No. 35219-2-II

COURT OF APPEALS - DIVISION II

OF THE STATE OF WASHINGTON

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DIVISION II
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STATE OF WASHINGTON
BY
DEPUTY

JAMES TOMLINSON,

Appellant,

v.

PUGET SOUND FREIGHT LINES,

Respondent.

APPELLANT'S REPLY BRIEF

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ORIGINAL

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A.[1] REPLY TO PSF'S "INTRODUCTION"

PSF's arguments that Tomlinson assigned error only to interpretation and application of RCW 51.32.080(5), not to "the facts *as found* by the agency and the trial court below,"[2] that he "effectively stipulated,"[3] and similar arguments elsewhere in its brief that his preinjury arthritis was a permanent disability under the statute,[4] are unsound.

First, as for findings by "the agency and the trial court," the trial court made no findings; the only fact findings of record were made by the Board.[5] Nothing in the Board's findings even contradicts, let alone precludes, Tomlinson's argument that § 080(5) should not apply.

Second, application of law to facts is a question of *law*. Watson v. Dep't of Labor & Indus., 133 Wn. App. 903, 911, 138 P.3d 177 (2006)

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[1] In his opening brief, Mr. Tomlinson, miscited the case of Cerrillo v. Esparza. The correct citation is 158 Wn.2d 194, 142 P.3d 155 (2006).

[2] Respondent's brief ("RB") at would be p. 1 of that brief (emphasis PSF's).

[3] *Id.*

[4] Respondent's brief (RB) 1-3 ("Introduction"); RB 3 (first issue pertaining to assignments of error); and RB 4 ("The only issue preserved for this Court's review is whether RCW 51.32.080(5) applies to the facts as found in the IAJ's PDO and affirmed by the Superior Court.") RB 6-7 ("As noted above, Appellant preserved no challenge to the IAJ's factual findings interpreting the medical evidence[,] [etc.]"); and RB 8 (at "Standard for review."

[5] CABR 10. This became the findings of the Board, by CABR 1. The trial court made no fact findings. *See* CP 50-52.

("Whether a statute applies to a set of facts is a conclusion of law that we review de novo." (citing *Wynn v. Earin*, cited in Tomlinson's opening brief at 17)). Whether, at the time of injury, Tomlinson had arthritis in his knee, and the nature of the arthritis, are questions of fact. Whether his arthritis was a "permanent partial disability" under § 080(5) is a question of law.

Third, Tomlinson's opening brief directly argued the ultimate issue in the case: whether his preinjury arthritis was "permanent partial disability" to be taken into account in determining his permanent partial disability benefit. Accordingly, the matter is properly before the court. *See* State v. Kinneman, 120 Wn. App. 327, 341-42, 84 P.3d 882 (2003), *affirmed*, 155 Wn.2d 272, 119 P.3d 350 (2005):

> Unchallenged findings of fact are verities on appeal. [Citation omitted.]. However, **"[i]n a case where the nature of the appeal is clear and the relevant issues are argued in the body of the brief ... so that the court is not greatly inconvenienced and the respondent is not prejudiced, there is no compelling reason for the appellate court not to exercise its discretion to consider the merits of the case or issue."** State v. Olson, 126 Wn.2d 315, 323, 893 P.2d 629 (1995).

(Emphasis added.)[6] *See also* Peste v. Mason County, 133 Wn. App. 456,

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[6] *Cf.* Robel v. Roundup Corp., 103 Wn. App. 75, 85, 10 P.3d 1104 (2000), *affirmed/reversed in part*, 148 Wn.2d 35, 59 P.3d 611 (2002):

> A preliminary issue is the appropriate standard of review. Fred Meyer has not assigned error to the court's findings of fact. They therefore are treated as verities

470, 136 P.3d 140 (2006) (**"we have inherent authority to consider all issues necessary to reach a proper decision"** (citation omitted, emphasis added)).

B. REPLY TO PSFL'S "ANSWER TO ASSIGNMENTS OF ERROR AND RESPONSE TO ISSUES PERTAINING TO ASSIGNMENTS OF ERROR"

Tomlinson replies below to PSFL's arguments pertaining to assignments of error and related issues.

C. REPLY TO PSFL'S "ANSWER TO STATEMENT OF THE CASE"

PSFL's argument that certain facts – presence of arthritis, a history of episodes of pain and medical treatment, a doctor having told Tomlinson, years before, that he was heading toward TKR, and a Veterans Administration disability determination (for *both* knees[7]) – evidence that

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on appeal. *See* Davis v. Dep't of Labor & Indus., 94 Wn.2d 119, 123, 615 P.2d 1279 (1980); RAP 10.3(g). However, an appellate court is not bound by a trial court's designation of factual findings or legal conclusions; a finding of fact that is really a legal conclusion will be treated as a legal conclusion, subject to de novo review. Local Union 1296, Int'l Ass'n of Firefighters v. City of Kennewick, 86 Wn.2d 156, 161-62, 542 P.2d 1252 (1975); *see* Dempere v. Nelson, 76 Wn. App. 403, 406, 886 P.2d 219 (1994), *review denied,* 126 Wn.2d 1015, 894 P.2d 565 (1995).

