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**OREGON DEPARTMENT OF INSURANCE AND FINANCE
WORKERS' COMPENSATION DIVISION
OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 30**

CLAIMS EVALUATION AND DETERMINATION

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**EXHIBIT "A"
OREGON ADMINISTRATIVE RULES
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436-30-001 Authority for Rules

These rules are promulgated under the Director's authority contained in ORS 656.726(3) and ORS 656.268.

History: Filed 2/6/75 as WCB Admin. Order 5-1975, effective 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-000, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-002 Purpose of Rules

These rules provide uniform guidelines for disability evaluation under the Workers' Compensation Act, describe the functions of Evaluation and prescribe the claim closure process.

History: Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-002, May 1985
Amended 12/19/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-003 Applicability of Rules

(1) These rules are effective January 1, 1988 and apply to all accepted claims for worker's compensation benefits.

(2) All orders or requests issued by Evaluation are considered an "order or request of the director."

(3) These rules take the place of the rules adopted on January 1, 1982 by Workers' Compensation Department Administrative Order 5, 1981, and carry out the provisions of ORS 656.726(3).

- (a) ORS 656.206;
- (b) ORS 656.214;
- (c) ORS 656.268; and
- (d) ORS 656.325;

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-000, May 1985
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436-30-005 Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Board" means the Workers' Compensation Board of the Department of Insurance and Finance.

(2) "Combine" means to find a value for any two numbers, A and B, by using the

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formula: $A + B(1.00-A)$, where A and B are written as decimals.

(3) "Department" means the Department of Insurance and Finance.

(4) "Determination" means the review by Evaluation which establishes the extent of temporary or permanent disability to which a worker is entitled as a result of a compensable disabling injury.

(5) "Director" means the Director of the Department of Insurance and Finance or the Director's delegate for the matter.

(6) "Evaluation" means the Evaluation Section of the Workers' Compensation Division of the Department of Insurance and Finance.

(7) "Insurer" means the State Accident Insurance Fund, an insurer authorized under ORS chapter 731 to transact worker's compensation insurance in Oregon, a self insured employer or a self-insured employer group.

(8) "Medically stationary" means that no further material improvement in a worker's condition would reasonably be expected from treatment, or the passage of time.

(9) "Return to Work" means that a worker has been hired in a permanent job (defined as permanent employment in OAR 436-110-005(6)(b)) and has demonstrated the physical capacity to perform that job.

(10) "Scheduled disability" means disability which results from injuries to those body areas listed in ORS 656.214(2)(a) through (4).

(11) "Unscheduled disability" means disability arising from those losses contemplated by ORS 656.214(5) and not to body parts or functions listed in ORS 656.214(2)(a) through (4).

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-004, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-008 Administrative Review

(1) Evaluation may change or cancel any order it issues if it has made an error or if additional information is provided which affects the order. Evaluation shall act within 180 days after the order being changed or canceled is mailed only if a hearing has not been requested.

(2) Any party to a claim who does not agree with an order of Evaluation may, within 180 days:

(a) Request a review of that determination order, by writing to the Evaluation Section, Workers' Compensation Division, Department of Insurance and Finance, Room 203, Labor and Industries Building, Salem, OR 97310, or by calling 378-3306; or

(b) Ask Evaluation for a reconsideration as provided in OAR 436-30-050; or

(c) Request a hearing on the claim by writing to the Hearings Division of the Workers' Compensation Board.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80

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Renumbered from OAR 436-65-998, May 1985
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436-30-010 Evaluation Responsibility

(1) Evaluation, when requested by a party to a claim, is responsible for but not limited to:

- (a) Determining the extent of permanent disability;
- (b) Authorizing termination of temporary disability benefits;
- (c) Establishing permanent total disability;
- (d) Reviewing Notice of Closures;
- (e) Reconsidering Determination Orders;
- (f) Deciding if claims are non-disabling; and,
- (g) Establishing medically stationary dates.

History: Filed 2/6/75 as WCB Admin. Order 5-1975, effective 2/26/75
Amended 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-004, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-020 Insurer Claim Closure

(1) The insurer may issue a notice of closure on a disabling claim when medical information indicates the worker is medically stationary, and the worker has returned to work.

(a) When the insurer elects to close the claim, the insurer shall issue a notice of claim closure to the worker within 14 calendar days after evidence is received which shows the condition to be medically stationary and sufficient medical information is available to determine the extent of disability. If the worker's condition became stationary on or after January 1, 1988, the insurer may determine the extent of permanent disability. The insurer shall apply the same standards for the rating of permanent disability as those used by Evaluation.

(b) The original notice of closure shall be effective the date mailed. The notice must inform the worker of the amount of any permanent disability; the amount and duration of temporary disability compensation; the right of the worker to request a redetermination by, and a personal interview with, Evaluation within 180 days after the Notice of Closure is mailed; the right of the worker to request a hearing within 180 days after the notice; and, of the worker's aggravation rights.

(c) The original notice of closure (white) shall be mailed to the worker. A goldenrod copy shall be simultaneously mailed to the employer; a yellow copy shall be simultaneously mailed to the Department; and, a copy shall be simultaneously mailed to the worker's attorney pursuant to ORS 656.331(1)(b).

(2) A worker who has returned to work may request closure from the insurer. The insurer may:

- (a) Request Determination Order;

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(b) Issue a Notice of Closure if medically stationary; or,

(c) Issue a Notice of Refusal to close.

(3) If the worker disagrees with the notice of closure the worker may request a redetermination by, and a personal interview with Evaluation. If the worker disagrees with the notice of refusal to close, the worker may request redetermination by Evaluation.

(a) The request shall be made in writing.

(b) The request must be made within 180 days from the date of the notice of closure or 60 days from the date of the notice of refusal to close.

(c) The request for a redetermination regarding the notice of closure or notice of refusal to close will not be acted on if made after a request for hearing is filed.

(4) Regardless whether a request under section (2) has been made by the worker, Evaluation may change or cancel a notice of closure within 180 days after the notice is mailed.

(5) If the worker disagrees with an insurer's notice of closure or notice of refusal to close, the worker may request a hearing in writing by delivering or mailing that request to the Hearings Division of the Workers Compensation Board within 180 days after the notice of closure is mailed, or 60 days after the notice for refusal to close.

(6) Nothing in these rules prevents the insurer from paying, voluntarily or otherwise, amounts in excess of the compensation required to be paid to the injured worker or beneficiaries under ORS 656.001 to 656.794. However, such payments must be clearly identified as payments made under ORS 656.018, and not compensation required by the Workers' Compensation Law.

(7) Nothing in these rules shall prohibit an insurer from rescinding or correcting its notice of closure prior to the time a request for redetermination is filed with Evaluation or a request for hearing is filed with the Board.

(8) Upon returning to work, if a notice of closure has not been previously issued, the worker may request claim closure by writing to the insurer. Within 10 working days of receiving the worker's written request, the insurer shall either close the claim, if medically stationary, request a determination from Evaluation, or issue a notice of refusal to close. A notice of refusal to close shall advise the worker of the decision on to close, of the right of the worker to request a hearing within 60 days of the notice, of the right to be represented by an attorney, and of the right to request a redetermination by Evaluation within 60 days of the notice.

History: Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
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Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-030 Evaluation Determination: Procedure

(1) Requests by the insurer for determination by Evaluation shall be in the form and format prescribed by the Director.

(2) The worker or representative may write to Evaluation and request determination. If the worker has returned to work, Evaluation will notify the insurer of the worker's request so the insurer may choose whether to close the claim pursuant to OAR 436-30-020. If the insurer does

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not state that it will proceed to close the claim, Evaluation will act on the request for determination. The insurer shall submit all records to Evaluation within 14 calendar days after being notified of the worker's request.

(3) Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close:

(a) Within 14 calendar days after the worker becomes medically stationary and sufficient medical information is available to determine the extent of disability;

(b) After the 60th day following Department approval to suspend compensation benefits;

(c) After reasonable attempts to locate the worker have proven unsuccessful; or

(d) After the worker elects not to have further necessary treatment and there is little likelihood of the worker's condition improving with the passage of time.

(4) The insurer shall notify the worker and the worker's attorney pursuant to ORS 656.331(1)(b), when a request for determination is made.

(5) The insurer shall provide to Evaluation any medical records, work histories, vocational reports, and agency reports about the worker and their injury which have not been provided to the Department when requesting claim determination. Pursuant to ORS 656.268(2), the same records shall be supplied to the worker or the worker's attorney, if requested. The following conditions govern requests for determination:

(a) Evaluation may require the insurer to provide specific information held by the employer, the worker, any health care provider, or others involved in returning the worker to work. The insurer must provide such information to Evaluation within 60 days of the request, or the request for determination shall be invalid. Civil penalties may be imposed as provided in OAR 436-30-580.

(b) Evaluation may order additional medical examinations, or studies to determine work potential.

(c) Evaluation may conduct a personal interview with the worker.

(6) Evaluation shall:

(a) Apply guidelines and standards developed pursuant to ORS 656.726(3) when evaluating the permanent disability of an injured worker; and

(b) Issue a determination order within 10 working days following receipt of the request for determination; or

(c) Postpone the determination to obtain additional information necessary to that determination and notify the worker and any representative of the worker within 10 working days following receipt of the request; or

(d) Deny determination and notify the worker and any representative of the worker within 10 working days following receipt of the request, if the worker's condition has not become medically stationary.

(7) The effective date of the determination order shall be the date it is mailed. The

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mailing date appears on the order under "Date of Determination."

(8) Evaluation may allow adjustment of payments to the worker for the following purposes:

- (a) Recover payments for permanent partial disability which were made too early;
- (b) Recover overpayments for temporary disability; or
- (c) Recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed or other benefits payable under ORS 656.001 to .794.

(9) Evaluation may deny any request to recover if it finds the overpayment results from benefits paid during a training program not approved by the Department.

(10) Evaluation may only allow overpayments to be deducted from compensation to which the worker is entitled but has not yet been paid.

(11) When requested by the insurer, Evaluation shall declare the date on which the worker became medically stationary if the worker was in training pursuant to OAR 436-120, and the worker's date of injury was after December 31, 1973. This date will control administrative fund reimbursements to insurers by the Department for injuries prior to January 1, 1986.

