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Evidence-Based Vocational Evaluations - Review and Analysis of Medical Documents: California Workers' Compensation

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Reports prepared by medical experts must meet specific criteria established by the California Worker's Compensation system in order to be considered Substantial Medical Evidence. This article addresses the evidence-based, scientific vocational assessment process of analyzing medical reports and related information resulting in conversion of medical impairments to vocational factors of disability. This vocational evaluation model meets the measurement criteria of California's Worker's Compensation System, which involves the Labor Code, case law relevant to issues of work and disability, and specific issues relating to employability and earning capacity of injured workers. Reports prepared by vocational experts must meet the criteria for Substantial Vocational Evidence in a similar fashion. Thus, California's Worker's Compensation system is expecting vocational experts to being held to similar standards. No longer can vocational experts rely upon the basis of their "years of experience" in the field. Rather, they must carefully analyze medical documents to identify, extract, and analyze for vocational impact of the medical condition. Reviewing and analyzing medical information is the foundation of the evidence-based vocational evaluation designed to meet the specific requirements for determining the impact of industrial injuries in terms of the ability to engage in competitive employment.

Keywords: Vocational Evaluation, Vocational Rehabilitation, Worker's Compensation, California, Forensic Rehabilitation

A major component of forensic vocational evaluations is analysis and interpretation of medical reports and related documents. The evidence-based model has been well-received in the workers' compensation field by the legal community and triers-of-fact. This scientific methodology assures a greater likelihood of complete analysis with a solid foundation in determining injured worker employability, the ultimate goal of the forensic evaluation. The purpose of the evidence-based forensic vocational evaluation is in part to consider all relevant medical factors and determine the specific vocational impact on an individual's ability to engage in competitive work. In order to complete this assessment, the forensic vocational evaluation must include a specific, definable process that accurately measures the vocational impact of each identified medical impairment. Professional opinions offered by an expert witness are based upon a foundation of medical evidence that accurately reflects an individual's impairments, as well as a clinical judgment from a forensic vocational evaluation.

Clinical judgment requires that the final opinion be predicated on valid, reliable and relevant foundation of information and data that are scientifically established through theory and tech-

> nique building which has been tested, peer reviewed, and published, with known error rates, and is generally accepted within the professional community (Blackwell, Field, Johnson, Kelsay & Neulicht, 2005, p. 104).

This article highlights the history of evidence-based analysis and effective documentation of medical reports. Powerful medical-legal terms are discussed and clarified. A challenging orthopedic evaluation, as well as a discussion of a complex psychological/psychiatric report is included. Authors' comments are interspersed throughout to explain the reasoning for documentation. This article provides appropriate California Labor Codes and significant case law determinations. Ultimately, the resulting documentation and analysis of medical reports will be included by the vocational expert in the forensic evaluation as a critical foundation for other evidence-based components.

Medical Reports and the Evidence-Based Model

One of the primary foundation pieces of workers' compensation forensic vocational rehabilitation evaluations is the medical record provided by the referring attorney or judge. This article addresses the appropriate process necessary to assure complete analysis and consideration of medical reports used in forensic vocational evaluations. While the workers' compensation evaluation has unique requirements based on statute and case law, every vocational rehabilitation evaluation process requires consideration of the nature of the vocational disability and the impact on employability, including in the public sector (Leahy, Arokiasamy, et al., 2010). This paper addresses evidence-based requirements, with a primary emphasis on analysis done in workers' compensation forensic evaluations. It is the authors' belief that were public vocational rehabilitation programs to utilize selected components of the evidence-based model the success ratio of vocational rehabilitation individual plans would increase culminating in more people with disabilities going to work. The Evidence-Based model has several components; however, this paper addresses only scientific vocational analysis of medical records. California Code of Regulations Title 8, Section states §10606.5. Vocational Experts' Reports as Evidence.

> (a) The Workers' Compensation Appeals Board favors the production of vocational expert evidence in the form of written reports. Direct examination of a vocational expert witness will not be received at a trial except upon a showing of good cause. Good cause shall not be found if the vocational expert witness has not issued a report and the party offering the witness fails to demonstrate that it exercised due diligence in attempting to obtain a report. A continuance may be granted for rebuttal testimony if a report that was not served sufficiently in advance of the close of discovery to permit rebuttal is admitted into evidence.
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> (b) A vocational expert's written report shall meet the following requirements:

(1) The report shall contain a declaration by the vocational expert signing the report stating: "I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. I further declare under penalty of perjury that there has not been a violation of Labor Code section 139.32." The foregoing declaration shall be dated and signed by the vocational expert and shall indicate the county wherein it was signed.

(2) The report shall disclose the qualifications of the vocational expert signing the report, which may be satisfied by attaching a curriculum vitae.

(3) Except as provided in subdivision (b)(4), the body of the report shall contain a statement, above the declaration under penalty of perjury, that: "No person, other than the vocational expert signing the report, has participated in the nonclerical preparation of the report, including all of the following: (i) taking a history from the employee; (ii) reviewing and summarizing medical and/or non-medical records; and (iii) composing and drafting the conclusions of the report."

(4) Notwithstanding subdivision (b)(3), it is permissible for a person or persons, other than the vocational expert signing the report, to prepare an initial outline of the employee's history and/or to excerpt prior medical and non-medical records. If this is done, however, the vocational expert signing the report:

(a) shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant issues;

(b) shall include in the statement required by subdivision (b)(3) that, as applicable, an initial outline of the employee's history and/or an excerpt of the employee's prior medical and non-medical records were prepared by another person or persons and that the vocational expert signing the report has reviewed any such excerpts and/or outline and has made any additional inquiries and examinations necessary and appropriate to identify and determine the relevant issues; and

(c) shall comply with subdivision (b)(5), below.

(5) The report shall disclose the name(s) and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation.

(c) The vocational expert's report should include, where applicable:

(1) the date(s) of any evaluation(s), interview(s), and test(s);

(2) the history of the injury;

(3) the employee's vocational history;

(4) the injured employee's complaints;

(5) a listing of all information reviewed in preparation of the report or relied upon for the formulation of the vocational expert's opinion;

(6) the injured employee's medical history, including injuries and conditions, and residuals thereof, if any;

(7) findings and opinion on evaluation;

(8) the reasons for the opinion; and

(9) the signature of the vocational expert.

A failure to comply with the requirements of subdivision (c) will not make the report inadmissible but will be considered in weighing the evidence.

(d) Statements concerning any vocational expert's bill for services are admissible only if they comply with subdivision (b)(1).

Note: Authority: Sections 133, 5307, 5309 and 5708, Labor Code. Reference: Sections 139.32, 4628, 5502(d)(3) and 5703(j), Labor Code.

History

1. New section filed 9-23-2013; operative 10-23-2013. Submitted as a file and print by the Workers' Compensation Appeals Board pursuant to Government Code section 11351 (Register 2013, No. 39).

In addition, a vocational apportionment analysis is required (*Estrada*, 2016).

Honorable Clint Feddersen, WCJ, Van Nuys, California in an article entitled "How a Judge Views Substantial Vocational Evidence (You Are Writing the Vocational Report for Me)" adds:

> The vocational expert's report must include all of the criteria for substantial evidence, i.e., it must be framed in terms of reasonable probability, must not be speculative, must be based on pertinent facts on an adequate examination and history, and it must set forth reasoning in support of its conclusions (Johnson, p. 955).

This Evidence-Based forensic vocational evaluation model has been designed to meet the specific criteria needed by the California Workers' Compensation System for addressing employability/disability, cause of disability, and apportionment of disability. Additionally, ongoing case law issues are considered for adjustments to the process. The specific components of this vocational evaluation process are as follows:

1. Review and analysis of Medical, Legal, and Vocational documents.
2. Face-to-Face Interview with Injured Worker
3. Vocational Testing designed to measure cognitive abilities, academic skills, and functional abilities (Dexterity Tests/Work Samples)
4. Situational Assessment designed to measure the ability to engage in work-like activities at the Sedentary Work level. This is a criterion-referenced process. The criteria are behavioral observations of the evaluee during the interview and vocational testing results. A typical simulated work day is up to a 6-hour period of time.