[7] CABR Chaplin testimony, p. 35 lines 11-21 (disability of 10 percent for each knee).

the arthritis was permanently disabling before the industrial injury[8] should be unpersuasive. PSFL cites no supporting authority, and the law refutes the arguments, point by point.

Sec. 080(5) addresses preexisting conditions that are both disabling and permanent. A history of previous symptoms, diagnosis, and treatment, without more, establish *neither* disability nor permanence. In regard to *disability*, *see* In re Leonard Norgren, No. 04 18211 (Bd. of Indus. Ins. Appeals, Jan. 12, 2006):

> Unfortunately, the Industrial Insurance Act does not define the term "disability."[9]... We have discussed the meaning of disability before. In *In re Forrest Pate, Dec'd*, Dckt. No. 90 4055 (May 7, 1992), we surveyed a number of court decisions interpreting the term "disability," including *Henson v. Department of Labor & Indus.*, 15 Wn.2d 384 (1942). ...
>
> ....
>
> In an effort to enhance understanding of the term "disability," the court in *Henson* related disability to its negative effect upon an individual's physical or mental functioning as well as his or her earning capacity. **Something more than existence of prior conditions requiring periodic medical attention was contemplated.** In the context of second injury fund relief,[10] **a**

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[8] RB 4-5.

[9] *See also* Harry v. Buse, 134 Wn. App. 739, 745 n.22, 132 P.3d 1122 (2006) ("'Partially disabled' is not defined in ch. 51.08 RCW.")

[10] Permanent disability "in the context of second injury fund relief" means the same thing as under § 080(5); both statutes operate only if, at the time of the industrial injury, the claimant already had a permanent disability. *See* RCW 51.16.120(1):

> **"preexisting disability" is more than a mere preexisting medical condition and must, in some fashion, permanently impact on the worker's physical and/or mental functioning.** ...

(Emphasis added.)

Similarly, that a doctor supposedly said that Tomlinson was heading toward TKR (information that came into evidence through Tomlinson, not medical testimony) does not evidence disability. Tomlinson was told that in March of 1992[11] – more than seven years before the fall down the stairs in this claim.[12] Throughout those seven years he continued to work, despite episodes of knee pain.[13] (Further,

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> Whenever a worker has a previous bodily disability from any previous injury or disease, whether known or unknown to the employer, and shall suffer a further disability from injury or occupational disease in employment covered by this title and become totally and permanently disabled from the combined effects thereof or die when death was substantially accelerated by the combined effects thereof, then the experience record of an employer insured with the state fund at the time of said further injury or disease shall be charged and a self-insured employer shall pay directly into the reserve fund only the accident cost which would have resulted solely from said further injury or disease, had there been no preexisting disability ...

[11] CABR Transcripts, Tomlinson testimony at p. p. 16 line 47 - p. 17.

[12] CABR Transcripts, Tomlinson testimony at p. 5 lines 39-45.

[13] *See* *In re Cecil L. Channing*, No. 88 2165 (Bd. of Indus. Ins. Appeals, July 25, 1990):

> We recognize that both Dr. Thorson and Dr. Winegar felt that Mr. Channing would have needed a total left knee replacement at some point in time, regardless of the industrial injury. However, we believe their testimony, taken as a whole, indicates that **Mr. Channing needed total left knee replacement surgery *when he did* because of the industrial injury of July 2, 1980.**

(Emphasis added.)

there is no evidence that during those seven years, when he saw doctors for knee symptoms, any doctor ever mentioned TKR again.) There is no evidence that if the industrial injury had not occurred, he would have been able to work out the rest of his work life.[14]

Regarding permanence, Tomlinson's opening brief sets out solid authority that under the Act, a condition does not become permanent until there is no more curative treatment for it, or in other words, it has become fixed and stable. The facts PSFL argues at RB 4-5 do not evidence permanence under the Act. (The fact that the Veterans Administration, in 1992,[15] determined him to have disability, when the criteria therefor are not in evidence, should be irrelevant. "The right to workers' compensation benefits is statutory, and a court will look to the provisions of *the Act* to determine whether a particular worker is entitled to compensation." Clauson v. Dep't of Labor & Indus., 130 Wn.2d 580, 584, 925 P.2d 624 (1996) *See also* Brand v. Dep't of Labor & Indus., 139 Wn.2d 659, 668, 989 P.2d 1111 (1999) (the "industrial Insurance Act is a self-contained system that provides specific procedures and remedies for

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[14] When he testified at hearing, on August 12, 2005, he was 63 years old. *See* CABR Transcripts at p. 1 line 6, then at p. 5 lines 21-27. This made him about 57 at the time of injury.