(12) If, after claim closure, a worker is in training pursuant to OAR 436-120, the permanent disability shall be redetermined pursuant to ORS 656.265(5) when the worker is no longer engaged in such training. The insurer shall promptly request determination or issue a notice of closure when the worker's training ends, if the worker's condition is medically stationary.

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Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Amended 12/30/81 as WCD Admin. Order 5-1981, effective 1/1/82
Renumbered from OAR 436-65-010, May 1985
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436-30-050 Reconsideration of Determinations

A determination order shall be reconsidered if:

(1) One of the parties asks for reconsideration by writing to the Department and providing medical information which was not available at the time the original determination was made; and

(2) A request for a hearing has not been made and

(3) The request is delivered or mailed within 180 days after the determination order is mailed; and

(4) No lump sum payment of the permanent partial disability has been made.

History: Filed 6/30/78 as WCD Admin. Order 8-1978, effective 7/10/78
Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
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436-30-055 Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. A suitable and gainful occupation is an occupation for which the worker has the necessary physical capacity and the ability, training, or experience to perform.

(2) Disability which existed before the injury shall be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

(a) Prove permanent and total disability.

(b) Show a willingness to seek regular work at a suitable and gainful occupation and make reasonable efforts to find such work, or actively participate in a vocational assistance program unless the medical condition makes such efforts futile.

(4) Every determination order which grants permanent total disability shall notify the worker that:

(a) The claim shall be reviewed by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker shall make the statement on a form provided by the insurer, in accordance with the requirements under section (5) of this rule.

(c) The worker must tell the insurer immediately if the worker obtains any employment.

(5) If asked to provide a statement under (4)(b) the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the Director shall suspend the worker's permanent total disability benefits. Benefits may be resumed when the statement is provided. Benefits not paid for the period the report was withheld shall be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete or inaccurate, the insurer shall investigate. The investigation may result in suspension of permanent total disability benefits.

History: Filed 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-065 Review of Permanent Total Disability Awards

(1) The insurer shall review each permanent total disability claim every two years or when requested to do so by the Director to see if the worker's medical or vocational status has changed. The insurer shall send the results of the review to the Department.

(2) An award of permanent total disability for scheduled injuries before July 1, 1975, shall be reviewed by Evaluation only when the insurer has evidence that the medical condition has changed for the better.

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(3) An award of permanent total disability for scheduled injuries after July 1, 1975, or for unscheduled injuries, shall be reviewed by Evaluation only when the insurer has evidence that the worker is working at a regular, suitable, and gainful occupation or is capable of doing so.

(4) Any request from the insurer to Evaluation to reduce permanent total disability shall be accompanied by documentation to support the request. That documentation may include medical, vocational, or investigation reports (including visual records, if available) which demonstrate a change in the physical condition or in employability.

(5) Evaluation shall issue a determination order stating that the permanent total disability award has been reduced when the evidence demonstrates that the worker is no longer permanently and totally disabled.

(6) The worker may request a hearing if the permanent total disability award is reduced.

(a) Requests for hearing must be made in writing to the Workers' Compensation Board.

(b) Requests for hearing must be made within 180 days after the mailing date of the order reducing the award.

History: Filed 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-120 Guidelines for the Rating of Scheduled Permanent Disability

(1) Rules 436-30-120 through 436-30-370 apply to the rating of scheduled permanent partial disability under the Workers' Compensation Law.

(2) The criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury.

(3) Ranges of motion and ankylosis positions are measured from the anatomically neutral joint position at zero degrees. Ranges of motion are active arcs of joint motion. Any arc of retained motion is valued the same as an equal arc of active motion commencing at the neutral position, unless otherwise indicated.

(4) Where a maximum allowance is shown for a given complete loss, it is understood that a proportion of the maximum is allowed for less than a complete loss.

(5) At no time will the rating of disability in a scheduled area exceed the statutory allowance for an amputation at the most proximally involved level.

(6) At no time will any combination of losses in a scheduled area result in an allowance in excess of 100% loss of the most proximally involved radical (scheduled body part).

History: Amended 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-500, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-130 Parts of the Upper Extremity

(1) Thumb and fingers. Disabilities arising at or distal to the metacarpophalangeal (MP) articulations are rated as a percentage of the respective thumb or finger. When the disability involves two or more digits, the disability may be converted to a rating for loss in the hand.

(2) Hand. The hand includes that area from the distal surfaces of the distal row of carpal

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bones to the metacarpophalangeal joints of the digits.

(3) Forearm. The forearm does not include the elbow joint, but extends distally therefrom to the distal surfaces of the distal row of carpal bones.

(4) Arm. The arm begins with the elbow joint and includes all structures of the upper extremity proximal thereto, including the humerus and those muscles which have as their primary function movement of the arm.

History: Filed 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-501, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-140 Amputations Involving the Upper Extremity

(1) Thumb. Amputation at the interphalangeal (IP) joint, including the adjacent epiphyseal region of the proximal phalanx, represents 50% loss of the thumb, or a proportion thereof for amputation distal to that level. The loss of more than one phalanx of a thumb, including the distal epiphyseal region of the proximal phalanx, represents 100% loss of the thumb.

(2) Any finger:

(a) Amputation at the distal interphalangeal (DIP) joint, including the adjacent epiphyseal region of the middle phalanx, represents 50% loss of the finger, or a proportion thereof for amputation distal to that level.

(b) Amputation at the proximal interphalangeal (PIP) joint, including the adjacent epiphyseal region of the proximal phalanx, represents 75% loss of the finger, or a proportion thereof for amputation distal to that level.

(c) Amputation proximal to the distal epiphyseal region of the proximal phalanx represents 100% loss of the finger.

(3) For metacarpal ray resection, 10% loss of a hand is allowed for each resected metacarpal, in combination with other hand losses.

(4) Amputation of the forearm at or proximal to the wrist joint represents 100% loss of the forearm.

(5) Amputation of the arm at or proximal to the elbow joint represents 100% loss of the arm.

History: Filed 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-502, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-150 Loss of Opposition in Finger/Thumb Amputations

(1) Loss of opposition is rated in terms of percentage of loss of function of the digit(s) deprived of effective opposition.

(2) For thumb amputations:

(a) At the interphalangeal level, 20% loss of opposition in the index finger, 20% loss of opposition in the middle finger, 10% loss of opposition in the ring finger, and 5% loss of

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opposition in the little finger is allowed;

(b) At the metacarpophalangeal level, 40% loss of opposition in the index finger, 40% loss of opposition in the middle finger, 20% loss of opposition in the ring finger, and 10% loss of opposition in the little finger is allowed.

(3) For index or middle finger amputations:

(a) At the distal interphalangeal level, 10% loss of opposition in the thumb is allowed;

(b) At the proximal interphalangeal level, 25% loss of opposition in the thumb is allowed;

(c) At the metacarpophalangeal level, 30% loss of opposition in the thumb is allowed.

(4) When multiple finger/thumb losses are converted to a rating on the hand radical, according to OAR 436-30-180, an additional rating for loss of opposition is not to be included.

History: Filed 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-503, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-160 Thumb

(1) Interphalangeal joint:

(a) Flexion. For the complete loss of interphalangeal thumb flexion, a maximum of 45% loss of the thumb is allowed.

(b) Flexion ankylosis. Ankylosis in interphalangeal thumb flexion represents a minimum of 35% loss of the thumb, if in the position of function (40°). This allowance increases proportionally to 45% loss of the thumb for ankylosis in full flexion (80°), or for ankylosis in the neutral position (0°).

(2) Metacarpophalangeal joint:

(a) Flexion. For the complete loss of metacarpophalangeal thumb flexion, a maximum of 55% loss of the thumb is allowed.

(b) Flexion ankylosis. Ankylosis in metacarpophalangeal thumb flexion represents a minimum of 43% loss of the thumb, if in the position of function (20%). This allowance increases proportionally to 80% loss of the thumb for ankylosis in full flexion (60%), or to 55% loss of the thumb for ankylosis in the neutral position (0°).

History: Filed 3/20/80 as WCD Admin. Order 4-1980, effective 4/1/80
Renumbered from OAR 436-65-505, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-170 Any Finger

(1) Distal interphalangeal joint:

(a) Flexion. For the complete loss of distal interphalangeal finger flexion, a maximum of 45% loss of the finger is allowed.

(b) Flexion ankylosis. Ankylosis in distal interphalangeal finger flexion represents a minimum of 30% loss of the finger, if in the position of function (40°). This allowance increases proportionally to 45% loss of the finger for ankylosis in full flexion (70°), or for ankylosis in the

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neutral position (0°).

(2) Proximal interphalangeal joint:

(a) Flexion. For the complete loss of proximal interphalangeal finger flexion, a maximum of 60% loss of the finger is allowed.

(b) Flexion ankylosis. Ankylosis in proximal interphalangeal finger flexion represents a minimum of 50% loss of the finger, if in the position of function (40°). This allowance increases proportionally to 70% loss of the finger for ankylosis in full flexion (100°), or to 60% loss of the finger for ankylosis in the neutral position (0°).

(3) Metacarpophalangeal joint:

(a) Flexion. For the complete loss of metacarpophalangeal finger flexion, a maximum of 55% loss of the finger is allowed.

(b) Flexion ankylosis. Ankylosis in metacarpophalangeal finger flexion represents a minimum of 45% loss of the finger, if in the position of function (30°). This allowance increases proportionally to 100% loss of the finger for ankylosis in full flexion (90°), or to 55% loss of the finger for ankylosis in the neutral position (0°).

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436-30-180 Conversion of Thumb/Finger(s) Value(s) to Hand Value

(1) 100% loss of a thumb represents 43% loss of a hand, or a proportion thereof for less than a complete loss.

(2) 100% loss of an index finger represents 22% loss of a hand, or a proportion thereof for less than a complete loss.

(3) 100% loss of a middle finger represents 20% loss of a hand, or a proportion thereof for less than a complete loss.

(4) 100% loss of a ring finger represents 9% loss of a hand, or a proportion thereof for less than a complete loss.