The other specific components involved with this vocational evaluation process are as follows:

- Building rapport with the evaluee.
- Statement of purpose and legal basis for the forensic vocational evaluation.
- Identification and documentation of time spent, outline of components, and identification of assistance including editing and language interpreting.
- Employee Profile.
- Dates of Permanent and Stationary Status deemed by evaluating physicians.
- Mechanism of Injury according to the evaluee and medical records.
- Return to Work activity and consequences.
- Medical Treatment History according to the evaluee and medical records.
- Medical-Legal File Review of records and depositions that were presented by the referring attorney.
- Education and Employment History of the evaluee. Proficiency with computers and software according to the evaluee.
- Occupational Classification of Position at Time of Injury.
- Identification of Similarly Situated Employees.
- Vocational Analysis of Medical Factors of Disability and Work Restrictions, including converting Medical Impairment(s) to Vocational Factors of Disability.
- Analysis for Transferable Skills, including identification of professional software employed by the vocational evaluator, with a Summary of Findings.
- Clinical Interview, including current medication usage with side-effects.
- Vocational Testing, as appropriate, with results and interpretation of results in terms of vocational relevance.
- Behavioral Observations in accordance with Chapter 18 of the AMA *Guides* and physicians' observations.
- Pre and Post Injury Earnings.
- Wage and Salary Information Similarly Situated Employees, including comparison to Employment Development Department data and Occupational Employment Statistics.
- Assessment for Residual Employability.

- Access to Employment, with data and calculations attached in addendum form.
- Diminished Future Earning Capacity.
- Return to Work Process (Montana Employability Factors).
- Vocational Rehabilitation determination of Amenability to Vocational Rehabilitation, including a LeBoeuf Analysis in consideration of *Dahl*.
- Causation and Apportionment Analysis (Medical and Vocational) in consideration of *Benson*.
- Assessment for Rebuttal of 2005 Permanent Disability Rating Schedule.
- Vocational Evaluator Summary and Conclusions.
- Legal Declaration per California Code of Regulations Section §10606.5(b).
- Reservation of right to augment or modify.
- Signature and County where signed.
- Addenda including all computer data, explanation of the LeBoeuf Analysis, and additional data unique to the individual evaluee.

The authors intend to ultimately address each component of the Evidence-Based model in conference presentations, published articles, and webinars. We have already published articles on Causation and Apportionment and the Impact of Opioids on employment (Rockett. & Stoneburner, 2017) (Stoneburner & Rockett, 2018). We have also presented at the National Conference in 2017 and the California IARP statewide conference in 2018.

The authors recently noted the following Workers' Compensation Appeals Board decision regarding one of our vocational evaluations for consideration.

> Permanent Disability—Rating—AMA Guides—Rebuttal of Scheduled Rating—Vocational Evidence—WCAB affirmed WCJ's finding that applicant suffered 100 percent permanent disability, without apportionment, as result of admitted industrial injury to his left shoulder, neck, low back, and neurological system sustained on 11/15/2014 while he was employed by defendant as mechanic, when WCAB found that changes in Labor Code § 4660.1 applicable to injuries on or after 1/1/2013, which remove language regarding consideration of future diminished earning capacity, do not preclude rebuttal of strict AMA Guides rating with vocational expert evidence, and concluded that in this case WCJ's finding of permanent total disability was supported by medical reports indicating that applicant had difficulty with almost all of his activities of daily living and by reporting of applicant's vocational expert, which considered and discussed medical reports and established that applicant's medical limitations and constant pain made vocational retraining impossible and rendered applicant unable to compete in open labor market, and that there was no substantial medical evidence in record to support apportionment of applicant's permanent disability (*Hanus*, 2018).

Legal Foundation for the Evidence-Based Forensic Evaluation

The authors believe that the evidence-based documentation required of physicians is guidance for forensic vocational evaluations. Physicians practice Evidence-Based Medicine with every patient; however, physicians confront new sources of evidence at a far greater pace than is required by the vocational expert (Masic I, Miokovic M, Muhamedagic B., 2008). From the California Department of Industrial Relations Division of Workers' Compensation Medical Unit Qualified Medical Evaluator Competency Examination Study Guide:

> Substantial evidence is "relevant evidence a reasonable mind might accept as adequate to support a conclusion." (City of Jackson v. Workers' Comp. Appeals Bd. (Cal. Ct. App., Apr. 26, 2017, No. C078706) 2017 WL 1488733, at *5.) To constitute substantial evidence, a physician must

conduct an adequate and comprehensive examination of the injured worker before making impairment determinations. (See, e.g., Escobedo v. Marshalls (2005) 70 Cal. Comp. Cases 604) (WCAB) (en banc) [". . . [A] medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess."]; see also Milpitas Unified Sch. Dist. v. Workers' Comp. Appeals Bd. (2010) 187 Cal.App.4th 808, 825 ["In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. . . . Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. . . . Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions. . . ."] citing E. L. Yeager Const. v. Workers' Comp. Appeals Bd. (2006) 145 Cal.App.4th 922, 928.) The AMA Guides also require physicians to perform a thorough and comprehensive medical examination.

A QME must address the worker's history and symptoms, the results of her medical examination, the results of various tests and diagnostic procedures, the diagnosis, the anticipated clinical course, the need for further treatment, and the residual functional capacity and ability to perform activities of daily living. In making impairment determinations, a QME must use her entire range of clinical skills and judgment to assess whether or not the measurements or test results are plausible and consistent with the impairment. Further, an appropriate rating under the AMA Guides for any illness or injury should take into account all impairments, not only the primary body part or organ system impacted, but the full impact of the illness and injury and its treatment.

The ultimate goal of the forensic vocational evaluation process is acceptance by the triers-of-fact. Acceptance is based on scientific facts substantiated by vocationally relevant information. The thread of analysis must run through the evaluation from beginning to end with no interruption of or divergence from vocational relevance.

Another important goal of the vocational evaluator is the ability to access information in the final report efficiently. Testimony by the vocational evaluator may not be required for months or years, and then may only be in the form of a sworn deposition. Thus, the written evaluation requires a consistent, logical format and clearly written content to enable the evaluator to access information efficiently. This paper focuses on the fact-based process in the California Workers' Compensation System; however, the principles are dynamic, general, and applicable for all those who are vocational rehabilitation experts. Medical evaluations are the cornerstone of eligibility and service delivery for each individual with a disability. The process provided in this paper is acceptable by the triers-of-fact and it will assure conformance with the regulatory process acceptable in public vocational rehabilitation (*Hanus*, 2018).

The authors use the term "evidence-based" to conform to the legal standards in forensic venues. Our professional reports are based on scientific analysis. Any competent, ethical professional could replicate the analytical results. However, there may be differences in interpretation of the facts by otherwise competent professionals so long as those differences are presented in factual and unbiased manners. The evidence-based vocational evaluation model has medical, legal, and vocational components. The focus of this paper identifies and discusses the analysis of medical reports. The identification and vocational analysis of medical facts by the vocational expert form the basis of a disability of the injured worker. As noted, the process for identifying substantial medical evidence is similar to the process for identifying substantial vocational evidence. There must be a link between the medical evidence and the vocational evidence, the thread, in order to meet the substantial evidence criteria. For purpose of this discussion, the authors will consider two common types of medical reports, the orthopedic examination and the psychological/psychiatric (mental health) examination. These two examples are the most prevalent types of reports encountered by the vocational expert, yet there are some subtle differences.

For years, there have been numerous calls to follow the scientific method in the development of forensic vocational evaluations (Stein, 2002). "Since the 1970s, increased demands have been made on rehabilitation professionals to present quantifiable evidence for insurance companies, attorneys, claims agents, physicians, and Social Security hearings" (Power, Chapter 15, p. 406). The evidence-based process is based on the scientific method. The evidence-based process is detailed and unique to the individual evaluee. Every aspect of the forensic vocational evaluation must be based on facts presented as a foundation piece for each essential component. The thread of the presentation, based on the individual's situation must be maintained throughout the analysis and report. This subtlety is appreciated by the legal system, because the triers-of-fact will, by definition, only consider well-supported facts. There must be sufficient factual data backing up the expert's conclusions. "The conclusions cannot be *ipse dixit* (I say it therefore it is)." The conclusions have to be based on the actual facts of the case, with the expert's opinion applied to the facts to come up with conclusions within the expert's field of expertise, whether medical or vocational (Johnson, 2019).