[15] CABR Chaplin testimony, p. 35, lines 11-21.

injured workers").[16]

"Courts must avoid readings of statutes that result in unlikely, absurd, or strained consequences." *Ballard Square Condo. Owners' Assn' v. Dynasty Construction Co.*, 158 Wn.2d 603, 622, 146 P.3d 914 (2006) (citation omitted). PSFL's argument that permanent disability after TKR should be determined by subtracting a rating for preexisting arthritis from post-TKR disability would produce such results. TKR removes arthritis. That is why permanent disability after TKR depends solely and entirely on knee function with the prosthesis. If the court were to adopt PSFL's formula for post-TKR permanent disability, in every case where preinjury progressive arthritis was advanced, and the result from TKR was "good" or "fair" – for which the *Guides* would assign permanent disability ratings of 37 percent or 50 percent of the lower extremity, respectively – the injured worker would get no permanent disability benefit at all (because the disability rating for preexisting arthritis would exceed the post-TKR disability rating[17]). If the Legislature had intended such a result it would

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[16] Also cited at appellant's opening brief (AB) 18 n.63.

[17] *See* CABR EXHIBITS to Dr. Smith's testimony: *Guides* p. 544, Table 17-31, the row titled "Knee," in the column for "0 mm," which directs that advanced arthritis (when permanent; see *Guides* sections set out below at p. 11) results in an impairment rating of 50 percent of the leg. Then see the *Guides* at p. 546-47, Table 17-33, which directs that after TKR, a "good" outcome results in an impairment rating of 37 percent of the leg, and a "fair" outcome results in impairment of 50 percent of the leg. Those pages are set out separately

have said so.[18, 19] Where neither the Legislature, in the Act, nor the

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in the Appendix.

[18] *Cf.* Edelman v. State ex rel. Pub. Disclosure Comm'n, 152 Wn.2d 584, 590, 99 P.3d 386 (2004), *review denied,* 139 1002, 989 P.2d 1139 (1999):

> If the legislature intended to create an exemption for situations in which the parent organization does not participate, it would have done so in the language of the statute. It didn't.

[19] The Legislature did, in fact, provide for permanent partial disability to be determined differently for some conditions than others. For example, in § 080(1), (2), and (3), the Legislature provided that permanent disability of extremities be determined by the *Guides*, but that permanent disability for other body parts or systems be determined by the "category" system set out in WAC 296-20-200 through 670. Similarly, the Department has disallowed *Guides* criteria for determining permanent disability where the Department believes such criteria do not reflect the Act. For example, in WAC 296-20-19030, the Department rejected an entire chapter of the *Guides* that allows permanent disability for pain, separate from and in addition to objective findings:

> WAC 296-20-19030. To what extent is pain considered in an award for permanent partial disability?
>
> The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. **No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.**
>
> For example:
>
> **Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints.** The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. **Chapter 18 of the 5th Edition of AMA *Guides to the***

Department, by regulation, provided that permanent partial disability after TKR be determined differently than provided by the *Guides*, the court should decline to adopt such an interpretation.

D. REPLY TO PSFL'S "SUMMARY OF ARGUMENT"

PSFL's argument that "The fact that the condition [*i.e.*, the arthritis] was progressive is not germane, given that the *level* of disability extant before the injury would not recede,"[20] and its later elaboration that because the title of the *Guides* is *"Guides for the Evaluation of Permanent Impairment*," a condition becomes "permanent disability" as soon as its symptoms, if permanent, would be ratable thereunder,[21] are dead wrong. In his opening brief, Tomlinson cited authority that under the Act, an injured worker has no permanent disability until a physician determines[22] that it has become fixed and stable,[23] meaning untreatable,[24] and static,[25]

Evaluation of Permanent Impairment **cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.**

(Emphasis added.)

[20] RB 7.

[21] RB 12 (emphasis PSFL's).

[22] AB 3, text and n.4.

[23] AB 3, text and n.5.

[24] AB 3 and 22.

[25] AB 7 n.29.

not progressing.[26] The *Guides* says those same things:

> An impairment is considered permanent when it has reached **maximum medical improvement (MMI)**, meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment. The term *impairment* in the *Guides* refers to **permanent impairment**, which is the focus of the *Guides*.[27]

(Bold and italics original, underline added.)

> An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized, often termed the date of **maximal medical improvement (MMI)**. It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once impairment has reached MMI, a permanent impairment rating may be performed. ...[28]

(Bold original, underline added.) Again,[29] in this case no physician applied the *Guides* until long after the industrial injury, at which time there was no arthritis (the arthritis having been surgically removed), but only impairment resulting from TKR. Therefore, § 080(5) does not apply.

In reply to the rest of PSFL's summary, Tomlinson reiterates, simply, that (1) the purpose of the Act is to minimize injured workers'

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[26] AB 2, and 20-23.

[27] *See*, in the Appendix, *Guides* Chapter 1, "Philosophy, Purpose, and Appropriate Use of the Guides[,]" part 1.2, "Impairment, Disability, and Handicap[,]" at p. 2.

[28] *Id.*, at 2.4, "When Are Impa9irment Ratings Performed?"

[29] *See* AB 16.

suffering and economic loss; (2) until Tomlinson fell down the stairs at work he was able to work, without surgery, despite arthritis; (3) at the time of the industrial injury, the arthritis was not fixed and stable; (4) the industrial injury worsened the arthritis, necessitating the TKR; (5) after TKR, Tomlinson's permanent partial disability was 75 percent of the leg, solely and entirely because of poor function with the prosthetic knee; (6) uncertainty about the meaning of Act provisions should be resolved in injured workers' favor, and courts should avoid interpretations that restrict benefits.