(5) 100% loss of a little finger represents 6% loss of a hand, or a proportion thereof for less than a complete loss.

(6) When converting thumb/finger losses to hand values according to this Section, an additional loss of opposition allowance for amputation findings is not to be included.

(7) The impairment of hand values according to this rule shall be added.

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436-30-190 Forearm (Wrist Joint)

(1) Dorsiflexion. For the complete loss of wrist joint dorsiflexion, a maximum of 10% loss of the forearm is allowed.

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(2) Dorsiflexion ankylosis. Ankylosis in wrist joint dorsiflexion represents a minimum of 25% loss of the forearm, if in the position of function (30°). This allowance increases proportionally to 90% loss of the forearm for ankylosis in full dorsiflexion (60°), or to 30% loss of the forearm for ankylosis in the neutral position (0°).

(3) Palmar flexion. For the complete loss of wrist joint palmar flexion, a maximum of 11% loss of the forearm is allowed.

(4) Palmar flexion ankylosis. Ankylosis in wrist joint palmar flexion represents a minimum of 30% loss of the forearm, if in the neutral position (0°). This allowance increases proportionally to 90% loss of the forearm for ankylosis in full palmar flexion (70°).

(5) Radial deviation. For the complete loss of wrist joint radial deviation, a maximum of 4% loss of the forearm is allowed.

(6) Radial deviation ankylosis. Ankylosis in wrist joint radial deviation represents a minimum of 30% loss of the forearm, if in the position of function (0°). This allowance increases proportionally to 90% loss of the forearm for ankylosis in full radial deviation (20°).

(7) Ulnar deviation. For the complete loss of wrist joint ulnar deviation, a maximum of 5% loss of the forearm is allowed.

(8) Ulnar deviation ankylosis. Ankylosis in wrist joint ulnar deviation represents a minimum of 30% loss of the forearm, if in the position of function (0°). This allowance increases proportionally to 90% loss of the forearm for ankylosis in full ulnar deviation (30°).

(9) Pronation or supination. For the complete loss of wrist joint pronation or supination, a maximum of 13% loss of the forearm is allowed. Losses of pronation and supination are to be rated in terms of percentage of loss of the forearm when the loss of motion arises from injury to the wrist. When the pathology resulting in these losses arises in the proximal radio-ulnar or radio-humeral articulations, the elbow should be considered involved, and the rating made in terms of loss of function of the arm.

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436-30-200 Conversion of Hand/Forearm Value(s) to Arm Value

100% loss of a hand or forearm represents a maximum of 80% loss of an arm, or a proportion thereof for less than a complete loss.

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Renumbered from OAR 436-65-524, May 1985
Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-210 Arm

Elbow joint:

(1) Flexion. For the complete loss of elbow joint flexion, a maximum of 39% loss of the arm is allowed.

(2) Extension. For elbow joint extension limited to 150°, a maximum of 30% loss of the arm is allowed, or a proportion thereof for elbow joint extension limited to less than 150°.

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(3) Ankylosis. Elbow joint ankylosis represents a minimum of 50% loss of the arm, if in the position of function (100°). This allowance increases proportionally to 95% loss of the arm for ankylosis in full flexion (150°), or to 65% loss of the arm for ankylosis in full extension (0°).

(4) Pronation or supination. For the complete loss of elbow joint pronation or supination, a maximum of 13% loss of the arm is allowed.

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436-30-220 Other Upper Extremity Findings

(1) Sensory loss in the hand/finger(s)/thumb. Loss of palmar sensation in the hand, finger(s) or thumb is rated according to the location and quality of the loss:

(a) Location of sensory loss:

(A) Hand. Sensory loss arising from injury to the median nerve distribution, if total, represents 40% loss of the hand. Sensory loss arising from injury to the ulnar nerve distribution, if total, represents 10% loss of the hand.

(B) Finger(s). Sensory loss in a finger, if bilaterally total, represents 75% loss of the finger. Radial sensory loss, if total, represents 45% loss of the finger. Ulnar sensory loss, if total, represents 30% loss of the finger.

(C) Thumb. Sensory loss in the thumb, if bilaterally total, represents 75% loss of the thumb. Radial sensory loss, if total, represents 30% loss of the thumb. Ulnar sensory loss, if total, represents 45% loss of the thumb.

(b) Quality of sensory loss:

(A) Total. Total sensory loss is rated as in (a) above, according to the location of the loss.

(B) Partial. A proportion of the allowances in (a) above is allowed if the sensory loss is less than total, according to the location of the loss.

(c) Dorsal sensory loss in the hand, digit(s) or thumb represents no functional loss.

(2) Nerve impairment in the forearm/arm:

(a) Sensory deficit:

(A) For complete median nerve sensory loss (above or below mid-forearm), a maximum of 40% loss of the forearm is allowed.

(B) For complete radial triceps (musculospiral) nerve sensory loss, a maximum of 5% loss of the arm is allowed.

(C) For complete ulnar nerve sensory loss (above or below mid-forearm), a maximum of 10% loss of the forearm is allowed.

(b) Motor deficit (decreased grip strength, neurological in origin):

(A) For complete median nerve motor loss above the mid-forearm, a maximum of 55% loss of the forearm is allowed.

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(B) For complete median nerve motor loss below the mid-forearm, a maximum of 35% loss of the forearm is allowed.

(C) For complete radial triceps (musculospiral) nerve motor loss, a maximum of 55% loss of the arm is allowed.

(D) For complete radial (musculospiral) nerve motor loss, a maximum of 40% loss of the forearm is allowed.

(E) For complete ulnar nerve motor loss above the mid-forearm, a maximum of 35% loss of the forearm is allowed.

(F) For complete ulnar nerve motor loss below the mid-forearm, a maximum of 25% loss of the forearm is allowed.

(c) When decreased grip strength is not neurological in origin, but results from amputation or decreased joint range(s) of motion, an additional allowance for loss of grip strength is not to be included.

(d) When decreased grip strength results from tissue loss (other than amputation) or atrophy, the loss is rated according to section (5) of this rule.

(3) Pain. Chronic upper extremity pain in the affected radical shall be rated based on the degree of impairment produced.

(4) Causalgia. When true causalgia persists despite appropriate treatment, the loss of function of the affected member may be as much as 100% impairment of that member.

(5) Loss of strength or grip due to tissue loss (other than amputation) or atrophy:

(a) For complete loss of grip strength, a maximum of 50% loss of the forearm is allowed. For severe grip strength loss (20% of normal), 40% loss of the forearm is allowed. For moderate grip strength loss (40% of normal), 30% loss of the forearm is allowed. For mildly moderate grip strength loss (60% of normal), 20% loss of the forearm is allowed. For mild grip strength loss (80% of normal), 10% loss of the forearm is allowed.

(b) When decreased grip strength results from amputation or decreased joint range(s) of motion, and not from tissue loss, atrophy, or neurological impairment, an additional allowance for loss of grip strength is not to be included.

(6) Surgery:

(a) Radial head resection represents 15% impairment of the arm.

(b) Ulnar distal head resection represents 10% impairment of the forearm.

(c) Prosthetic joint replacement in the elbow, with good results, represents a minimum of 25% impairment of the arm.

(7) Dermatological conditions limited to the upper extremity. Consider the actual functional loss, rather than the extent of cosmetic or cutaneous involvement, according to the following classifications:

(a) Class 1: 0%-5% impairment of the radical. A worker belongs in Class 1 when:

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- (A) Signs and symptoms of skin disorder are present; and
- (B) With treatment there is minimal limitation in the radical's functions, although certain physical and/or chemical agents may temporarily increase the extent of functional limitation.
- (b) Class 2: 15% impairment of the radical. A worker belongs in Class 2 when:
 - (A) Signs and symptoms of skin disorder are present; and
 - (B) Intermittent treatment is required; and
 - (C) There is limitation in some of the radical's functions.
- (c) Class 3: 40% impairment of the radical. A worker belongs in Class 3 when:
 - (A) Signs and symptoms of skin disorder are present; and
 - (B) Continuous treatment is required; and
 - (C) There is limitation in many of the radical's functions.
- (d) Class 4: 70% impairment of the radical. A worker belongs in Class 4 when:
 - (A) Signs and symptoms of skin disorder are present; and
 - (B) Continuous treatment is required which may include periodic confinement at home or other domicile; and
 - (C) There is limitation in many of the radical's functions.
- (e) Class 5: 90% impairment of the radical. A worker belongs in Class 5 when:
 - (A) Signs and symptoms of skin disorder are present; and
 - (B) Continuous treatment is required which necessitates confinement at home or other domicile; and
 - (C) There is severe limitation in the radical's functions.

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436-30-230 Multiple Losses in the Upper Extremity

- (1) When two or more joints within a radical are involved, combine the impairment values.
- (2) When two or more ranges of motion within a joint are involved, add the impairment values.
- (3) When two or more ankylosis positions are documented within a joint, the larger (or largest) ankylosis allowance represents the joint impairment due to ankylosis.
- (4) When two or more radicals are involved within an extremity, the impairment of each radical is converted to the corresponding impairment value in the most proximally involved radical, and these corresponding values are combined.

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(5) When any other scheduled findings which result in impairment are documented; their impairment values are combined with any values obtained as a result of the application of (1) through (4) above.

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436-30-240 Parts of the Lower Extremity

(1) Great toe and toes. Disabilities arising at or distal to the metatarsophalangeal (MP) articulations are rated as a percentage of the respective toe.

(2) Foot. The foot includes that area from the metatarsophalangeal joints of the toes to, but not including, the knee joint.

(3) Leg. The leg begins with the knee joint and includes all structures of the lower extremity proximal thereto, including the femoral head and acetabulum.

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436-30-250 Amputations Involving the Lower Extremity

(1) Great toe. Amputation at the interphalangeal joint represents 50% loss of the great toe, or a proportion thereof for amputation distal to that level. Amputation at the metatarsophalangeal joint represents 100% loss of the great toe, or a proportion thereof for amputation distal to that level.

(2) Second through fifth toes.

(a) Amputation at the distal interphalangeal joint represents 50% loss of the toe, or a proportion thereof for amputation distal to that level.

(b) Amputation at the proximal interphalangeal joint represents 75% loss of the toe, or a proportion thereof for amputation distal to that level.

