequency of the impairment and the type of obstruction present. These classifications follow the A.M.A. Guides.

8 MCAR § 1.9022 - Reproductive And Urinary Tract Schedule

This rule provides criteria for evaluating disability due to impairment of the reproductive and urinary systems. Section B describes standard medical procedures to be followed in evaluating the impairment. Because of the diversity of potential impairments and injuries to these systems, tests which would apply to all conditions could not be specified. The listing of test procedures at paragraph 2 is thus not mandatory. It is included to give guidance to the pratitioner in selecting appropriate tests and procedures.

Section B contains the upper urinary tract schedule. The disability rating for a solitary kidney at paragraph B.1 applies even where there is no impairment of function. The rationale for this rating is that reliance on only one kidney represents the loss of a normal safety factor. Dependence on a solitary kidney is thus a disability regardless of the present funtional ability of the renal system. When impairment of function is combined with a solitary kidney, the disability should be higher than the same functional impairment occuring with both kidneys. For this reason the rule provides for an increase in the disability rating for a class when a solitary kidney is present.

Section B. 2.-5. divides the upper urinary tract impairment into four classes. This division is essentially that of the A.M.A. Guides. As the creatine clearance test should be adequate in nearly all cases, the PSP test recommended by the A.M.A. Guides is not required.

Section C sets forth classes of bladder impairment. The extent of bladder reflex activity is the basis for distinguishing among the classes.

Section D provides two classes of urethral impairment. The class distinctions are those of the A.M.A. Guides and depend on the extent to which the disorder is controlled by treatment.

Sections E, F and G classify disorders of the male reproductive organs, and sections H, J and K classify parallel disorders of the female organs. The classification generally follows the A.M.A. Guides, except at Sections E and H, which deal with loss of sexual function. The standards set forth in sections E and H are simpler and more objective than those of the A.M.A. Guides.

8 MCAR § 1.9023 - Skin Disorders

The skin schedule is based on the A.M.A. Guides. The disability is evaluated according to the effect of the disorder on the ability to function and perform activities of daily living, and according to the degree of treatment required. The classes represent a logical progression and offer a workable and simplistic guide for the practitioner.

Each class requires the presence of signs or symptoms of a skin disorder. A Class 1 disorder, a two percent disability, must be supported by objective skin findings, thus eliminating cases involving vague complaints which cannot be objectively substantiated. The remaining classes are divided according to treatment and the effect of the disorder on activities of daily living, as defined at 8 MCAR § 1.9002 E.

No provision of 8 MCAR § 1.9023 specifically provides compensation for disfigurement or scarring. Some types of scarring may cause skin disorders. Any functional impairment due to disfigurement or scarring will be evaluated under this schedule according to the degree of treatment required and the effect on activities of daily living. In addition, if the loss of function from scarring or disfigurement is to a body part or system other than the skin, that loss will be evaluated in accordance with the applicable schedule for that body part or system.

In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry Governing Workers' Compensation Permanent Partial Disability Schedule

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Attorney, H. Theodore Grindal, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

H. Theodore Grindal
Special Attorney

Dated: December 28, 1983.

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
DIVISION OF WORKERS' COMPENSATION

In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry, Governing Workers' Compensation Permanent Partial Disability Schedule

AFFIDAVIT OF MAILING NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Jane Brie, being first duly sworn, deposes and says:

That on the 28th day of December, 1983, in the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United States Mailing at said City of St. Paul, a copy thereof, properly enveloped with postage prepaid, on all persons and associations who requsted notice that the rules in the above-entitled matter have been submitted to the Attorney General.

Jane Brie

Subscribed and sworn to before me
this 28th day of December, 1983.

Rosemary L LaRue

ROSEMARY L. LaRUE
NOTARY PUBLIC - MINNESOTA
RAMSEY COUNTY
My Commission Expires Nov. 11, 1984

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY
DIVISION OF WORKERS' COMPENSATION

In the Matter of the Proposed Adoption of Temporary Rules of the State Department of Labor and Industry, Governing Workers' Compensation Permanent Partial Disability Schedule

NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

PLEASE TAKE NOTICE that the above-captioned rules have been submitted to the Office of the Attorney General on this date, December 28, 1983, for review as to form and legality. Pursuant to Minn. Stat. § 14.32, the Attorney General will approve or disapprove the rules within five working days after receipt. Any person or association wishing to comment on the legality of the rules must do so within that time. If you desire to comment on the legality of the above-captioned rules, you should direct your comments to the Office of the Attorney General, 204 State Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155, telephone (612) 296-7030. Please note that a copy of any written comments submitted to the Attorney General must be submitted simultaneously to this agency.

Attached hereto is a copy of the change that was made in the proposed rules after publication in the State Register on December 5, 1983, and before submission to the Attorney General.

Dated: December 28, 1983

Steve Keefe

Steve Keefe, Commissioner
Department of Labor and Industry