Authors' comments. The issue of whether to reference years of practice may be one of confusion based on the fact that physicians are encouraged to indicate their years of experience as part of a rationale for a medical decision (*AMA Guides*, Ch. 1.5, pp. 10–11). Feedback from attorneys to the authors indicates that identification of years of experience is otiose when providing rationale for a decision. Of course, the vocational expert includes this information in the curriculum vitae attached to the vocational evaluation as a matter of appropriate presentation. In order to get the best results from this research paper, the reader must understand some terms used by the authors. The basis of physical medical diagnosis and reporting is derived primarily from the *AMA Guides*, 5th Edition (*AMA Guides,* 2001). Similarly, the basis for mental diagnosis is the *Diagnostic and Statistical Manual* (DSM), (4th or 5th ed.). More importantly, the *Guides* clarify the roles of the medical evaluator vis-à-vis the vocational expert.

Definition of Terms

It is general knowledge that the applicant is referred to by many titles in written reports from various professionals, such patient, client, applicant, evaluee, plaintiff, and individual. In this paper, the term "evaluee" is used to identify the individual being vocationally evaluated (Barros-Bailey, et al., 2008). The three primary professionals involved are the medical experts, vocational experts, and attorneys. Each professional may have ancillary or support staff, ranging from clerical staff to insurance adjudicators and diagnosticians. Next in the hierarchy are the triers-of-fact, which in California is typically an administrative law judge, the appeals board, the various levels of courts up to and including the Supreme Courts in each state, and the United States Supreme Court.

The evidence-based model is somewhat fluid in that it reflects the evidentiary impact of laws, statutes, and case law decisions. The authors have spent years making changes in order to adapt to the current medical and legal requirements. In the future, evidence-based process will inevitably change in conformance with labor code changes, ongoing medical progress, and case law decisions. Probably the most immutable aspect of the vocational evaluation is the documented review of medical examinations. The content and format of medical reporting are based on the designated professional relationship between the physician and the evaluee.

California Labor Code 139.2 spells out the qualifications of medical evaluators:

> Qualified Medical Evaluators (QMEs) are qualified physicians who are certified by the Division of Workers' Compensation (DWC) - Medical Unit to examine injured workers to evaluate disability and write medical-legal reports. The reports are used to determine an injured worker's eligibility for workers' compensation benefits. QMEs include medical doctors, doctors of osteopathy, chiropractic, dentists, optometrists, podiatrists, psychologists, and acupuncturists.
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> The doctor agreed upon by the applicant '. . . attorney and the claims administrator . . .' is called an Agreed Medical Evaluator (AME).

A QME is selected from a list of state-certified doctors issued by the DWC Medical Unit. An AME physician may also be a QME, but does not have to be one. Labor Code 139.2 also indicates designation of a Panel Qualified Medical Examiner (PQME). All of the above write their reports in conformance with the *AMA Guides* (5th ed.)

The next levels of evaluating doctors are Primary Treating Physician(s) (PTP) and Secondary Treating Physician(s), consulting physicians, and other treating entities, such as physical therapists, occupational therapists, functional capacity evaluators, and diagnosticians. Frequently, diagnosticians are also licensed medical doctors who have specialized in the various diagnostic categories. In some circumstances, confusion can occur about the status of the physician writing the report. For example, a physician may be writing the report as a Primary Treating Physician; however, in the report he/she may also be identified as a QME. Typically, in the introductory section of the medical report, the physician will identify the nature of their relationship with the patient. From the vocational expert standpoint in terms of gathering medical impairments and converting to vocational factors of disability there may be vocationally relevant facts in any of the documented medical reports, including sworn depositions. Typically, reports of substantial vocational relevance occur after Permanent and Stationary or Maximum Medical Improvement status. For example, a primary treating physician may have a complete history of injury and medical treatment simply because the information is fresh in the mind of the evaluee; however, the remainder of the report may not document other required aspects of a workers' compensation forensic evaluation. To the vocational expert, that history of injury is extremely valuable, vocationally relevant information. It behooves the vocational expert to read and consider every medical document in order to document a complete vocational evaluation.

Throughout this article, the authors refer to the word "thread". The thread of a forensic vocational evaluation commences with the establishment of measurement criteria designed to determine employability. Vocational information is collected and analyzed, followed by review/analysis of medical information. The basis of the thread is the industrial injury. Medical information followed by vocational information is captured as determined by measurement criteria. In other words, from section to section, the thread of employability is the focus. The thread is composed of vocationally relevant factual information, which addresses employability. Employability is defined in more detail in this section, but suffice it to say that any documentation that does not address the issue of employability based on factual information cannot be considered relevant data. Information must be considered substantial evidence, medical or otherwise.

The next terms that have workers' compensation distinct meanings are "impairment" and "disability." Use of these words is frequent in our everyday vernacular, but in Workers' Compensation they have unique and different meanings.

Impairment Evaluations in Workers' Compensation (AMA *Guides*, 1.8, p. 13.)

> Impairment percentages derived from the Guides criteria should not be used as direct estimates of the disability. Impairment percentages estimate the extent of the impairment on whole person functioning and account for basic activities of daily living, not including work. The complexity of work activities requires individual analyses. Impairment assessment is a necessary *first step* for determining disability.

Impairment is "a loss, loss of use, or derangement of any body part, organ system, or organ function (AMA *Guides*, p. 601). Further, "Work is not included in the clinical judgment for impairment percentages". "Impairment ratings are not intended for use as direct determinations of work disability." "Impairments interact with such other factors as the worker's age, education and prior work experience (occupational duties) to determine the extent of work disability." "Disability" is defined by the *Guides* as an 'alteration of the individual's capacity to meet occupational demands'" (AMA Guides, pp. 2-8) (Johnson, 2019, p. 924). As Mr. Johnson (2019) also points out on page 924 of the AMA *Guides*:

> The *Guides* is not intended to be used for direct estimates of work disability. Impairment percentage derived according to the *Guides* criteria do not measure work disability. Therefore, it is inappropriate to use the *Guides* criteria or ratings to make direct estimates of work disability (AMA *Guides*, p. 9).

Impairment is used in the profession of medicine and applies to performance of activities of daily living. Activities of daily living applies to those human behaviors done away from the workplace, typically at home, such as personal hygiene, meal preparation, shopping, paying bills, etc. (Shiel, 2018). In order to make the physician's report substantial evidence per Labor Code §4663 (a) "apportionment of permanent disability shall be based on causation." Physicians "sometimes apportion to causation of impairment" rather than disability (Johnson., 2019). To the vocational expert, the word "disability" applies to work-related impairments, including loss of bodily function for work, loss of ability to perform specific work activities, loss of earning capacity, and loss of ability to compete in the open labor market. The California Supreme Court in the *Welcher/Brodie* decision (2007) clearly defines disability as the loss of ability to work (Johnson, 2019).

> A permanent disability is one which causes an impairment of earning capacity, impairment of the normal use of a member, or a competitive handicap in the open labor market. Thus, permanent disability payments are intended to compensate workers for both physical loss and the loss of some or all of their future working capacity (*Welcher Brodie*, 2007).

When a person is away from work, the person can choose her activity, duration of activity, and level of performance. To the vocational evaluator, this is sometimes called "unforced work". On the other hand, when a person is at work she must perform productively and timely as required by the job. Physicians may not distinguish between activities of daily living and work on the job. The employer determines what the activity will be, the level of performance required, and how long the activity is performed. The vocational expert must distinguish between activities of daily living and work on-the-job based on the activity, location, and performance description. More importantly, the role of the vocational expert is to translate medical impairments into factors of vocational disability. The AMA *Guides* direct the medical evaluator to address employability; however, the vocational expert is uniquely qualified to address employability issues as the physician is uniquely qualified to address medical issues. Conversion of medical impairments to vocational factors of disability is rarely a skill of the evaluating physician. The fact is that evaluating physicians are trained in medicine, not in the determination of employability.