(c) Amputation at the metatarsophalangeal joint represents 100% loss of the toe, or a proportion thereof for amputation distal to that level.

(3) Foot.

(a) Amputation at the mid-metatarsal level represents 50% loss of the foot.

(b) Amputation at the tarsal level (Chopart's amputation) represents 75% loss of the foot.

(c) Amputation at the tibio-talar level, or at any level proximal thereto but below the knee joint, represents 100% loss of the foot.

(4) Leg. Amputation at the knee joint, or at any level of the leg radical proximal thereto, represents 100% loss of the leg.

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436-30-260 Great Toe

(1) Interphalangeal joint:

(a) Flexion. For the complete loss of interphalangeal great toe flexion, a maximum of 45% loss of the great toe is allowed.

(b) Flexion ankylosis. Ankylosis in interphalangeal great toe flexion represents a minimum of 35% loss of the great toe, if in the position of function (0°). This allowance increases proportionally to 45% loss of the great toe for ankylosis in full flexion (30°).

(2) Metatarsophalangeal joint:

(a) Dorsiflexion. For the complete loss of metatarsophalangeal great toe dorsiflexion, a maximum of 34% loss of the great toe is allowed.

(b) Dorsiflexion ankylosis. Ankylosis in metatarsophalangeal great toe dorsiflexion represents a minimum of 55% loss of the great toe, if in the position of function (0°). This allowance increases proportionally to 100% loss of the great toe for ankylosis in full dorsiflexion (50°).

(c) Plantar flexion. For the complete loss of metatarsophalangeal great toe plantar flexion, a maximum of 21% loss of the great toe is allowed.

(d) Plantar flexion ankylosis. Ankylosis in metatarsophalangeal great toe plantar flexion represents a minimum of 55% loss of the great toe, if in the position of function (0°). This allowance increases proportionally to 100% loss of the great toe for ankylosis in full plantar flexion (30°).

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436-30-270 Second Through Fifth Toes

(1) Distal interphalangeal joint:

(a) Restricted motion of the distal interphalangeal joint of the second through fifth toes represents no functional loss, except in ankylosis.

(b) Ankylosis. Ankylosis in the distal interphalangeal joint of the second through fifth toes represents a minimum of 30% loss of the toe, if in the position of function (0°). This allowance increases proportionally to 45% loss of the toe for ankylosis in full dorsiflexion, or to 45% loss of the toe for ankylosis in full plantar flexion ("hammer toe").

(2) Proximal interphalangeal joint:

(a) Restricted motion of the proximal interphalangeal joint of the second through fifth toes represents no functional loss, except in ankylosis.

(b) Ankylosis. Ankylosis in the proximal interphalangeal joint of the second through fifth toes represents a minimum of 45% loss of the toe, if in the position of function (0°). This allowance increases proportionally to 75% loss of the toe for ankylosis in full dorsiflexion, or for ankylosis in full plantar flexion ("hammer toe").

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(3) Metatarsophalangeal joint:

(a) Dorsiflexion. For the complete loss of metatarsophalangeal second through fifth toe dorsiflexion, a maximum of 29% loss of the toe is allowed.

(b) Dorsiflexion ankylosis. Ankylosis in metatarsophalangeal second through fifth toe dorsiflexion represents a minimum of 50% loss of the toe, if in the position of function (0°). This allowance increases proportionally to 100% loss of the toe for ankylosis in full dorsiflexion (40°).

(c) Plantar flexion. For the complete loss of metatarsophalangeal second through fifth toe plantar flexion, a maximum of 21% loss of the toe is allowed.

(d) Plantar flexion ankylosis. Ankylosis in metatarsophalangeal second through fifth toe plantar flexion represents a minimum of 50% loss of the toe, if in the position of function (0°). This allowance increases proportionally to 100% loss of the toe for ankylosis in full plantar flexion (30°, "hammer toe").

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436-30-280 Other Great Toe/Toe Findings

(1) Sensory loss. Complete loss of plantar sensation in any toe represents a maximum of 10% loss of the toe.

(2) Prosthetic toe joint surgery, whether replacement or resection (toe flail joint).

(a) For great toe interphalangeal joint prosthesis, 20% loss of the great toe is allowed. For great toe metatarsophalangeal joint prosthesis, 30% loss of the great toe is allowed.

(b) For second through fifth toe distal interphalangeal prosthesis, 15% loss of the toe is allowed. For second through fifth toe proximal interphalangeal prosthesis, 25% loss of the toe is allowed. For second through fifth toe metatarsophalangeal prosthesis, 25% loss of the toe is allowed.

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Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-290 Conversion of Great Toe/Toe Value(s) to Foot Value

(1) 100% loss of a great toe represents 13% loss of a foot, or a proportion thereof for less than a complete loss.

(2) 100% loss of a second through fifth toe represents 3% loss of a foot, or a proportion thereof for less than a complete loss.

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436-30-300 Foot

(1) Mid-foot (tarsometatarsal articulations):

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(a) For a severe loss of mid-foot motion, 10% loss of the foot is allowed, or a proportion thereof for less than a severe loss.

(b) Ankylosis. Each tarsometatarsal ankylosis represents 10% loss of the foot.

(2) Subtalar:

(a) Inversion. For the complete loss of subtalar inversion, a maximum of 5% loss of the foot is allowed.

(b) Inversion ankylosis ("triple arthrodesis"). Ankylosis in subtalar inversion represents a minimum of 30% loss of the foot, if in the position of function (0°). This allowance increases proportionally to 70% loss of the foot for ankylosis in full inversion (30°).

(c) Eversion. For the complete loss of subtalar eversion, a maximum of 4% loss of the foot is allowed.

(d) Eversion ankylosis. Ankylosis in subtalar eversion represents a minimum of 30% loss of the foot, if in the position of function (0°). This allowance increases proportionally to 70% loss of the foot for ankylosis in full eversion (20°).

(3) Ankle joint (tibio-talar):

(a) Dorsiflexion. For the complete loss of ankle joint dorsiflexion, a maximum of 7% loss of the foot is allowed.

(b) Dorsiflexion ankylosis. Ankylosis in ankle joint dorsiflexion represents a minimum of 50% loss of the foot, if in the position of (0°). This allowance increases proportionally to 70% loss of the foot for ankylosis in full dorsiflexion (20°).

(c) Plantar flexion. For the complete loss of ankle joint plantar flexion, a maximum of 14% loss of the foot is allowed.

(d) Plantar flexion ankylosis. Ankylosis in ankle joint plantar flexion represents a minimum of 40% loss of the foot, if in the position of function (10°). This allowance increases proportionally to 70% loss of the foot for ankylosis in full plantar flexion (40°).

(4) Ankylosis of both ankle joint and subtalar joint represents a minimum of 50% loss of the foot.

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436-30-310 Other Foot Findings

(1) Sensory loss. Complete loss of plantar sensation in the foot represents a maximum of 10% loss of the foot.

(2) Shortening of the lower extremity due to injury to the foot. Lower extremity shortening is rated on the leg radical, as in OAR 436-30-340(4).

(3) Ankle joint instability. For marked ankle joint instability, 30% loss of the foot is allowed, or a proportion thereof for instability less than marked.

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(4) Prosthetic ankle replacement, with good results, represents a minimum of 25% loss of the foot.

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436-30-320 Conversion of Foot Value to Leg Value

100% loss of a foot represents 90% loss of a leg, or a proportion thereof for less than a complete loss.

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436-30-330 Leg

(1) Knee Joint:

(a) Flexion. For the complete loss of knee flexion, a maximum of 53% loss of the leg is allowed.

(b) Extension. For the loss of knee extension to 50°, 27% loss of the leg is allowed, or a proportion thereof for a loss of extension to less than 50°. For the loss of knee extension beyond 50°, 90% of the leg is allowed.

(c) Ankylosis. Knee ankylosis represents a minimum of 50% loss of the leg, if in the position of function (10°). This allowance increases proportionally to 53% loss of the leg for ankylosis in full extension (0°), or to 80% loss of the leg for ankylosis in flexion to 40°. Knee ankylosis in flexion beyond 40° represents 90% loss of the leg.

(2) Hip joint:

(a) Forward flexion. For the complete loss of hip joint forward flexion, a maximum of 18% loss of the leg is allowed.

(b) Forward flexion ankylosis. Hip joint ankylosis in forward flexion represents a minimum of 50% loss of the leg if in the position of function (25°). This allowance increases proportionally to 70% loss of the leg for ankylosis in the neutral position (0°), or to 100% loss of the leg for ankylosis in full forward flexion (100°).

(c) Backward extension. For the complete loss of hip joint backward extension, a maximum of 5% loss of the leg is allowed.

(d) Backward extension ankylosis. Hip joint ankylosis in backward extension represents a minimum of 70% loss of the leg if in the neutral position (0°). This allowance increases proportionally to 100% loss of the leg for ankylosis in full backward extension (30°).

(e) Abduction. For the complete loss of hip joint abduction, a maximum of 16% loss of the leg is allowed.

(f) Abduction ankylosis. Hip joint ankylosis in abduction represents a minimum of 70% loss of the leg if in the position of function (0°). This allowance increases proportionally to 100% loss of the leg for ankylosis in full abduction (40°).

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(g) Adduction. For the complete loss of hip joint adduction, a maximum of 8% loss of the leg is allowed.

(h) Adduction ankylosis. Hip joint ankylosis in adduction represents a minimum of 70% loss of the leg if in the position of function (0°). This allowance increases proportionally to 100% loss of the leg for ankylosis in full abduction (20°).

(i) Internal rotation. For the complete loss of hip joint internal rotation, a maximum of 10% loss of the leg is allowed.

(j) Internal rotation ankylosis. Hip joint ankylosis in internal rotation represents a minimum of 70% loss of the leg if in the position of function (0°). This allowance increases proportionally to 100% loss of the leg for ankylosis in full internal rotation (40°).

(i) External rotation. For the complete loss of hip joint external rotation, a maximum of 13% loss of the leg is allowed.

(j) External rotation ankylosis. Hip joint ankylosis in external rotation represents a minimum of 70% loss of the leg if in the position of function (0°). This allowance increases proportionally to 100% loss of the leg for ankylosis in full internal rotation (50°).