E. REPLY TO PSFL'S "ARGUMENT"

1. Standard for review

Except for PSFL's argument about the scope of review, which Tomlinson has addressed above, he has no further comment about PSFL's section on "standard for review."

2. Reply to PSFL's argument about"Adhering to the remedial purpose of the Act"

PSFL characterizes Tomlinson's arguments as centering on three propositions, the first of which, according to PSFL, is that "The term 'permanent' is ambiguous and should, therefore, be liberally interpreted in

a manner that delivers compensation to the worker."[30] PSFL's characterization is mistaken. Tomlinson argued that "permanent" is *not* ambiguous,[31] but that *if* it were, the ambiguity should be interpreted in his favor.

PSFL's argument that "the remedial purpose of the Act was very much observed in this case" because "Appellant brought to this employment a longstanding, advanced and chronically problematic arthritic condition," directly contradicts settled precedent that employers take workers as they are, including all infirmities, and employers are responsible in full for worsening of preexisting conditions.[32] RCW 51.32.080(5) creates a narrow *exception* to that general principle, by excepting preexisting conditions that are *permanent and disabling*. Where a remedial statute, including the Act, states an exception to the overarching principle of compensability, the exception should be read narrowly, and strictly confined to its terms.[33] Where Tomlinson's

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[30] RB 9.

[31] AB 20-24.

[32] *See* AB 26-31.

[33] As cited previously, RCW 51.12.010 and substantial case law direct that the Act is remedial law, to be applied liberally to minimize injured workers' suffering and economic loss.

industrial injury was a proximate cause of his TKR,[34] and TKR residuals account for *all* of his 75 percent permanent partial disability,[35] PSFL should be responsible for the disability *in full*.

PSFL's remarkable claim that "Such benefits have or will be delivered as appropriate for a knee condition rated at 75% without discount or apportionment – just as if his work injury had originated the entire condition,"[36] is obviously false – as PSFL effectively admits, by saying that "For all benefit purposes other than the credit to be applied in calculating the actual payment, the Department order resulted in ultimate 'PPD award' of 75%."[37] The purpose of § 080 is to pay permanent partial disability benefits. There are no "other benefit purposes." The Department order from which this appeal originated – titled "PAYMENT

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[34] The fact that he had been told seven years earlier that he would or might need TKR in the future does not alter the fact that he did *not* need it until this industrial injury.

[35] PSFL's claim that "Appellant was *and will continue to be* afforded the panoply of workers' compensation benefits in the form of extensive medical treatment and knee replacement surgery, recuperative therapy, time loss and, if applicable, vocational assistance" (RB 11 (emphasis added)), is incorrect. Tomlinson's claim is closed. As things stand now, except as may result from this appeal he has no right to further benefits of any kind.

(In theory, he could become eligible for further benefits under RCW 51.32.160, which allows most closed claims to be reopened within seven years of first closing, if evidence shows the injury condition has worsened, objectively, since the claim was closed last. At this point this is entirely speculative.)

[36] RB 11, text and n.4.

[37] RB 11 n.4.

ORDER"[38] – did *not* award "75% without discount or apportionment – just as if his work injury had originated the entire condition." The order discounted the 75 percent rating by two thirds, for a preexisting condition that was *not* a permanent disability, and was *no* part of the permanent disability rating.

3. Reply to PSFL's argument about "Discerning the 'permanence' of disability associated with progressive arthritic conditions under RCW 51.32.080(5)"

PSFL's argument that because the title of the *Guides* is *"Guides for the Evaluation of Permanent Impairment,"*[39] any condition rated thereunder must be permanent, is addressed above at p. 10. In regard to PSFL's arguments that "To the extent Appellant's arguments constitute a collateral attack on the experts' factual conclusions [and] the IAJ's finding of permanence based upon them, Appellant failed to preserve such issues,"[40] and related arguments,[41] Tomlinson reiterates that (1) the

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[38] CABR 20.

[39] RB 12 (emphasis PSFL's).

[40] RB 13.

[41] *Id.*

medical witnesses did *not* testify that the arthritis was permanent;[42] (2) the IAJ did *not* make a fact finding that the arthritis was permanent;[43] and (3) if the doctors had so testified and the IAJ had so found, permanence still would be reviewed as a question of *law*, not fact, because "permanent disability" is statutory language, requiring application of law to facts.

In arguing that "the workers' compensation system recognizes 'permanent' disability caused by any number of 'relentlessly progressive maladies,'"[44] PSFL attacks an argument Tomlinson did not make. Tomlinson did not argue that progressive conditions cannot result in permanent disability; rather, he argued (supported by authority) that a progressive condition is not permanently disabling until it has become fixed and stable, *i.e.*, incapable of improvement by medical treatment. This is the essence of "permanent." PSFL cites no authority for its argument that "disability it [*i.e.*, a progressive condition] causes can be quantified and compensated at any given time if there is sufficient medical testimony that it meets the AMA criteria."[45] The *Guides*, themselves,

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[42] Tomlinson so asserted in his opening brief, effectively challenging PSFL to cite supporting testimony if any existed. PSFL has not done so.