Author's comment. Put bluntly, if the vocational expert automatically accepts the physician's determinations of vocational relevance without analysis of all facts, then the role of the vocational expert is superfluous. The vocational expert has the responsibility of determining vocational disabilities and must discern whether the physician has addressed vocational disabilities. That is, has the physician documented "work restrictions" in such a manner that the vocational expert can accurately assess and transition to issues of vocational impact? For example, an orthopedic physician can document a work restriction of "No Heavy Work". Without further development on the part of the physician, the concept of Heavy Work is undefined. Thus, the vocational expert is obligated to consider all of the results documented by the physician, and then convert medical impairments to vocational factors of disability. "Employability" and "placeability" are frequently used interchangeably. To the vocational expert, these two words have different meanings. There are many definitions of employability. The authors favor these definitions:

> **Employability** is "a set of achievements – skills, understandings and personal attributes – that makes graduates more likely to gain employment and be successful in their chosen occupations, which benefits themselves, the workforce, the community and the economy" (Yorke, 2004).
>
> **Placeability** is the likelihood that a client will actually secure and maintain work in a specific occupation. The dynamics of placeability include the availability of jobs in a certain geographic area, the evaluee's age, gender, race; employer attitudes; and specific hiring requirements (Farnsworth et. al. 2005).

There may be one or several reasons why a person could otherwise be employable, but not placeable. For example, a person might be employable as a postal worker, but not placeable because there are no jobs open for postal workers within reasonable commuting distance. We are bringing these two words to the fore, because sometimes physicians may inadvertently state that the evaluee is placeable when they mean employable. The vocational expert may need to explain the specific use of the two words in

the context of vocational relevance. Employability can be determined by the ability of an individual to meet the demands of competitive employment. Competitive employment contemplates the ability of the worker to meet demands for performance, productivity, and attendance for any occupation or job. Performance involves quality of work, ability to successfully engage in all of the exertional demands of the occupation or job, and ability to meet the interactive demands for coworkers and supervisors. Productivity involves the ability to meet the required job activities within specific time frames, ranging from hourly to yearly. Attendance involves the ability to maintain appropriate attendance on the job, given allowances for sick and vacation time. Every occupation and subsequent job classification has established criteria for employment qualifications that must be met before an individual is offered a specific position. If an individual's functional loss of ability is such that he or she cannot meet the demands of competitive employment, then employability is questioned.

When a physician examines and reports, the physician is focused on activities of daily living vis-à-vis medical impairments, not work disabilities. Physicians are directed to address work restrictions (AMA *Guides*, 2001). The physician usually addresses performance requirements that are quantifiable and then applies clinical judgment. The medical doctor may perform Range of Motion measurements and then conclude the limitations of physical activity. The mental health doctor may administer psychological testing and then conclude the limitations and/or parameters of psychological stress. Rarely do physicians understand the complete and/or actual performance requirements of specific jobs.

Employability Determinations (*AMA Guides*, 1.9, pp. 13-14)

> Physicians with the appropriate skills, training, and knowledge may address some of the implications of the medical impairment toward work disability and future employment. The physician may be asked whether an impaired individual can return to work in a particular job. The employer can provide a detailed job analysis, with the actual and anticipated essential requirements of the job and a review of the work environment, including potential hazards and the need for personal protective equipment. The physician can then determine whether the individual's abilities match the job demands. The physician needs to determine that the individual, in performing essential job functions, will not either be endangered or endanger colleagues or the work environment. The physician and other responsible persons should keep in mind the potential for impairment aggravation, as well as the possibility of changing an individual's job responsibilities. After reviewing all the necessary information, the physician may then make an objective and reproducible assessment of the ability of the individual to safely perform the essential functions of the job.
>
> More complicated are the cases in which the physician is requested to make a broad judgment regarding an individual's ability to return to any job in his or her field. **A decision of this scope usually requires input from medical and nonmedical experts, such as vocational specialists, and the evaluation of both stable and changing factors, such as the person's education, skills, and motivation, the state of the job market, and local economic considerations.** [Emphasis added.]

In the language of workers' compensation "restrictions" and "limitations" have different meanings. The authors prefer the following definitions: Restrictions are those behaviors that a person can perform but should not. Limitations are those behaviors that a person cannot perform. Physicians evaluating physical impairments sometimes use the terms restrictions, limitations, and preclusions, among others, so the vocational expert carefully determines what the physician intended and then convert to either restrictions or limitations. Mental health evaluations break down incapacities in even greater detail. The authors recommend defining terms as specifically as possible, so the triers-of-fact can understand the relationship between the medical impairment and vocational disability.

"Subjective complaints" or "current complaints" sections in medical reports are different than Subjective Factors of Disability. Subjective complaints frequently change during periods of temporary disability, before Permanent and Stationary and Maximum Medical Improvement are documented by

the physician. These sections document complaints of the patient about body part(s). Obviously, in the subjective complaint there may be exaggeration or even inadvertent misrepresentation of the body part. Subjective Factors of Disability, or a variation of the term, means that the physician validated behavior supportive of the subjective complaint.

Labor Code Section § 139.2: Disability Findings must be supported by clinical objective findings based on standardized examinations and testing techniques generally accepted by the medical community. Medical evaluation must include all findings and the reasons for the evaluating physician's opinion. Physicians must provide the reasoning for the assignment of subjective disability factors and describe how measurable physical elements of disability support disabling symptoms (subjective factors). The medical history, the objective examination & clinical findings must clearly support the reasons of the evaluating physician's medical opinion for the imposition of any level of work capacity functional loss, including the subjective factors of disability.

Subjective Disability Factors (8 CCR 9727): Regulation states that subjective factors of disability should be identified by a description of the activity that produces the symptoms. Pain becomes disabling when its degree affects function. Minimal pain is not disabling. However, slight, moderate and severe reflect increasingly greater degrees of disability on work activity.

5.8 CCR 46, 9725, 9727 states that the physician should describe any subjective complaints the patient may attribute to the injury and then give his opinion regarding validity and the reasons for his conclusions. The accurate description of current symptoms is very important, relevant to diagnosis, treatment and administrative matters, since the words 'pain', 'location', 'severity' and 'frequency' are words with specific implications. When evaluating subjective pain factors the evaluating must address and state an opinion within the bounds of reasonable medical certainty, as to:

5.1. The diagnosis, causation and classification of pain,

5.2. Whether the pain condition is permanent & stationary,

5.3. Whether all appropriate medical treatment(s) have been exhausted,

5.4. The relationship of the reported pain to the underlying pathological process,

5.5. The credibility of the injured worker and weight of ancillary information,

5.6. The assessment of the disability related to pain, not only on the intensity or frequency alone, but with consideration to the pain's impact on function,

5.7. Demonstrate that he/she understands the magnitude criteria for pain, how the pain affects performance/ability to work rather than how severely the injured worker perceives the symptoms.

6. The description of symptoms shall then be "translated" by the evaluator into ratable language in the "Subjective Factors of Disability Section" of the medical report, as defined by 8 CCR 46/9725/9727 and Evaluation of Industrial Disability (Packard Thurber, M.D.).

In cases in which a physician does not include the activities that produce the symptoms a supplemental report should be obtained to obtain a complete description of subjective disability as required by the evaluation guidelines and case law. Otherwise, it is to be assumed that the magnitude and frequency of pain occurs with all activities. Refer to 8 CCR 46, 9725 & 9727. Subjective factors of disability must be identified by a description of the activity that produces the symptoms (heavy work, repetitive use, heavy lifting, etc.), the duration or frequency of the symptoms (occasional, intermittent, frequent, constant), the intensity level of the symptoms (severe, moderate, slight, minimal/mild).

Physicians may also:

1. Compare the injured worker's description of pain and pain-like symptoms to the recognized "magnitude / severity levels" as defined by 8 CCR 46, 9725 and 7927,
2. Demonstrate that they understand the magnitude criteria for pain, how the pain affects performance/ability to work, rather than how severely the injured worker perceives the symptoms,

3. Describe what type of activities are limited, altered or prevented by the symptoms, or which bring out the symptoms,
4. Describe collateral symptoms, such as itching, cramping, tingling, etc., in regards to location, severity, frequency and relation to motion, effort and activity,
5. Outline factors or treatments, which tend to relieve the pain or symptoms.