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436-30-340 Other Lower Extremity Findings

(1) Sensory loss. Sensory loss in the leg radical represents no functional loss.

(2) Pain. Chronic lower extremity pain in the affected radical shall be rated based on the degree of impairment produced.

(3) Causalgia. When true causalgia persists despite appropriate treatment, the loss of function in the affected member may be as much as 100% impairment of that member.

(4) Shortening of the lower extremity. Lower extremity shortening is rated on the leg radical, whether above or below the knee in origin. For shortening in excess of one and a half inches, 20% loss of the leg is allowed, or a proportion thereof for shortening less than one and a half inches.

(5) Knee joint instability. For marked knee joint instability, 30% loss of the leg is allowed, or a proportion thereof for instability less than marked.

(6) Surgery:

(a) Prosthetic knee replacement, with good results, represents a minimum of 25% loss of the leg.

(b) Prosthetic hip replacement, with good results, represents a minimum of 25% loss of the leg.

(c) Menisectomy. Resection of a lateran or medical meniscus, with good results, represents a minimum of 5% loss of the leg. Resection of both lateral and medial menisci from one knee, with good results, represents a minimum of 20% loss of the leg.

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- (d) Patellectomy. Resection of a patella represents a minimum of 20% loss of the leg.
- (7) Vascular disease limited to the lower extremity:
 - (a) Class 1: 5% impairment of the radical. A worker belongs in Class 1 if:
 - (a) There is neither intermittent claudication nor pain at rest; and
 - (b) There is only transient edema. Vascular disease is not impairing if only the following findings are present:
 - (A) Loss of pulses;
 - (B) Minimal loss of subcutaneous tissue of toetips;
 - (C) Calcification of arteries as detected by x-ray examination; and
 - (D) Asymptomatic dialation of arteries (including painless aneurysms not amenable to surgery) or of veins, resulting in no loss of function in the radical.
 - (c) Class 2: 15% impairment of the radical. A worker belongs in Class 2 when any one of the following findings exists:
 - (A) Intermittent claudication occurs on walking at least 100 yards at an average pace;
 - (B) Vascular damage as shown be physical signs such as healed painless stump of an amputated single toe, with evidence of persistent vascular disease or healed ulcer; or
 - (C) Persistent edema of a moderate degree, incompletely controlled by elastic supports.
 - (d) Class 3: 40% impairment of the radical. A worker belongs in Class 3 when any one of the following findings exists:
 - (A) Intermittent claudication occurs on walking as little as 25 yards and no more than 100 yards at an average pace;
 - (B) Vascular damage as shown be physical signs such as healed amputation stumps of two or more toes of one extremity, with evidence of persistent vascular disease or persistent superficial ulceration; or
 - (C) Marked edema which is only partially controlled by elastic supports.
 - (e) Class 4: 70% impairment of the radical. A worker belongs in Class 4 when any one of the following findings exists:
 - (A) Intermittent claudication occurs on walking less than 25 yards, or pain at rest occurs at intervals;
 - (B) Vascular damage as shown be physical signs such as amputation at or above the ankle of one extremity, or amputation of two or more toes of two extremities, with evidence of persistent vascular disease or persistent widespread or deep ulceration involving one extremity; or
 - (C) Marked edema which cannot be controlled by elastic supports.
 - (e) Class 5: 90% impairment of the radical. A worker belongs in Class 5 when any one of the following findings exists:

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(A) Severe and constant pain at rest; or

(B) Vascular damage as shown by physical signs such as amputation at or above the ankle of two extremities, with evidence of persistent vascular disease, or persistent widespread or deep ulceration involving two extremities. Edema alone cannot be the basis for classification in Class 5.

(8) Skin conditions. For dermatological conditions limited to the lower extremity, apply the classifications found in OAR 436-30-220(7).

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436-30-350 Multiple Losses in the Lower Extremity

Multiple losses in the lower extremity are either added or combined as required by OAR 436-30-230, and calculated according to the same method there described.

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436-30-360 Hearing Loss

(1) Work-related hearing loss is rated based on information supplied to the Department by the insurer/self-insured employer. Information supplied shall include the complete audiometric testing record and the otolaryngologist's and/or licensed audiologist's record, history, examination, diagnosis, opinion and interpretation, if available.

(2) Compensation for work-related hearing loss, whether diagnosed as an occupational disease or acoustic trauma, will be offset by pre-existing hearing loss if previously compensated, presbycusis, or if supporting evidence such as base-line or pre-exposure audiograms are provided.

(3) The current audiogram showing the greatest retained levels of hearing will be used for rating compensable hearing loss. The frequencies reported shall be 500, 1000, 2000, 3000, 4000 and 6000 Hz, air conduction:

(a) Audiograms should be based on ANSI 1969 standards, although other standards are acceptable if clearly identified.

(b) Testing shall be performed only after the worker has been removed from significant noise exposure for fourteen consecutive hours.

(4) Calculation of monaural hearing loss. The sum of ANSI audiogram entries at 500, 1000, 2000, 3000, 4000 and 6000 Hz, if 550 or greater, represents 100% loss of hearing in one ear, or a proportion thereof for a sum less than 550. A sum of 150 or less represents no monaural hearing loss.

(5) Calculation of binaural hearing loss. Binaural hearing loss is calculated by finding the loss in each ear as in (4) of this rule, and then computing the binaural loss exactly as stated in ORS 656.214(2)(g).

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436-30-370 Visual Loss

(1) Work-related visual loss is rated with reference to central visual acuity, integrity of the visual fields, and ocular motility. Other losses to the visual system are rated according to OAR 436-30-530(3).

(2) Central visual acuity. Central visual acuity shall be reported both for distance and near vision, with best correction as medically prescribed.

(a) Distance acuity. For distance vision, reported in standard increments of Snellen 20/20 notation or its Metric equivalent, 20/20 or better represents no loss; 20/25 represents a 5% loss; 20/32 represents a 10% loss; 20/40 represents a 15% loss; 20/50 represents a 25% loss; 20/64 represents a 35% loss; 20/80 represents a 40% loss; 20/100 represents a 50% loss; 20/125 represents a 60% loss; 20/160 represents a 70% loss; 20/200 represents an 80% loss; 20/300 represents an 85% loss; 20/400 represents a 90% loss; 20/800 represents a 95% loss; and findings beyond 20/800 represent a 100% loss of distance vision.

(b) Near acuity. For near vision, reported in standard increments of Snellen 14/14 notation or its Jaeger or Point equivalent, 14/18 or better represents no loss; 14/22 represents a 5% loss; 14/28 represents a 10% loss; 14/35 represents a 50% loss; 14/45 represents a 60% loss; 14/56 represents an 80% loss; 14/70 represents an 85% loss; 14/87 represents a 90% loss; 14/112 represents a 95% loss; and findings beyond 14/112 represent a 100% loss of near vision.

(c) Calculating loss of central visual acuity. The arithmetic average of the appropriate two percentages of lost distance and near vision, as drawn from subsections (a) and (b) of this section, represents the percentage of lost central visual acuity which is to be compensated.

(d) When the lens has been removed, an additional loss of one eye is to be combined with the average found in subsection (c) of this section as follows:

- (A) Prosthetic lens implant 25%,
- (B) No implant 50%

(3) Visual fields. The extent of retained visual field shall be reported for each of the eight standard 45°, meridians whose directions and normal extent are: Temporally to 85°, Down temporally to 85°, Down to 65°, Down nasally to 50°, Nasally to 60°, Up nasally to 55°, Up to 45°, and Up temporally to 55°, for a total normal field of 500°, as measured from the point of fixation.

(a) Calculating visual field loss. The degrees of retained field along the eight standard meridians are added together. This sum is then subtracted from the normal field total of 500, to obtain the extent of visual field loss. This value, if 500 or larger, represents 100% loss of visual field, or a proportion thereof for a value less than 500.

(b) Quadrantanopsia or hemianopsia. For loss of a quarter or half field, add the normal extent of each meridian included within the lost field to half the sum of the normal extent of the two boundary meridians, and then proceed as in subsection (a) of this section.

(c) Scotoma. Central scotoma is rated as a loss of central visual acuity. Field loss due to

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scotoma in other areas is calculated by adding the degrees lost in each of the standard meridians affected, and then proceeding as in subsection (a) of this section.

(4) Ocular motility (diplopia). Visual impairment due to diplopia is rated in the eye with the greater loss.

(a) Diplopia in primary gaze, to a concentric 20°, represents 100% loss of vision in one eye.

(b) Diplopia in downward gaze from 20° to 30° represents 50% loss of vision in one eye, and beyond 30° represents 30% loss of vision in one eye.

(c) Percentages of diplopia loss in meridian directions other than Down: Temporally, Down temporally, Down nasally, or Nasally: from 20° to 30° represents a 20% loss; beyond 30° represents a 10% loss of vision in one eye. Up nasally, Up, or Up temporally: beyond 20° represents a 10% loss of vision in one eye.

(5) Calculation of monocular loss. Each finding of loss in an eye is calculated separately, with the results combined to obtain the total monocular loss.

(6) Calculation of binocular loss. Binocular visual loss is calculated by finding the loss in each eye as in (5) above, and then computing the binocular loss exactly as stated in ORS 656.214(2)(i).

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436-30-380 Guidelines for the Rating of Unscheduled Permanent Disability

(1) Rules 436-30-380 through 436-30-550 apply to the rating of unscheduled permanent partial disability under the Workers' Compensation Law.

(2) The criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad range of general occupations.

(a) Impairment of the whole person. This is the basic factor in the evaluation of lost earning capacity. The phrase, "the whole person," refers to the average functional capacity normally present in an uninjured worker. Injury-related impairment of the whole person must be documented in the medical record.

(b) Social/vocational considerations. These are additional factors to be included in the evaluation of lost earning capacity. Depending on the circumstances of the individual worker, they may include: Age, education, work experience, adaptability to less strenuous physical labor, mental capacity, emotional and psychological findings, and findings in the labor market. For each social or vocational factor a range of expected impact on disability is given. The range begins at zero impact. Those findings which tend to reduce the disabling effects of the injury are given negative (-) values. Those findings which tend to increase the disabling effects of the injury are given positive (+) values.