[43] *See* CABR 10.

[44] RB 13.

[45] RB 14.

quoted above at p. 10, directly refute PSFL's argument.

4. Reply to PSFL's argument about "Discerning the 'permanence' of disability due to preexisting arthritis in joints subsequently excised by surgery"

PSFL's argument that "Appellant interprets the statute [*i.e.*, § 080(5)] to mandate a focus on the nature and sources of permanent partial disability *only* at the point in time [when] the work injury claim is ultimately *closed*"[46] is not correct. This clause of the statute – "Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled..." – establishes that the time of injury is the moment in time at which there must be a permanent partial disability in order for § 080(5) to operate. That is just what Tomlinson argued in his opening brief: where the arthritis he had *at the time of injury* was not fixed and stable *then*, it was not "permanent disability."

The fact that permanent disability after TKR has nothing to do with arthritis addresses *other* language in subsection (5) – "aggravation or increase in such permanent partial disability," and "his or her compensation for such partial disability shall be adjudged with regard to

[46] RB 16 (first emphasis PSFL's, second emphasis added).

the previous disability of the injured member...". Where, as here, the injured worker had no permanent disability at the time of injury, there can be no "aggravation or increase in *such disability*,"[47] and there is nothing to subtract from permanent disability at the end of the claim. Tomlinson's permanent disability is not a combination of preexisting permanent disability, for arthritis, and additional permanent disability, for poor outcome of TKR. Rather, he has permanent disability from the TKR, alone.

PSFL's argument that "the statute addresses the calculation of PPD [*i.e.*, permanent partial disability] payments based on the respective *levels* of permanent disability *before and after* injury, not on respective causes of permanent disability extant at the time the industrial [condition] is ultimately rated,"[48] is correct – but it obscures the point that there must *be* some *permanent disability* at the time of injury for § 080(5) to apply. As a matter of law, Tomlinson's arthritis was not permanent, or permanent disability, because it was treatable – in other words, *not* fixed and stable – and was treated (by being removed).

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[47] Sec. 080(5) (emphasis added).

[48] RB 16 (emphasis PSFL's).

PSFL's argument about "amputation"[49] is similarly flawed. Where, at the time of injury, the arthritis was treatable, not fixed and stable, § 080(5) does not apply. Calling removal of the arthritis an "amputation" does not help PSFL, nor does the clause "from whatever cause." Sec. 080(5) requires increased disability of a body part "already...permanently partial disabled."[50] Tomlin's knee was not already permanently partially disabled.

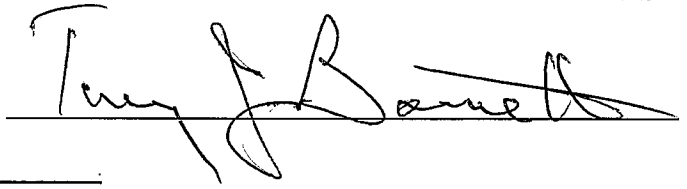
F. CONCLUSION

The arthritis Tomlinson had at the time of injury did not make his leg "already...permanently partially disabled," nor did the industrial injury "aggravat[e] or increase...such permanent partial disability." Therefore, RCW 51.32.080(5) did not apply. This court should reverse, and remand to the superior court for further action consistent this court's decision.

DATED this 23 of February 2007.

Respectfully submitted,

RUMBAUGH RIDEOUT BARNETT & ADKINS



[49] RB 17.

[50] "Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled..."

Terry J. Barnett, WSB 8080, Attorneys for appellant Tomlinson

CERTIFICATE OF SERVICE

I certify that on this date I mailed a copy of APPELLANT'S REPLY BRIEF to:

Jerald P. Keene
Reinisch, MacKenzie, Healey, Wilson & Clark, P.C.
10260 SW Greenburg Road #1250
Portland, OR 97223

DATED this 23 day of February 2007.

Michelle Rhodes
Michelle E. Rhodes, Legal Assistant

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WAC § 296-20-19030 (2007)

Washington Administrative Code
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*** THIS SECTION IS CURRENT THROUGH OCTOBER 4, 2006 ***

TITLE 296. LABOR AND INDUSTRIES, DEPARTMENT OF
CHAPTER 20. MEDICAL AID RULES

WAC § 296-20-19030 (2007)

WAC 296-20-19030. To what extent is pain considered in an award for permanent partial disability?

The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of **pain,** cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of **pain from the pain** already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.

For example:

Chapter **18** of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's **pain** complaints. The impairment caused by the worker's **pain** complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the **pain** already rated and compensated from the **pain** impairment that Chapter **18** purports to rate. Chapter **18** of the 5th Edition of AMA *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

Statutory Authority: RCW 51.04.010, 51.04.020, 51.04.030, 51.32.080, 51.32.110, 51.32.112, 51.36.060. 02-21-105, § 296-20-19030, filed 10/22/02, effective 12/1/02.