Pain Severity Levels

The following terms are used when describing subjective factors:

- SEVERE: Precludes the activity causing the pain.
- MODERATE: Pain that could be tolerated, but would cause a marked handicap in the performance of the activity precipitating the pain.
- SLIGHT: Pain that could be tolerated, but would cause some handicap in the performance of the activity precipitating the pain.
- MINIMAL / MILD: Pain that constitutes an annoyance, but causes no handicap in the performance of the particular activity causing the pain and would be considered a non-ratable permanent disability. Other types of subjective factors for which these terms apply: (1) weakness, (2) fatigue, (3) tenderness, (4) neurogenic residuals and/or (5) sensory disturbances.

Pain Frequency Levels: Symptom Occurrence

The following words are defined as having the following meanings:

- RARE: Approximately 20% (1/5 of the time)
- OCCASIONAL: Approximately 25% or 1/4 of the time.
- INTERMITTENT: A midpoint: approximately 50% or 1/2 of the time.
- FREQUENT: Approximately 75% or 3/4 of the time.
- CONSTANT: Approximately 90% to 100% of the time. Subjective Factors Appendix Page 4 www.pdratings.com

Credibility Testing

Waddell credibility testing

Grading system for evaluating/assessing nonobjective findings on physical examination. Grading Scale 1 to 5, 5 points being maximum.

1. For overreaction to examination and active movement.
2. For overreaction and excessive pain to light palpation.
3. For low back pain with axial compression of the head.
4. For low back pain with rotation of pelvis under 300°.
5. For inconsistent straight leg rising in the sitting/supine position.
6. Axial Loading, Passive Rotation, Distraction Test, Diffuse Tenderness, Non-Anatomic Nerve Dysfunction, Histrionic Movements, Non-Organic Physical Signs, etc. Clinical Correlation of Subjective Disability - What is relationship of the reported pain to the underlying pathological processes?

Although in most cases, when both subjective and objective factors are present they are added together, each may individually form the basis for the rating yielded by the 'Objective/Subjective Index'. Subjective factors of disability may be used as a standard and adjusted for occupation and age in those situations in which the subjective factors are not their own 'cause & effect'.

Evaluation: The examiner should evaluate the patient's threshold of pain, and express his opinion about how this pain affects the patient at his work. Is this pain consistent with the patient's injury, and if not, why not? Are any pre-existing conditions contributory?

Tenderness: Character - superficial or deep?

Degree - slight, moderate, severe?

Location - describe accurately.

Evaluation - is it consistent with the injury, in character, degree and location?

Sensory Disturbance: Character:

Hyperesthesia - Increased sensitivity to touch

Hypesthesia: Decreased sensitivity to touch.

Anesthesia: complete loss of sensation.

Paresthesia: Abnormal sensation.

Weakness & Fatigue: Character - purely subjective, owing to instability, etc.?

Degree - how and when does it evidence itself; what is its relation to physical effort? It is substantiated by the presence of atrophy, loss of muscle tone, or other objective findings?

Authors' comments. The issue of credibility does arise in medical reports. Both medical and mental health evaluators have objective ways of determining credibility at their disposal. Frequently the issue is one of exaggeration of symptoms. The role of the vocational evaluator in determining the veracity of the complaints by the evaluee is similar to the role in reviewing Sub Rosa surveillance videos. In other words, the vocational evaluator should document behavioral observations and compare them with the findings of the physicians. We strongly advise not making judgments about whether the evaluee is truthful or credible, because vocational evaluators do not have the ability to determine measurable evidence of false representations. Also, there are other factors that obfuscate. For example, many of our evaluees have been through so many physician evaluations that they learn the language and what behavior they need to emphasize for the physician to see. Many attorneys only refer their clients who have severe injuries to vocational evaluators, due to the complexity of the case. Generally, that means that the impairment has been established. Of particular note, psychological testing, while a component of diagnosis, is usually considered secondary to the clinical interview by the mental health evaluator, so the test may be determined invalid by the clinician. Making general statements about the truthfulness of an evaluee may lead to inappropriate bias and lack of objectivity by the vocational evaluator which can jeopardize the acceptance of the evaluation by the triers-of-fact. Stick to the evidence-based facts.

Sub Rosa video reviews are discussed in this article, because reference may be made in a medical report or supplemental medical report. Until the vocational expert actually reviews the video, any reference based on the content of the medical evaluation may be regarded by the trier-of-fact as hearsay. "The Latin phrase Sub Rosa means 'under the rose', and is used in English to denote secrecy or confidentiality, similar to the Chatham House Rule. The rose as a symbol of secrecy has an ancient history" (Wikipedia, 2019). Sub Rosa videos are typically made by private investigators at the behest of the defense. The goal of the video(s) is to record the evaluee in a candid time frame when performing a physical action that is deemed a restriction or limitation. The defense then sends the video to the applicant's attorney, who in turn reviews the video with the applicant. The video information may then be presented to a physician and the vocational expert for analysis and comment. Video evidence may then be sufficient to cause a change of factual information and/or the opinions of doctors and vocational experts. Typically, videos are concise and taken outside of the home. The vocational expert views the Sub Rosa video from the perspective of work limitations and restrictions. There may be many factors that allow a person to perform an action that is a restriction. For example, a person may be "having a good day" in relationship to their affected body part(s). A person may be under the influence of pain medication. The observer of the video usually has no idea if the person is experiencing

pain and discomfort or not. They do not know if the person is rendered incapable after the observed action due to pain or fatigue. Remember, short term activity, is usually not the same as activity required at work. However, if there is clear video information that the person performed a work limitation, then that should be noted and included in the vocational evaluation or supplemental report. Performance of a restricted work activity may result in pain and discomfort that is not visible or masked by pain medication, so there is no vocational conclusion that can be made. For example, if the physician has indicated that the evaluee is precluded from lifting above shoulder level, meaning that they cannot perform the act, and the Sub Rosa video shows that activity, then doubt may be cast on the work limitation. If, however, there is a restriction for lifting over shoulder level, and the video shows some lifting above shoulder level, then it is plausible that the work restriction remains, because restriction means can perform the action, but should not. This may lead to a question from the vocational expert at time of the clinical interview.

In the examples of medical reports provided, there are common headings. As the vocational expert documents vocationally relevant information, each heading will usually correspond to those used by the physician; however, some physicians combine aspects that could have been separated and under a different heading. For example, in a "Discussion" section, sometimes physicians will include mechanism of injury, impairment ratings, causation and apportionment, activities of daily living, work restrictions, etc. If there is potential confusion, then it behooves the vocational expert to separate critical sections and to provide appropriate headings.

In workers' compensation medical reports there are requirements for specific topics to be addressed by the evaluating physician (AMA *Guides*, Chapter 2). The same information may be utilized and restated in more than one section of the medical evaluation. There are significant reasons for this apparent redundancy. In some documentation, a specific component may require a reiteration that addresses that component in the legally required terminology of that component. In other words, while the facts remain the same as in other sections of a report, how they are presented may change to suit the legal requirements of the section. Redundancy may be the best method of maintaining the thread of the report. Information in medical reports may be presented initially as a subjective complaint and later as an objective fact. In supplemental reports and depositions, which are also documented in a written format, redundancy may reinforce the original professional opinion in whole or in part. Redundancy is also handy when being asked about a particular component of a report such as might occur during testimony or deposition. The expert may efficiently address the question in complete form, rather than referring to other sections of the report. A simple example of this is when the expert indicates a particular date of occurrence of an injury and subsequent exacerbation or aggravation. There may be multiple injury dates in the record during continuing trauma. Identifying the specific date of each injury for each specific body part will make the testimony efficient and clearer no matter how many times that information is documented.

Sample Listing of Medical Legal Records

Medical Legal Records provided by Attorney Charles Lister:

This brief statement (Medical Legal Records Provided by Attorney) attributes the records to the attorney who made the referral to the vocational expert. The vocational expert should never consider records provided by any other source, unless so directed or verified by the referring attorney in writing. All records must be signed and dated; however, there are times when that information is illegible or pages are missing. Occasionally, an evaluee will attempt to provide a medical report directly to the vocational expert. In that case, refer the evaluee back to the referring attorney and do not accept a copy of the version that the evaluee presents. Immediately after this section outlining the documents you have reviewed; the vocational expert must then accurately review the relevant documents in detail through the lens of a vocational expert. If the vocational expert follows the same pattern every time a report is written, then the ability to reference in testimony is more comfortable. Never reference a secondary review of information based on the medical record review by the primary evaluator, without

clearly identifying the information source. For example, the vocational expert may not have the original P&S determining report, but noted in the medical records of the evaluating physician. The best remedy for this situation is to request the original report from the referring attorney; however, if that report is not available, then clearly identify how the information was acquired. The issue herein is potential hearsay evidence, which may render the information inadmissible.