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436-30-390 Assembling the Factors Relating to Loss of Earning Capacity

(1) Determine the basic value which represents the impairment of the whole person, according to the appropriate findings and classifications described in OAR 436-30-470 through 436-30-550 below. If impairment is present, this will always be a positive (+) value.

(2) Identify the appropriate social/vocational factors applicable to the injured worker, according to the relevant findings described in OAR 436-30-400 through 460. Depending on their impact on the worker's disability, these may be determined to represent either positive (+), negative (-), or zero values.

(3) In two separate calculations,

(a) Combine together the positive (+) values found in (1) and (2) above, and then

(b) Combine together the negative (-) values found in (2) above.

(4) The final negative (-) combination value is then taken as a percentage of the final positive (+) combination value, and is subtracted therefrom. The result, when rounded to the nearest five percent, represents the percentage of lost earning capacity to be compensated.

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436-30-400 Age

(1) The range of impact for the age factor is valued from -10 to +10. The impaired worker's age at the time of disability rating determines which value within that range is applied.

(2) The median group, ages thirty-six through forty, is valued at zero.

(3) For ages twenty and younger, a value of -10 is given, or a proportion thereof for ages twenty-one through thirty-five.

(4) For ages fifty-six and older, a value of +10 is given, or a proportion thereof for ages forty-one through fifty-five.

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436-30-410 Education

(1) The range of impact for the education factor is valued from -25 to +15.

(2) The median educational level, twelfth grade or its equivalent, is valued at zero.

(3) For less than an eighth grade education, a value of +15 is given, or a proportion thereof for educational levels eighth grade through eleventh grade.

(4) For an educational level greater than four years of post-secondary schooling, a value of -25 is given, or a proportion thereof for educational levels greater than twelfth grade.

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436-30-420 Work Experience

- (1) The range of impact for work experience is valued from zero to +10.
- (2) Workers who have successfully performed in their relevant occupations for a sufficient length of time to have become proficient in them are assumed to possess the skills generally associated with those jobs. In most cases, after proficiency is reached, further time spent on the job adds no further skills.
- (3) Work requiring only a short demonstration, or a period up to and including thirty days, to develop adequate performance skills is valued at zero.
- (4) Work requiring more than thirty days, up to and including six months, to develop adequate performance skills is valued at +3.
- (5) Work requiring more than six months, up to and including one year, to develop adequate performance skills is valued at +5.
- (6) Work requiring more than one year, up to and including two years, to develop adequate performance skills is valued at +8.
- (7) Work requiring more than two years to develop adequate performance skills is valued at +10.

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436-30-430 Adaptability to less Strenuous Physical Labor

- (1) This factor considers whether a worker's residual functional capacity at the time of disability rating is less than the level of physical exertion required for the successful performance of his/her relevant occupation. "Physical exertion" here includes the general strength requirements of lifting, carrying, pushing and/or pulling. This factor is not considered for workers whose residual functional capacity equals or exceeds the physical exertion levels required in their relevant occupations.
- (2) Occupations, when classified according to physical exertion levels, include:
 - (a) Heavy work (frequently up to 50 lbs., occasionally over 50 lbs.);
 - (b) Medium work (frequently up to 25 lbs., occasionally up to 50 lbs.);
 - (c) Light work (frequently up to 10 lbs., occasionally up to 20 lbs.); and
 - (d) Sedentary work (frequently up to 5 lbs, occasionally up to 10 lbs.).
- (3) The range of impact for this factor is valued from zero to +20.
- (4) Workers formerly performing at the Heavy level, whose residual functional capacity permits:
 - (a) Medium work, receive a value of +5;
 - (b) Light work, receive a value of +10;
 - (c) Sedentary work, receive a value of +20.

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(5) Workers formerly performing at the Medium level, whose residual functional capacity permits:

- (a) Light work, receive a value of +5;
- (b) Sedentary work, receive a value of +15.

(6) Workers formerly performing at the Light level, whose residual functional capacity permits Sedentary work, receive a value of +10.

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436-30-440 Mental Capacity

(1) This factor considers actual intellectual capacity as distinguished from formal educational level:

- (2) The range of impact for this factor is valued from -25 to +15.
- (3) An average mental capacity is valued at zero.
- (4) Workers shown to perform in the range:
 - (a) Borderline-retarded, receive a value of +15;
 - (b) Dull-normal, receive a value of +5;
 - (c) Bright-normal, receive a value of -10; or
 - (d) Superior, receive a value of -25.

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436-30-450 Emotional and Psychological Findings

(1) A psychological or emotional condition may contribute to incapacity to perform in an occupational setting. Such mental conditions may range in severity from psychopathological responses such as chronic depression, to self-pity, malaise or lack of interest in appropriate vocational adjustments.

(2) If caused by the injury, mental or emotional conditions may themselves constitute a disability. If so, they are rated as an impairment of the whole person pursuant to OAR 436-30-540, and are not considered in this Section.

(3) The range of impact for the emotional and psychological factor is valued from -25 to +15.

(4) Workers emotionally or psychologically unable to adjust to the results of their injuries receive a value up to +15.

(5) Workers demonstrating an average adjustment to the results of their injuries receive a value of zero.

(6) Workers demonstrating an unwillingness to adjust to the results of their injuries

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receive a value up to -25.

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436-30-460 Labor Market Findings

(1) This factor considers the general availability of work which the impaired worker could be expected to obtain and hold. It is based on the normal availability of occupational opportunities in Oregon and is not adjusted for periodic business booms/recessions, sheltered or "charity" jobs, or work performed only by "superhuman" efforts. When a worker has successfully returned to work, or has been medically certified as capable of resuming his/her regular occupation, there is deemed to be an immediate and continuing demand for his/her services.

(2) The range of impact for this factor is valued from -25 to +15.

(3) For workers who can reasonably expect to find:

- (a) Few potential openings, a value of +15 is given;
- (b) Moderate restriction in openings, a value of +5 is given;
- (c) Average availability of openings, a value of zero is given;
- (d) Many openings, a value of -10 is given; or
- (e) Immediate and continuous demand, a value of -25 is given.

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Amended 12/17/87 as WCD Admin. Order 13-1987, effective 1/1/88

436-30-470 Unscheduled Impairment

(1) Rules 436-30-470 through 436-30-550 provide guidelines for rating impairment of the whole person in the unscheduled areas. Assessing the level of impaired function is the first step in rating lost earning capacity.

(2) Where impairment results from injury to more than one unscheduled body area or system, the appropriate values are combined to determine the basic impairment value.

(3) Where a maximum allowance is shown for a given complete loss, it is understood that a proportion of the maximum is allowed for less than a complete loss.

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436-30-480 Shoulder Joint

(1) Forward elevation. For the complete loss of shoulder joint forward elevation, a maximum of 10% impairment of the whole person is allowed.

(2) Forward elevation ankylosis. Shoulder joint ankylosis in forward elevation represents a minimum of 24% impairment of the whole person, if in the position of function (30°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full

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forward elevation (150°), or to 36% impairment of the whole person for ankylosis in the neutral position (0°).

(3) Backward elevation. For the complete loss of shoulder joint backward elevation, a maximum of 3% impairment of the whole person is allowed.

(4) Backward elevation ankylosis. Shoulder joint ankylosis in backward elevation represents a minimum of 36% impairment of the whole person, if in the neutral position (0°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full backward elevation (40°).

(5) Abduction. For the complete loss of shoulder joint abduction, a maximum of 10% impairment of the whole person is allowed.

(6) Abduction ankylosis. Shoulder joint ankylosis in abduction represents a minimum of 24% impairment of the whole person, if in the position of function (45°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full abduction (150°), or to 36% impairment of the whole person for ankylosis in the neutral position (0°).

(7) Adduction. For the complete loss of shoulder joint adduction, a maximum of 2% impairment of the whole person is allowed.

(8) Adduction ankylosis. Shoulder joint ankylosis in adduction represents a minimum of 36% impairment of the whole person, if in the neutral position (0°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full adduction (30°).

(9) Internal rotation. For the complete loss of shoulder joint internal rotation a maximum of 4% impairment of the whole person is allowed.

(10) Internal rotation ankylosis. Shoulder joint ankylosis in internal rotation represents a minimum of 36% impairment of the whole person, if in the neutral position (0°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full internal rotation (40°).

(11) External rotation. For the complete loss of shoulder joint external rotation, a maximum of 9% impairment of the whole person is allowed.

(12) External rotation ankylosis. Shoulder joint ankylosis in external rotation represents a minimum of 24% impairment of the whole person, if in the position of function (20°). This allowance increases proportionally to 60% impairment of the whole person for ankylosis in full external rotation (90°) or to 36% impairment of the whole person for ankylosis in the neutral position (0°).

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436-30-490 General Spinal Findings

(1) Vertebral fractures:

(a) For fracture of the body of one vertebra:

(A) 25% compression equals 5% impairment

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(B) 50% compression equals 10% impairment

(C) Greater than 50% compression means 20% impairment of the whole person will be allowed.

(b) For fractures of two or more vertebrae, with residuals, calculate the impairment of the whole person contributed by each fractured vertebra, and then combine the values for all fractured vertebrae. This value represents the impairment of the whole person contributed by two or more fractured vertebrae.

(2) Intervertebral disc lesion:

(a) If operated, with disc removed, represents 5% impairment of the whole person.

(b) Operated or non-operated disc derangement with residuals will be evaluated based on findings showing (1) restricted motion in the affected region of the spine, (2) sensory deficits attributable to the disc derangement, (3) motor deficits, or any combination thereof. These residuals' values are combined with the basic value in (a) above, to obtain the final impairment of the whole person appropriate to these cases.

(c) Decompression laminectomy without disc removal represents 1% impairment of the whole person.

(d) Excision of the spinous process represents 5% impairment of the whole person.

(3) Intervertebral fusion (ankylosis):

(a) For ankylosis of the seven cervical vertebrae, in the favorable or neutral position, a maximum of 20% impairment of the whole person is allowed, or a proportion thereof for ankylosis of fewer than seven. This value is doubled for ankylosis in an unfavorable position.