Source: Washington > Statutes & Regulations > WA - Washington Administrative Code - Selected Documents
TOC: Washington Administrative Code > /. . . / > CHAPTER 20. MEDICAL AID RULES > WAC 296-20-19030. To what extent is pain considered in an award for permanent partial disability?
Terms: 18 /99 pain (Edit Search | Suggest Terms for My Search)
View: Full
Date/Time: Thursday, February 22, 2007 - 5:26 PM EST

A-1

American Medical Association
Physicians dedicated to the health of America

Guides *to the* Evaluation *of* Permanent Impairment

Fifth Edition

Linda Cocchiarella, MD, MSc, AMA Medical Editor
Gunnar B. J. Andersson, MD, PhD, Senior Medical Editor

AMA press

A-2

The fifth edition includes most of the common conditions, excluding unusual cases that require individual consideration. Since this edition encompasses the most current criteria and procedures for impairment assessment, it is strongly recommended that physicians use this latest edition, the fifth edition, when rating impairment.

1.2 Impairment, Disability, and Handicap

1.2a Impairment

The *Guides* continues to define **impairment** as **"a loss, loss of use, or derangement of any body part, organ system, or organ function."**[2] This definition of impairment is retained in this edition. A medical impairment can develop from an illness or injury. An impairment is considered permanent when it has reached **maximal medical improvement (MMI),** meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment. The term *impairment* in the *Guides* refers to **permanent impairment,** which is the focus of the *Guides*.

An impairment can be manifested objectively, for example, by a fracture, and/or subjectively, through fatigue and pain.[3] Although the *Guides* emphasizes objective assessment, subjective symptoms are included within the diagnostic criteria. According to the *Guides,* determining whether an injury or illness results in a permanent impairment requires a medical assessment performed by a physician. An impairment may lead to functional limitations or the inability to perform activities of daily living.

Table 1-1, adapted from a report by the AMA Council on Scientific Affairs, lists various definitions of impairment and disability used by four main authorities: the AMA *Guides*, the World Health Organization, the Social Security Administration, and a state workers' compensation statute.[4] Although a nationally accepted definition for impairment does not exist, the general concept of impairment is similar in the definitions of most organizations. Several terms used in the AMA definition, and their application throughout the *Guides*, will be discussed in this chapter and Chapter 2.

Loss, loss of use, or derangement implies a change from a normal or "preexisting" state. ***Normal*** is a range or zone representing healthy functioning and varies with age, gender, and other factors such as environmental conditions. For example, normal heart rate varies between a child and adult and according to whether the person is at rest or exercising. Multiple factors need to be considered when assessing whether a specific or overall function is normal. A normal value can be defined from an individual or population perspective.

When evaluating an individual, a physician has two options: consider the individual's healthy preinjury or preillness state or the condition of the unaffected side as "normal" for the individual if this is known, or compare that individual to a normal value defined by population averages of healthy people. The *Guides* uses both approaches. Accepted population values for conditions such as extremity range-of-motion or lung function are listed in the *Guides*; it is recommended that the physician use those values as detailed in the *Guides* when applicable. In other circumstances, for instance, where population values are not available, the physician should use clinical judgment regarding normal structure and function and estimate what is normal for the individual based on the physician's knowledge or estimate of the individual's preinjury or preillness condition.

2.4 When Are Impairment Ratings Performed?

An impairment should not be considered permanent until the clinical findings indicate that the medical condition is static and well stabilized, often termed the date of **maximal medical improvement** (MMI). It is understood that an individual's condition is dynamic. Maximal medical improvement refers to a date from which further recovery or deterioration is not anticipated, although over time there may be some expected change. Once an impairment has reached MMI, a permanent impairment rating may be performed. The *Guides* attempts to take into account all relevant considerations in rating the severity and extent of permanent impairment and its effect on the individual's activities of daily living.

Impairments often involve more than one body system or organ system; the same condition may be discussed in more than one chapter. Generally, the organ system where the problems originate or where the dysfunction is greatest is the chapter to be used for evaluating the impairment. Thus, consult the vision chapter for visual problems due to optic nerve dysfunction. Refer to the extremity chapters for neurological and musculoskeletal extremity impairment from an injury. However, if the impairment is due to a stroke, the neurology chapter is most appropriate. Whenever the same impairment is discussed in different chapters, the *Guides* tries to use consistent impairment ratings across the different organ systems.

2.5 Rules for Evaluation

2.5a Confidentiality

Prior to performing an impairment evaluation, the physician obtains the individual's consent to share the medical information with other parties that will be reviewing the evaluation. If the evaluating physician is also that person's treating physician, the physician needs to indicate to the individual which information from his or her medical record will be shared.