Sample Continued

ORTHOPEDIC

- QME Brakish E. Fondster, M. D. (Orthopaedic Surgery) Qualified Medical Evaluation Report ML103 dated 6/20/2017;

PAIN MANAGEMENT

- Phillip R. Rothman M. D. (General Medicine) Initial Pain Management Consultation Report, Medical Record Review and Request for Authorization dated 4/11/2014 & Secondary Treating Physician's Progress Report (PR-2) dated 7/9/2014;

NEUROLOGIC

- PQME Lawrence Richman, M. D. (Psychiatry & Neurology) Complex Neurologic Consultation Represented Panel Qualified Medical Examination dated 4/13/2017 & Complex Neurologic Supplemental Report Review of Additional Medical Records Represented Panel Qualified Medical Examination dated 9/18/2017;

INTERNAL/PULMONARY

- F. Francis Stark, M. D., Ph. D. (Internal) Pulmonary Consultation dated 10/16/2007;
- PTP Ralph Finster M. D. (Internal) Medical Report in Internal Medicine/Toxicology dated 5/20/2013 & Treating Physician Report in Internal Medicine/Toxicology Supplemental Medical Report dated 3/21/2019;

RHEUMATOLOGY

- PQME Marilyn T. Lightfoot, M. D. (Rheumatology/Arthritic Disorders) Panel Qualified Medical Examination in Rheumatology dated 2/6/2018 and Panel Qualified Medical Examination in Rheumatology Supplemental Report dated 5/5/2019;

PSYCHIATRIC/PSYCHOLOGICAL

- George Y. Naught, M. D. (Psychiatric) Initial Psychiatric Evaluation and Report and Request for Authorization for Treatment dated 1/25/2013;
- PQME Lucille Pleasant, Ph. D. (Psychological) Panel Qualified Medical Evaluation Report with Psychological Test Results and Review of Records dated 10/27/2016 and Panel Qualified Medical Evaluator's (Psychology) Medical-Legal 106 Supplemental Review of Records Report dated 2/27/2019;

MISCELLANEOUS

- Philo Masteret, M. D. Urine Toxicology Review Report dated 3/23/2013; and
- Charles Lister, Attorney at Law—Advocacy Letter to Dr. Marilyn Lightfoot dated 1/11/2018.

DEPOSITIONS

- Deposition of Marvin Tulips dated 9/28/2018.
- Deposition of Marilyn Lightfoot, M. D. dated 11/6/2018.

Authors comments. Although it should go without saying, accuracy in spelling, punctuation, dates, titles, and names of reports should be perfect. Pages should be numbered along with the name of the evaluee and the kind of the report. For Example:

Sample Header
Vocational Evaluation May 19, 2019
Mary Franklin

Authors comments. The authors recommend detailed proofreading and editing by another vocational expert familiar with the case file. Another vocational expert with editorial skills understands the nature and terminology of the report. He or she can address whether the author is clear in presentation and composition. If editing is done, then that must be acknowledged in the report. The goal is an error-free document. It is human nature to question the content of a report based on presentation. The trier-of-fact may wonder if the content is similarly inaccurate. The documents listed above are those that have been read and understood by the vocational expert; however, not all will be documented in detail for vocational relevance. It is important that the vocational expert document receipt and review of every report, either in the original vocational evaluation or a supplemental report.

There are occasions when not all of the relevant medical documentation has been provided for a vocational evaluation. Not having all of the same documents as another vocational expert may adversely affect the vocational analysis and subsequent vocational evaluation report. If reviewed by a second vocational expert for rebuttal purposes, lack of review of all relevant medical/legal documents can result in the exclusion of the report by the administrative law judge. Thus, if there are missing reports initially, referring attorney must be notified and a request made for all missing documents. Missing medical/legal reports such as depositions, Sub Rosa videos, and supplemental reports can be identified by reading the medical record review by evaluating physicians' reports initially referred. Request those records, and if not delivered so note in the report. The vocational evaluation report requires a comprehensive and complete medical records review. A trier-of-fact will compare reports, so the foundational documents must be equivalent. The authors prefer to treat the medical and diagnostic reports as continuous; however, other documents are regarded as discrete. There is no harm in including medical depositions under the same heading as the particular physician. Just be sure that the editor confirms clarity and flow in the presentation.

ORTHOPEDIC EVALUATION SAMPLE

In the following reports, comments are inserted after each section.

ORTHOPEDIC

PQME Thomas T. Clark, M. D. (Orthopedic Surgeon) Initial Orthopedic Joint Panel Qualified Medical Evaluation dated 4/11/2016 & Orthopedic Joint Panel Qualified Medical Re-Evaluation dated 6/13/2017.

Authors' comments. This heading is exactly the same as in the listing of medical/legal reports at the beginning of records review. Please note changes in punctuation and emphasis.

Dr. Clark performed an Orthopedic PQME Re-Evaluation dated 6/13/2017.

Information will be from this report, unless otherwise indicated.

Authors' comments. It is common practice to review all medical reports but to document vocationally relevant information especially from the last comprehensive report. However, that report may not be the last chronologically. Usually, the initial evaluation has better information about mechanism of injury and history of injury due to chronological proximity to the actual date of injury, when the applicant's memory is relatively fresh.

Dr. Clark documented current complaints, interval history, and a physical examination. Dr. Clark reviewed medical records. He considered results of diagnostic studies.

Authors' comments. These two sentences attest to foundation of the physician's report. In addition, the vocational expert infers that previous records and diagnostic studies are addressed in this report.

Remember that any reviewed medical report occurred prior to the date of this report. The same holds for Supplemental Record reviews. While the evaluating physician may include copies of diagnostic studies, the vocational expert need only consider the final physician's report, which will address the various diagnostic studies, as appropriate.

Diagnoses:

1. "Blunt force head trauma with contusion and loss of consciousness secondary to date of injury of November 15, 2014.
2. Post-concussive syndrome with residual effects of disequilibrium and chronic headaches secondary to injury of November 15, 2014.
3. Sprain-strain cervical spine secondary to injury of November 15, 2014, with underlying nonindustrial C1 congenital lack of fusion.
4. Left cervical radiculopathy C5-C6 with industrial aggravation through the date of injury of November 15, 2014.
5. Mild subclinical left cubital and carpal tunnels, nonindustrial, per EMG.
6. Sprain-strain lumbosacral spine with nonindustrial lumbar degenerative disc disease with left radiculopathy and left distal sciatica confirmed by EMG and MRI scan.
7. Blunt force contusion, left knee, secondary to date of injury and resolved.
8. Sprain-strain left shoulder, contusion with post-traumatic impingement and partial biceps tear, left shoulder, secondary to injury of November 15, 2014."

ROM studies are on pages 3-7.

Authors' comments. The reporting physician may use another term for "Diagnoses", such as "Impressions". This section, if completed properly, establishes a medical treatment timeframe for this medical specialty. Upon completion of the medical record review, the vocational expert can meld information from the various current reports in each specialty to form a chronologically accurate Medical Treatment summary.

In the vocational reports, reference is made to Range of Motion (ROM) studies, without documenting every detail.

Medications:

- Nexium—reduces stomach acid.
- Ibuprofen—NSAID for pain.
- Tramadol—narcotic-like pain reliever.