(b) For ankylosis between the C7 and T1 vertebrae, in the favorable or neutral position, 2% impairment of the whole person is allowed, or 4% for ankylosis in an unfavorable position.

(c) For ankylosis of the twelve thoracic vertebrae, in the favorable or neutral position, a maximum of 10% impairment of the whole person is allowed, or a proportion thereof for ankylosis of fewer than twelve. This value is doubled for ankylosis in an unfavorable position.

(d) For ankylosis between the T12 and L1 vertebrae, in the favorable or neutral position, 3% impairment of the whole person is allowed, or 6% for ankylosis in an unfavorable position.

(e) For ankylosis of the five lumbar vertebrae, in the favorable or neutral position, a maximum of 20% impairment of the whole person is allowed, or a proportion thereof for ankylosis of fewer than five. This value is doubled for ankylosis in an unfavorable position.

(f) For ankylosis between the L5 vertebra and the sacrum, in the favorable or neutral position, 5% impairment of the whole person is allowed, or 10% for ankylosis in an unfavorable position.

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436-30-500 Spinal Ranges of Motion

(1) Cervical region:

(a) Flexion. For the complete loss of neck flexion, a maximum of 4% impairment of the whole person is allowed.

(b) Extension. For the complete loss of neck extension, a maximum of 4% impairment of the whole person is allowed.

(c) Right or left lateral flexion. For the complete loss of right or left lateral neck flexion, a maximum of 2% impairment of the whole person is allowed.

(d) Right or left rotation. For the complete loss of right or left neck rotation, a maximum of 4% impairment of the whole person is allowed.

(2) Thoracolumbar region:

(a) Flexion. For the complete loss of thoracolumbar or low back flexion, a maximum of 9% impairment of the whole person is allowed.

(b) Extension. For the complete loss of thoracolumbar or low back extension, a maximum

(c) Right or left lateral flexion. For the complete loss of thoracolumbar or low back right or left lateral flexion, a maximum of 4% impairment of the whole person is allowed.

(d) Right or left rotation. For the complete loss of thoracolumbar or low back right or left rotation, a maximum of 5% impairment of the whole person is allowed.

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436-30-510 Pelvis

(1) Pelvic fracture, healed without residuals and without displacement, represents no impairment of the whole person.

(2) Pelvic fractures healed with displacement and deformity:

(a) In a single ramus, represent 2% impairment of the whole person;

(b) Of bilateral rami, represent 5% impairment of the whole person;

(c) Of the ilium, represent 2% impairment of the whole person;

(d) Of the innominate, displaced one inch or more, represent 10% impairment of the whole person;

(e) Of the symphysis pubis, displaced or separated, represent 15% impairment of the whole person;

(f) Of the sacrum, into the sacroiliac joint, represent 10% impairment of the whole person;

(g) Of the coccyx, with non-union or subsequent excision, represent 5% impairment of the whole person.

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(2) Pelvic fracture involving the acetabulum is rated on the basis of any residual restricted motion of the hip joint, according to the findings described in OAR 436-30-330.

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436-30-520 Heart Disease

(1) Class 1: 0%-10% impairment of the whole person. A worker belongs in Class 1 when:

- (a) Organic heart disease exists but without resulting symptoms;
- (b) Walking, climbing stairs freely, and the performance of the usual activities of daily living do not produce symptoms;
- (c) Prolonged exertion, emotional stress, hurrying, hill-climbing, recreation (prophylactic restriction of activity such as strenuous competitive sport does not exclude a worker from this class), or similar activities do not produce symptoms; and
- (d) Signs of congestive heart failure are not present; and
- (e) A pacemaker is implanted permanently.

(2) Class 2: 30% impairment of the whole person. A worker belongs in Class 2 when:

- (a) Organic heart disease exists, but without resulting symptoms at rest;
- (b) Walking freely on the level, climbing at least one flight of stairs, and the performance of the usual activities of daily living do not produce symptoms;
- (c) Prolonged exertion, emotional stress, hurrying, hill-climbing, recreation, or similar activities produce symptoms; and
- (d) Signs of congestive heart failure are not present.

(3) Class 3: 60% impairment of the whole person. A worker belongs in Class 3 when:

- (a) Organic heart disease exists but without resulting symptoms at rest;
- (b) Walking more than one or two blocks on the level, climbing one flight of ordinary stairs, or the performance of the usual activities-of daily living produce symptoms;
- (c) Emotional stress, hurrying, hill-climbing, recreation, or similar activities produce symptoms; and
- (d) signs of congestive heart failure, if present, are usually relieved by therapy.

(4) Class 4: 90% impairment of the whole person. A worker belongs in Class 4 when:

- (a) Organic heart disease exists with symptoms even at rest;
- (b) The performance of any of the activities of daily living beyond the personal toilet or its equivalent produces increased discomfort;
- (c) Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest; and
- (d) Signs of congestive heart failure, if present, are usually resistant to therapy.

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436-30-530 Cranial Nerves

(1) I (Olfactory). Complete bilateral inability to detect any odors (anosmia) represents 3% impairment of the whole person. Parosmia (perversion of the sense of smell) may also be sufficiently disturbing to constitute a 3% impairment of the whole person.

(2) II (Optic). Lesions of the optic nerve are rated according to their effects on scheduled vision, according to OAR 436-30-370.

(3) III (Oculomotor), IV (Trochlear), and VI (Abducens). Lesions in these nerves are rated according to their effects on ocular motility, according to OAR 436-30-370(4). Other visual losses may include such findings as excessive or diminished tearing, photophobia, irritability, nervousness, and headache. If mild, these findings represent no impairment of the whole person. If moderate, they represent 5% impairment of the whole person. If severe, they represent 10% impairment of the whole person.

(4) V (Trigeminal).

(a) Sensory distribution. Loss of sensation in the trigeminal distribution on one side represents 3% to 10% impairment of the whole person. Bilateral trigeminal sensory loss represents 20% to 35% impairment of the whole person.

(b) Typical trigeminal neuralgia. Intractable typical trigeminal neuralgia (unilateral or bilateral tic douloureux) represents impairment of the whole person ranging from 10% to 50%, depending on the frequency and severity of the attacks. Rating the pain of so-called "atypical trigeminal neuralgia" is based on the extent of interference with the worker's daily activities, and represents 0% to 20% impairment of the whole person.

(c) Motor distribution. Complete loss of the motor function of one trigeminal nerve represents 3% to 5% impairment of the whole person. Complete bilateral motor loss represents 30% to 45% impairment of the whole person, depending on the difficulty the worker experiences in speech and swallowing.

(5) VII (Facial).

(a) Sensory distribution. Sensory loss from damage to one or both facial nerves represents no impairment of the whole person. If, however, loss of taste results, the allowance is 3% impairment of the whole person.

(b) Motor distribution. Complete unilateral motor loss of the facial nerve represents 10% to 15% impairment of the whole person. Bilateral facial nerve motor loss represents 30% to 45% impairment of the whole person.

(6) VIII (Auditory).

(a) Cochlear involvement is rated according to the scheduled loss of hearing findings in OAR 436-30-360.

(b) Vestibular involvement. Complete loss of vestibular function, if permanent,

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represents a maximum allowance of 55% impairment of the whole person, depending on the extent the loss interferes with the daily activities of the worker, and depending on the extent of compensation by other neural mechanisms.

(c) Tinnitus. Mild or moderate tinnitus represents no impairment. Severe tinnitus represents a 5% impairment of the whole person.

(7) IX (Glossopharyngeal), X (Vagus), and XI (Cranial Accessory).

(a) Impairment of swallowing. If, due to damage to any one or any combination of these nerves, diet is restricted to semi-solid foods or, in general, diet is restricted to soft foods, 15% impairment of the whole person is allowed. If diet is limited to liquid foods, 25% impairment of the whole person is allowed. If food can be taken only by tube feedings or gastrostomy feedings, 50% impairment of the whole person is allowed.

(b) Impairment of speech production. If, due to damage to any one or any combination of these nerves, speech production is impaired, the maximum allowance is 35% impairment of the whole person, depending on the extent speech production required for the needs of daily living is impaired.

(8) XII (Hypoglossal). Bilateral loss is rated according to the same criteria given in (7) above for the glossopharyngeal, vagus and cranial accessory nerves.

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436-30-540 Mental Illness

(1) Permanent aggravation of mental disorder. Permanent aggravation based on adequate documentation of findings may be considered a primary impairment. When mental illness is rated as a primary impairment under this section, the "Emotional and Psychological" factors in OAR 436-30-450 are not considered.

(2) Permanent aggravation of personality disorder. The criterion for consideration of a personality disorder is the long-term inability of a worker to adapt to the ordinary stresses of daily living.

(3) Permanent aggravation of sociopathic personality disturbance (psychopathic personality). Criteria for rating permanent impairment due to sociopathic personality disturbance are described as:

(a) Class 1: 0%-15% impairment of the whole person. A worker with little insight, some deficiency of judgment, and difficulty with the control of personal behavior, but with ability to avoid serious disturbance of relationships with the community or significant self-harm, belongs in Class 1.

(b) Class 2: 20%-45% impairment of the whole person. A worker who shows a considerable loss of self-control and an inability to learn from experience to the extent of causing damage to the community or to self, in a continuing fashion, belongs in Class 2.

(4) Permanent aggravation of psychoneuroses (neuroses). Loss of function due to the psychoneuroses is classified in accordance with six major aspects of psychoneurotic reactions:

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Anxiety, depressive, phobic, psychophysiologic, obsessive-compulsive, and conversion.

(a) Class 1: 0%-5% impairment of the whole person. A worker belongs in Class 1 who uses ego-protection and regressive techniques at a psychoneurotic level in personal adjustment to the stresses of daily living, but not to a degree that results in any substantial loss of personal or social efficiency. No periods of continuing regression and no instances of structuralized pathology in the organs or tissues occur. One or more of the following psychoneurotic reactions are demonstrated:

(A) Anxiety Reactions. These vary from mild anxiety episodes which are predominantly in response to stress situations, require little or no treatment, and are seldom associated with clear-cut subjective suffering, e.g., "pre-appearance" jitters, to those moderate anxiety episodes which are predominantly the result of a stress situation and which may also require no treatment. These are usually associated with some degree of a subjectively unpleasant tension during which the anxiety is present. The presence of apprehension may lead to limitation of such activities as public appearances.