2.5b Combining Impairment Ratings

To determine **whole person impairment,** the physician should begin with an estimate of the individual's most significant (primary) impairment and evaluate other impairments in relation to it. It may be necessary for the physician to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. Related but separate conditions are rated separately and impairment ratings are combined unless criteria for the second impairment are included in the primary impairment. For example, an individual with an injury causing neurologic and muscular impairment to his upper extremity would be evaluated under the upper extremity criteria in Chapter 16. Any skin impairment due to significant scarring would be rated separately in the skin chapter and combined with the impairment from the upper extremity chapter. Loss of nerve function would be rated within either the musculoskeletal chapters or neurology chapter.

In the case of two significant yet unrelated conditions, each impairment rating is calculated separately, converted or expressed as a whole person impairment, then combined using the Combined Values Chart (p. 604). The general philosophy of the Combined Values Chart is discussed in Chapter 1.

2.5c Consistency

Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's lumbosacral spine range of motion (Section 15.9) are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.

17.2h Arthritis

Roentgenographic grading systems for inflammatory and degenerative arthritis are well established and widely used for treatment decisions and scientific investigation. For most individuals, roentgenographic grading is a more objective and valid method for assigning impairment estimates than physical findings, such as the range of motion or joint crepitation. While there are some individuals with arthritis for whom loss of motion is the principal impairment, most people are impaired more by pain and sometimes weakness, but they still can maintain functional ranges of motion, at least in the early stages of the process. Range-of-motion techniques are therefore of limited value for estimating impairment secondary to arthritis in many individuals. Crepitation is an inconstant finding that depends on such factors as forces on joint surfaces and synovial fluid viscosity.

Certain roentgenographic findings that are of diagnostic importance, such as osteophytes and reactive sclerosis, have no direct bearing on impairment. The best roentgenographic indicator of disease stage and impairment for a person with arthritis is the cartilage interval or joint space. The hallmark of all types of arthritis is thinning of the articular cartilage; this correlates well with disease progression.

The need for joint replacement or major reconstruction usually corresponds with complete loss of the articular surface (joint space). The impairment estimates in a person with arthritis (Table 17-31) are based on standard x-rays taken with the individual standing, if possible. The ideal film-to-camera distance is 90 cm (36 in), and the beam should be at the level of and parallel to the joint surface. The estimate for the patellofemoral joint is based on a "sunrise view" taken at 40° flexion or on a true lateral view.

In the case of the knee, the joint must be in neutral flexion-extension position (0°) to evaluate the x-rays. Impairments of individuals with knee flexion contractures should not be estimated using x-rays because measurements are unreliable. In these individuals, the range-of-motion method should be used. X-rays of the hip joint are taken in the neutral position. The cartilage interval (joint space) of the hip is relatively constant in the various positions; therefore, positioning is not as critical as for the knee x-rays. The ankle x-ray must be taken in a mortise view, which is 10° internal rotation: 10° flexion or extension is permissible. Evaluation of the foot joints requires a lateral view for the hindfoot and an anteroposterior view for the midfoot and forefoot. If there is doubt or controversy about the suitability of the radiographic method in a specific individual, range-of-motion techniques may be used instead.

Table 17-31 Arthritis Impairments Based on Roentgenographically Determined Cartilage Intervals

	Whole Person (Lower Extremity) [Foot] Impairment (%)			
	Cartilage Interval			
Joint	3 mm	2 mm	1 mm	0 mm
Sacroiliac (3 mm)*	—	1 (2)	3 (7)	3 (7)
Hip (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Knee (4 mm)	3 (7)	8 (20)	10 (25)	20 (50)
Patellofemoral†	—	4 (10)	6 (15)	8 (20)
Ankle (4 mm)	2 (5) [7]	6 (15) [21]	8 (20) [28]	12 (30) [43]
Subtalar (3 mm)	—	2 (5) [7]	6 (15) [21]	10 (25) [35]
Talonavicular (2-3 mm)	—	—	4 (10) [14]	8 (20) [28]
Calcaneocuboid	—	—	4 (10) [14]	8 (20) [28]
First metatarsophalangeal	—	—	2 (5) [7]	5 (12) [17]
Other metatarsophalangeal	—	—	1 (2) [3]	3 (7) [10]

* Normal cartilage intervals are given in parentheses.

† In an individual with a history of direct trauma, a complaint of patellofemoral pain, and crepitation on physical examination, but without joint space narrowing on x-rays, a 2% whole person or 5% lower extremity impairment is given.

A person who has an intra-articular fracture and subsequent rapid onset of arthritis should be evaluated using the arthritis section combined with Section 17.2j on diagnosis-based estimates.

Example 17-13
15% Impairment Due to Arthritis and Malalignment From a Tibia Fracture

Subject: 48-year-old man.

History: Fell from a loading dock 23 years ago, sustaining a right tibia fracture.

Current Symptoms: Resumed work. Over the last several years, had right knee pain toward the end of the day. Occasional mild swelling of the knee joint.

Physical Exam: The fracture healed with a 10° varus deformity of the right tibia. He has almost full range of motion of the injured knee, 0° through 125°, and mild crepitation.