Authors' comments. Many of the medical reports do not identify the specific reason for the prescribed medication, and sometimes the evaluee does not know why they are taking a particular medication. We use www.Drugs.com as our reference source. The vocational expert may use any of the many credible drug reference books or websites, and identify the source. Usually, there is no need to identify dosage with the exception of *pro re nata* (p.r.n.) (as necessary). If the reason for the prescription is unclear, then note the various applications identified on the website and leave it at that. The primary reason for including prescriptions is to consider possible side-effects and their impact on performance, production, and attendance. If a drug is identified with potentially vocationally relevant side-effects, the evaluee is asked during the clinical interview if they are aware of any side-effects from any medications. If the side-effect is vocationally relevant, it will be noted in the report. Evaluees may not know if a medication has a side-effect, so noting the opinion of the evaluee is not diagnostic; it is just an opinion of the evaluee. Whether evaluee-identified or not, we do mention in the vocational evaluation the possibility of intrusion of the potential side-effects on performance. We do not diagnose, nor do we diagnose side-effects. Instead, we document our observations and findings in an objective manner, pointing out the possibility and leaving to the consideration of the attorney and physician. Notes are made of obvious vocational restrictions that might impair the safety of the evaluee or be otherwise vocationally relevant. For example, if the person has ingested opioids and in-

tends to drive, the legal consequences are discussed and alternative transportation recommended. Attorneys generally are willing to assure alternative transportation both to and from the vocational evaluation, and it is a good idea to confirm the appointment along with transportation with time to spare before the actual evaluation date.

Previous Injuries:

2006—Non-industrial steel door closed on head. Diagnosed with a concussion by Dr. Wilber Smith; no treatment received.

Medical History:

Diabetes managed by diet.

Authors' comments. It is imperative for the vocational expert to know about previous injuries and medical conditions, both industrial and non-industrial, as well as dates of medical diagnosis. The vocational expert must determine causation and apportionment of the vocational disability. We verify previous injuries and compare them with the physicians' findings. If there is a significant discrepancy, we document the discrepancy. Physicians are charged with determining the causation of the disability, but may determine the causation of the impairment. It is our job to identify any undocumented discrepancies in comparison with the physician's report. For example, in the vocational clinical interview, our evaluees sometimes remember a prior injury that they have not reported to the physician or their attorney. That we include this in the vocational evaluation is a matter of accuracy and ethical reporting. We also compare dates of medical conditions other than the industrial injury, because there may be a relationship between condition and injury. For example, a person who suffered a physical trauma may also have a diagnosis of hypertension for the first time after the date of injury. While it is up to the attorney and medical provider to determine if there is a connection, it is certainly our responsibility to identify the reported proximity in dates for them to consider.

Vocationally Relevant Behavioral Observations:

Right hand dominant.

Some balance impairment during testing.

Authors' comments. The vocational expert utilizes the process of behavioral observations in accordance with principles of vocational evaluation and Chapter 18 of the AMA *Guides*. The behavioral observations are then compared with behavioral observations of the physicians' or ancillary medical personnel. This information may support the rationale for vocational factors of disability. The observations must be unobtrusive. In other words, the evaluee should not be aware that they are under observation. The vocational evaluator may document different behavioral observations. That too should be recorded. The difference in observations between the vocational evaluator and physician may be reasonable discussion topics. In some cases, the evaluee may not show discernable pain-related behavior. For example, prison guards often practice hiding evidence of injury or pain, because showing weakness on the job might result in conflict with inmates. In that case, it is reasonable to ask the evaluee about pain they are feeling, rather than relying on observations alone.

Disability Status:

"For rating purposes, the examinee is permanent and stationary."

Authors comments. In most cases the vocational expert should be documenting medical examinations after the determination of Permanent and Stationary (P&S) status aka Maximum Medical Improvement (MMI). Stability and permanence is assured. That said, sometimes reports from Primary Treating Physicians or other Treating Physicians after the P&S date may provide vocationally relevant information.

Permanent Impairment Rating Per Fifth Edition AMA *Guides*:

- Cervical Spine:
  Category II. WPI = 8%.
- Lumbar Spine:
  Category II. WPI = 8%.
- Left Shoulder (Upper Extremity):
  WPI = 15%.
- Left Knee:
  WPI = 0%.
  Total WPI = 24%.

Authors' Comments. Physicians determine Impairment Ratings based on the AMA *Guides*. This is not an example of a vocational disability rating; however, sometimes the physician will refer to Whole Person Impairments as disabilities. While these ratings are important to attorneys, they reflect a category of symptoms in which the patient's medical impairment falls, so all of the symptoms identified in the category may not apply to the individual patient. The information contained in each rating is of little use to the vocational expert, because it is a general statement about the category, not the individual.

Causation

"Causation is to the periods of temporary total disability is to the industrial injury."

Authors' Comments. In the medical report, causation usually refers to the industrial event(s) and vocational disability(s); however, as noted sometimes the physician is basing causation on industrial impairment, not vocational disability.

Apportionment

"Clearly, there are degenerative changes in the cervical and lumbar spine as well as the left shoulder, and I would apply an equal ratio of nonindustrial causation of 25% and 75% industrial to the date of injury.

"This is based on interview with the examinee, physical examination, review of all medical records, imaging studies, and my 35-plus years of treating orthopedic patients and performing WC evaluations within a reasonable medical probability."

Authors' comments. Apportionment refers to the percentage of the disability that is industrial vis-à-vis non-industrial. The physician is required to explain how and why the percentage of each was determined. It must be a detailed and logical rationale to be accepted by the triers-of-fact. How does medical apportionment affect vocational apportionment, if at all? If medical apportionment is not a factor, is the claimant totally disabled based on industrial factors alone? Was there vocational disability due to the industrial injury in question? What are the functional losses/work restrictions set forth by the physicians? Have the physicians covered all of the functional losses/work restrictions? Do the work injuries constitute total vocational disability? How and why have you reached that conclusion? The vocational expert will need to document consideration of medical apportionment in later sections of the vocational evaluation (Johnson, 2019).

Work Restrictions:

"The examinee would require 100% sedentary work with minimal requirement for use of the left hand with no repetitive gripping or grasping, no repetitive side-to-side motion with the head and the ability to utilize a cane throughout his work day."

Authors' comments. While appearing to be a reasonable and valuable list of work restrictions, it is incomplete, because the physician did not define "sedentary." Often, physicians use functional terms such as "heavy work" or "heavy lifting" without a clear definition of meaning. Vocational experts must convert the medical factors of impairments as documented by medical experts to vocational factors of disability using the definitions of work as identified in the *Dictionary of Occupational Titles* (1991 ed.). It is the vocational expert's job to determine the details of the restrictions by review of all relevant medical impairments for vocational analysis and conversion to vocational factors of disability. This includes other medical reports, the range of motion studies, comments made by the physician, and questions directed to the evaluee. Then the vocational expert must match the actual job duties done by the evaluee with the actual and complete work restrictions.

Future Medical Treatment/Recommendations

Please see page 10. Dr. Clark indicated that cervical spine surgery should be considered if pain management is unsuccessful.

Authors' comments. In keeping with the mandate of documenting vocational relevance, only future medical treatment that would potentially interfere with employment is documented here. For example, if daytime medical treatment is recommended, it might impact attendance. Similarly, if medications with significant side-effects are recommended, it might impact performance. The reference to cervical spine surgery is written, because it could be an obstacle to employment in the future.

Psychological/Psychiatric Evaluations

Chapter 14 of the AMA Guides, Mental and Behavioral Disorders, provides guidance for psychologists and psychiatrists. Too often the vocational evaluator ignores or minimizes the impact of mental impairments on employability, because sometimes the mental health evaluator indicates no work restrictions, when in fact the discerning vocational evaluator will be able to identify impairments that do indeed represent work restrictions. The format for mental health evaluations is multi-faceted and includes a comprehensive history of behavior while performing activities of daily living. In addition to a review of records, a detailed clinical interview, which may include family members, is conducted. The goal is to determine "detailed descriptions of the individual's activities of daily living, social functioning, concentration, persistence, pace and ability to tolerate increased mental demands (stress)" (AMA, *Guides*, pp. 358). The mental health evaluator uses standardized psychological tests to assist with diagnosis. In California, whole person impairment is based on conversion of Axis V: Global Assessment of Functioning (Hoch, 2005). Axis I consists of major clinical syndromes; Axis II personality and developmental disorder; Axis III relevant physical disorders; and Axis IV psychosocial stressors. The mental health evaluator typically considers effects of medication on the evaluee's functioning, which may have significant vocational relevance in terms of employability. Section 14.2b of the *Guides* discusses clinical assessment of motivation, which is significant in converting medical impairment to vocational factors of disability as well as amenability to vocational rehabilitation.

Four main areas of functioning are assessed:

1. Ability to perform activities of daily living;
2. Social functioning;
3. Concentration, persistence, and pace; and
4. Deterioration or decompensation in work or worklike settings.