(B) Depressive Reactions. The usual activities of daily living can be accomplished but are associated on occasion with symptoms of lack of ambition, energy, and enthusiasm for the current situation of the day or week. There may be psychophysiological disturbances such as mild anorexia and malaise.

(C) Phobic Reactions. These may vary from being purely subjective and not associated with any overt or demonstrable disturbance in adjustment to minor deviant patterns of adjustment under special conditions, e.g., mild claustrophobia, fear of snakes.

(D) Psychophysiological Reactions. These include self-limiting reactions to passing stress, e.g., gastrointestinal upsets. Treatment of either symptoms or the other components of the illness is of short duration. The period of treatment is unassociated with any persistent interference with the usual pattern of personal and social adjustment, and there is no irreversible body-system or organ pathology.

(E) Obsessive-Compulsive Reactions. These may vary from ruminative experiences unassociated with overt or demonstrable disturbances in adjustment to peculiar individualized reactions of rigid adjustment, such as overwork, ritualism, dogmatic attitudes, or excessive fastidiousness, which only slightly disturb the worker's personal and social adjustment.

(b) Class 2: 10%-45% impairment of the whole person. A worker belongs in Class 2 when there is a demonstration of one or more of the following psychoneurotic reactions:

(A) Anxiety Reactions. Moderately severe anxiety and apprehension are present and may require extended treatment. Startle reactions, foreboding that leads to indecision, fear of being alone, and insomnia may also be present. However, no associated disturbance of thinking, concentration, or memory is found.

(B) Depressive Reactions. These reactions last several weeks or longer, with disturbances of the sleep cycle and eating habits, loss of interest in usual and customary personal and social activities, and moderate psychomotor retardation or suicidal preoccupation, but there remains continued ability to take care of personal hygiene and other self-care activities.

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(C) Phobic Reactions. The worker shows fear-motivated behavior which interferes in a mild to moderate way with the normal daily activities. The worker may be partially homebound, refuse to ride in elevators or go into closed rooms, and may openly modify behavior in response to superstitious needs.

(D) Psychophysiological Reactions. There are frequent, recurrent organ dysfunctions which disrupt daily living and require substantial treatment. These may include stress diarrhea, functional chest pains, vertebral, limb, and neck muscle spasms, smothering sensations, hyperventilation. The emotions are "physiologized," but no structuralization of pathology in the organs or tissues is shown.

(E) Obsessive-Compulsive Reactions. Because of rigid thinking and actions, personal and social activities are curtailed. Selfishness, dogmatism, demanding nature, and inability to work well with others are demonstrated. The worker is "set" in his ways and may be unable to accept changes.

(F) Conversion or Hysterical Reactions. Episodes of loss of physiological function (e.g., transient but recurrent hoarseness, blindness, or weakness of a limb) occur more frequently than twice a year, may last several weeks or longer, and require treatment.

(c) Class 3: 50%-95% impairment of the whole person. A worker belongs in Class 3 when there is a demonstration of one or more of the following psychoneurotic reactions:

(A) Anxiety Reactions. Severe states of foreboding, tension, and apprehension are present. There is interference with the functions of memory and concentration. Recurrent and persistent periods of anxiety may cause profound disturbances in interpersonal relationships, as the worker requires continuous reassurance and comfort from family and others.

(B) Depressive Reactions. These reactions tend to persist, and there is a marked loss of interest in the usual activities of daily living, such as eating or self-care. As a result, loss of weight or unkempt appearance may be objective findings. There may be marked retardation of psychomotor activity with suicidal preoccupations and attempts, or there may be agitation as well as depression.

(C) Phobic Reactions. Such severe phobic patterns of adjustment occur that behavior becomes bizarre and disruptive. In the more severe degrees of impairment, most of the everyday activities are so disturbed that the worker is homebound or even roombound. Strange rituals may require isolation and protective care by others.

(D) Psychophysiological Reactions. These reactions result in tissue modifications in one or more of the body systems or organs, and these may not be reversible, such as the changes in the wall of the intestine in mucous colitis.

(E) Obsessive-Compulsive Reactions. These reactions are so marked that the worker's usual personal and social activities are precluded due to channeled thinking and ritualistic behavior. These may require supervised care or assistance. The worker, if not directed, may take hours to dress or eat.

(F) Conversion or Hysterical Reactions. Episodes of loss of physiological function occur frequently and last several weeks or longer, and there is persistent evidence of physiological

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changes after each episode; or a prolonged episode (18 months or longer) of loss of physiological function is associated with far-advanced physiological regressive changes in tissues and organs, such as limb muscle atrophy or generalized flabbiness.

(5) Permanent aggravation of psychoses. A severe disturbance of mental function, reflecting varying degrees of impairment, depending on the severity, duration and type of psychotic reaction. Psychosis is manifested in (a) perception, (b) thinking process, (c) social behavior, and (d) emotional control. Classification of degrees of impairment due to psychotic manifestations are described as follows:

(a) Class 1: 0%-15% impairment of the whole person. A worker belongs in Class 1 when there is a psychosis manifested by disturbances in one or more of the following functions:

(A) Perception. The worker tends to misinterpret conversations or events. Ideas of reference appear, and the worker may assume that people overheard or observed are talking about him or laughing at him.

(B) Thinking Process. The worker is aware that he is absent-minded, forgetful, daydreaming excessively, thinking slowly, or that he may be having recurrent unusual thoughts (obsessions). The worker may show mild deficiency in judgment with or without insight.

(C) Social Behavior. Obvious but minor deviations occur in behavior, but these are not particularly disturbing to others. There may be overactivity or depression, and appearance may be slovenly, unkempt, unwashed.

(D) Emotional Control. There may be periods during which the worker feels depressed, "blue," or melancholy, and has little interest in external matters, or may be mildly stimulated and euphoric. Usually productive and controlled activity can be maintained but the worker may be irritable and irascible.

(b) Class 2: 20%-45% impairment of the whole person. A worker belongs in Class 2 when daily medication is required to avoid hospitalization or rehospitalization, and when such medication affords poor control.

(A) Perception: Moderately severe disturbance in understanding the meaning of personal surroundings, e.g., cannot always sharply distinguish imaginings and daydreams from reality. May have fantasies about expected money or extreme power, but recognizes they are unusual and tends to keep them to himself. Worker's persecutory or expansive impressions may cause him to be too domineering; peremptory, irritable, or suspicious with others.

(B) Thinking Process. Disturbances of thought cause the worker to believe he may be having serious mental trouble, e.g., obsessive thinking, blocking, memory loss severe enough to interfere with work or recreation, periods of confusion, exceptionally vivid daydreams, or long periods spent in reverie.

(C) Social Behavior. The worker can control behavior on request, but deviation is sufficient (e.g., severe overactivity, disarranged clothing, or inappropriate speech and gestures) to cause concern in others.

(D) Emotional Control. There may be emotional incontinence, e.g., anger disproportionate to the provocation, weeping for little or no reason, euphoria, and expansiveness

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sufficient to cause difficulty with family and colleagues.

(c) Class 3: 50%-85% impairment of the whole person. A worker belongs in Class 3 when a psychosis is manifested by disturbances in one or more of the following functions:

(A) Perception. Frank illusions or hallucinations occupy the greater part of the worker's time and attention, e.g., he may follow the commands of hallucinations or act in a socially disruptive way as a result of impaired perception of reality.

(B) Thinking Process. Disturbances of thought are so severe that there is inability to communicate readily. Abnormalities also are obvious to the casual observer, e.g., rambling speech, circumstantiality, primitive language, openly expressed delusions, poor judgment, absence of insight.

(C) Social Behavior. The behavior deviation is so severe that the worker is a nuisance or a menace to others. Interferes with activities of others, e.g., shouting, using profanity, being careless about excretions, uttering threats, or behaving in ways which endanger others.

(D) Emotional Control. Extremely irritable and overactive, so severely depressed that he becomes suicidal, or so expansive that he is unable to control his own behavior.

(d) Class 4: 90%-95% impairment of the whole person. A worker belongs in Class 4 when a psychosis is manifested by disturbances in one or more of the following functions:

(A) Perception. Preoccupation with hallucinations or illusions to the extent that self-care becomes impossible. May make violent outbursts in response to hallucinations.

(B) Thinking Process. Thoughts take the form of delusions, and there may be severe confusion, use of neologisms, muteness, incoherence, and irrelevance. Communication is very difficult or impossible.

(C) Social Behavior. Behavior endangers himself and others, e.g., his disturbed perception and thinking may cause him to be assaultive, homicidal, suicidal, withdrawn, or inaccessible.

(D) Emotional Control. The worker is either so emotionally disturbed that he usually is in a delirious, uncontrolled state, or is so depressed that he is mute, hostile, and destructive. Such lack of emotional control over anger and rage may result in homicidal acts.

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436-30-550 Losses Not Described in These Rules

Any documented impairment to a body part or system which is not considered in the foregoing Sections will be rated according to the recommendations found in the most current edition of the American Medical Association's publication, Guides to the Evaluation of Permanent Impairment, 1977 edition, or other authoritative medical reference. In no case, however, will such references be used where they conflict with the Oregon statutes.

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436-30-570 Rating in the Presence of Prior Injury

(1) When subsequent injuries occur to a scheduled body part, the aggregate of awards shall in no case exceed 100% loss of the body part;

(2) When subsequent injuries occur to unscheduled areas, the prior disability shall be offset against the current permanent disability findings only if the effects of the prior injury have not dissipated. If the effects have dissipated, no offset will be made.

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436-30-580 Penalties

If the insurer fails to provide information requested by Evaluation, or fails to provide information in a timely manner, a civil penalty, pursuant to ORS 656.745 may be assessed. This penalty may be as much as \$2,000 for each violation or up to \$10,000 in the aggregate for all violations in any three-month period. Each day the information is not provided timely shall be considered a separate violation. OAR 436-60-200 will be followed in establishing penalties.

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