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Table 17-33 Impairment Estimates for Certain Lower Extremity Impairments

Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Pelvis*	
Pelvic fracture	
Undisplaced, nonarticular, healed, without neurologic deficit or other sign	0
Displaced nonarticular fracture: estimate by evaluating shortening and weakness	—
Acetabular fracture: estimate according to range of motion and joint changes	—
Sacroiliac joint fracture: consider displacement	1-3 (2-7)
Ischial bursitis (weaver's bottom) requiring frequent unweighting and limiting of sitting time	3 (7)
Hip	
Total hip replacement; includes endoprosthesis, unipolar or bipolar	
Good results, 85-100 points†	15 (37)
Fair results, 50-84 points†	20 (50)
Poor results, less than 50 points†	30 (75)
Femoral neck fracture, healed in	
Good position	Evaluate according to examination findings
Malunion	12 (30) plus range-of-motion criteria
Nonunion	15 (37) plus range-of-motion criteria
Girdlestone arthroplasty Or estimate according to examination findings; use the greater estimate	20 (50)
Trochanteric bursitis (chronic) with abnormal gait	3 (7)
Femoral shaft fracture	
Healed with 10°-14° angulation or malrotation	10 (25)
15°-19°	18 (45)
20°	+1 (2) per degree up to 25 (62)

Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Knee	
Patellar subluxation or dislocation with residual instability	3 (7)
Patellar fracture	
Undisplaced, healed	3 (7)
Articular surface displaced more than 3 mm	5 (12)
Displaced with nonunion	7 (17)
Patellectomy	
Partial	3 (7)
Total	9 (22)
Meniscectomy, medial *or* lateral	
Partial	1 (2)
Total	3 (7)
Meniscectomy, medial *and* lateral	
Partial	4 (10)
Total	9 (22)
Cruciate *or* collateral ligament laxity	
Mild	3 (7)
Moderate	7 (17)
Severe	10 (25)
Cruciate *and* collateral ligament laxity	
Moderate	10 (25)
Severe	15 (37)
Plateau fracture	
Undisplaced	2 (5)
Displaced	
5°-9° angulation	5 (12)
10°-19° angulation	10 (25)
20°+ angulation	+1 (2) per degree up to 20 (50)
Supracondylar or intercondylar fracture	
Undisplaced fracture	2 (5)
Displaced fracture	
5°-9° angulation	5 (12)
10°-19° angulation	10 (25)
20°+ angulation	+1 (2) per degree up to 20 (50)

*Refer also to Section 15.14 on the pelvis.

†See Table 17-34 or Table 17-35 for point rating system.

‡A stress x-ray is an anterior-posterior view taken with a varus or valgus stress applied by a knowledgeable physician.

§The tibia–os calcis angle is measured as shown in Figure 17-7.

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Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Total knee replacement including unicondylar replacement	
Good result; 85-100 points†	15 (37)
Fair results, 50-84 points†	20 (50)
Poor results, less than 50 points†	30 (75)
Proximal tibial osteotomy	
Good result	10 (25)
Poor result	Estimate impairment according to examination and arthritic degeneration
Tibial shaft fracture, malalignment of	
10°-14°	8 (20)
15°-19°	12 (30)
20°+	+1 (2) per degree up to 20 (50)
Ankle	
Ligamentous instability (based on stress x-rays‡)	
Mild (2-3 mm excess opening)	2 (5) [7]
Moderate (4-6 mm)	4 (10) [14]
Severe (> 6 mm)	6 (15) [21]
Fracture	
Extra-articular with angulation	
10°-14°	6 (15) [21]
15°-19°	10 (25) [35]
20°+	+1 (2) [3] per degree up to 15 (37) [53]
Intra-articular with displacement	8 (20) [28]
Hindfoot	
Fracture	
Extra-articular (calcaneal)	
With varus angulation 10°-19°	5 (12) [17]
With varus angulation 20°+	0.5 (1) [1] per degree up to 10 (25)
With valgus angulation 10°-19°	3 (7) [11]
With valgus angulation 20°+	0.5 (2) [1] per degree up to 10 (25) [35]

Region and Condition	Whole Person (Lower Extremity) [Foot] Impairment (%)
Loss of tibia–os calcis angle§	
Angle is 120°-110°	5 (12) [17]
Angle is 100°-90°	8 (20) [28]
Angle is less than 90°	+1 (2) [3] per degree up to 15 (37) [54]
Intra-articular fracture with displacement	
Subtalar bone	6 (15) [21]
Talonavicular bone	3 (7) [10]
Calcaneocuboid bone	3 (7) [10]
Midfoot deformity	
Cavus	
Mild	1 (2) [3]
Moderate	3 (7) [10]
"Rocker bottom"	
Mild	2 (5) [7]
Moderate	4 (10) [14]
Severe	8 (20) [28]
Avascular necrosis of the talus	
Without collapse	3 (7) [10]
With collapse	6 (15) [21]
Forefoot deformity	
Metatarsal fracture with loss of weight transfer	
1st metatarsal	4 (10) [14]
5th metatarsal	2 (5) [7]
Other metatarsal	1 (2) [3]
Metatarsal fracture with plantar angulation and metatarsalgia	
1st metatarsal	4 (10) [14]
5th metatarsal	2 (5) [7]
Other metatarsal	1 (2) [3]

A-7