Sections 14.3a through 14.3d, pp. 361-362 describes each area. The ratings are listed on page 363. Mental health evaluators typically detail complaints, social and recreational activities, family and developmental history, educational, mechanism of injury, work status, issues at work, medical history, medical treatment history, return to work, legal history & status, financial history & status, personal habits, and hobbies, as well as past and current psychological state. They frequently ask about a typi-

cal day and from that description the vocational evaluator may be able to identify barriers to employability. The AMA *Guides* offer a format of the mental health impairment report in section 14.6.

Authors' comments. A review of the comprehensive psychological report is an excellent place to start documentation for the vocational evaluator because often a historical framework can be constructed for the remainder of the vocational evaluation. Some aspects that may not be of vocational relevance, such as sexual activity, can be left out of the remaining report in most cases. In general, few vocational evaluations are solely based on psychological impairments. Rather, the psychological state is a consequence of the original injury or treatment. Mental health evaluators offer some in depth information about concentration, persistence, and pace that may or may not be associated with medication or the evaluee's psychological state. Also, decompensation may be documented. They offer detailed descriptions of dress, appearance, grooming, and hygiene, as well as how long it takes the evaluee to perform activities of daily living. Vocational evaluators sometimes focus so much on production, performance, and attendance that they forget the social aspect of work; however, these issues may be critical factors in employability and placeability. Pain and discomfort frequently contribute to less than satisfactory mental performance on the job.

Mental health evaluators perform a mental status examination, which includes behavioral observations, mood, hearing, vision, facial expressions, eye contact, and composure, including physical behavior and communication patterns. They assess intellectual functioning, fund of knowledge, level of education, and socioeconomic status. They address insight, judgment, impulse control, and patient reality. Evaluators usually perform testing that is different than vocational testing and they list the testing instruments as well as results. Diagnostic testing is identified by the vocational evaluator as diagnostic tools. The authors recommend using the mental health evaluators' findings and conclusions, rather than attempting to analyze testing results. That is up to the mental health clinician to do. Vocational evaluators see the evaluee as an individual, not as a medical classification; therefore do not assume that the description of the diagnosed major mental disorder is a completely accurate description for the individual evaluee. The mental health evaluator will describe the evaluee and the diagnoses as they apply to the individual. In reporting mental health vocationally relevant information, such as behavioral observations, it is essential to compare with those of the mental health evaluator, as it is with all physicians' behavioral observations.

Diagnoses are in the Diagnostic and Statistical Manual-IV format. The Diagnostic and Statistical Manual-V was published (2013) and there have been multiple changes particularly in the number of diagnoses. The Global Assessment of Functioning (GAF) is omitted in the DSM-V, and some of the mental health reports provide the first four Axes in terms of the DSM-V, and continue to use the GAF from the DSM-IV. The change away from the GAF is of little consequence to the vocational evaluator, because the GAF scales are so vague that the evaluator must rely on a discussion of performance and behavior to determine vocational relevance. The mental health evaluator has to decide the impact of the diagnoses. If based on reasonable medical probability, the rating is above 50%, then the diagnosis is meaningful for workers' compensation purposes; however, the vocational evaluator must scrutinize the report to identify any vocationally relevant factors. Regardless of the percentage rating, there may be vocationally relevant behavior.

Authors' general comments. Whether or not an individual can perform the duties of their last job depends on the duties compared to the work restrictions and limitations and the subsequent medical analysis for "Qualified Injured Worker". While the physician documents work restrictions and limitations, they may do so based on medical impairments, not (f)actual job duties. It then becomes the responsibility of the vocational expert to convert medical impairments to factors of vocational disability. In other words, the vocational expert determines the quantifiable restrictions and limitations imposed by the injury as delineated by the physician and convert those restrictions into vocational restrictions and limitations. Remember the physician is basing impairments on activities of daily living not the physical requirements of full time competitive employment. If the vocational expert merely restates the work restrictions and limitations documented by the physician critical information may be missed in the forensic vocational evaluation. In large part that is the theme of this paper; that is,

how to extract valuable vocationally relevant factual information and apply that to the findings of the vocational evaluation regarding employability.

In defining the duties of the job one may utilize the broad definition encompassed by the job description in the *Dictionary of Occupational Titles*. Computer programs, such as SkillTrans© and McCroskey©, generally utilize that definition. The modern usage definitions represent approximately 12,972 different occupations, many of which are consolidations of other similar jobs. Sometimes the job title given by the evaluee is the one used by the employer, but that may be inaccurate when compared to the Department of Labor definition and therefore, misleading. In the final vocational evaluation, the authors refer to these titles as "Company Titles". We have found that the job duties described by the evaluee are frequently not a complete match with the definitions in the computer programs, so it is necessary to explain why the selection of that particular job and description to identify the job last worked. It may be that the vocational expert will find the evaluee's job has components in different job titles. In documenting a selection of the correct job title(s), it will be necessary to identify the various job titles and to explain why they were selected. It is appropriate to list each of the job titles and associated relevant information. There are two types of job duties, essential and non-essential. An essential job duty is a core component of the job description. Moreover, without the essential job duty, the job is no longer the job. A non-essential job duty, is one which if removed would not change the job. For example, a machine tender may have two essential job duties, running the machine and maintaining the machine, whereas, non-essential job duties might be opening the workshop and filing work orders for the clerical staff from the day before.

Credible Evidence

The authors have loosely ranked credible evidence for consideration from highest to lowest, as follows:

1. AME, PQME, and QME information based on clinical interview, behavioral observations, Range of Motion components, and interpretation of multiple psychological tests and, or interpretation of diagnostic studies.
2. Primary Treating Physician comprehensive report with Permanent and Stationary determination
3. Primary Treating Physician Permanent and Stationary Progress Report Form (PR-4).
4. Primary Treating Physician Progress Report Form (PR-2).
5. Patient subjective complaints or statements substantiated by the evaluating physician and documented as Subjective Factors of Disability by the evaluating physician.
6. Functional Capacity Evaluation with measurable and reliable results, including Physical Therapy progress reports, as requested and endorsed or substantiated by a physician.
7. Sworn testimony by the evaluee, such as in a deposition transcript.
8. Unobtrusive direct behavioral observation, i. e., vocational expert observation without patient/evaluee awareness, compared to pain-related behavior identified in Chapter 18 of the AMA *Guides*.
9. Sub Rosa videos of extended duration with clearly observable physical activity supporting or refuting physicians' determination of work limitations and/or restrictions
10. Sub Rosa videos of short duration with clearly observable physical activity supporting or refuting physicians' determination of work limitations.
11. Patient form/test completion with weighted scores and medical interpretation.
12. Patient form/test completion with simple addition scoring.
13. Family member statements verified by direct observation by the vocational expert.

After a complete review of the medical report, the vocational expert may feel that there is more to the vocational factors of disability than documented by the physician. For the vocational expert, as much specific information as possible is critical in determining vocational disability. The vocational expert gathers data about diagnoses beyond that which is documented in the medical evaluation. If the ex-

aminer explains the medical impairment as it applies to the individual examinee and the vocational expert understands the meaning of the diagnosis that is satisfactory; however, there are methods of increasing knowledge about a diagnosis. There are three alternative sources of information concerning diagnosed impairments: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition and 5th Edition (DSM-4 & DSM-5), The International Classification of Functioning, Disability, and Health-11 (ICF), and International Statistical Classification of Diseases and Related Health Problems-10 (ICD-10). The Commission on Rehabilitation Counselor Certification (CRCC) offers "Using DSM-5 and ICF Tools to Understand Client Cultural and Environmental Perspectives" as part of their continuing educations units. As indicated previously, the evaluation must be individualized, rather than generalized, so the vocational expert should document that the specific diagnosis is unique to the evaluee and how that was determined. The medical evaluator will usually provide sufficient guidance in their reports to narrow down vocational factors of disability.

It is essential to remember that vocational experts are not medical experts, but rather experts in the analysis of medical information from a vocational perspective. The medical expert (physician and related specialists) must diagnose and evaluate the medical impairments of an industrial injury, meeting the standards for substantial medical evidence. Only then can the vocational expert pick up "the thread" and follow through to identify vocational factors of disability and meeting the standards for substantial vocational evidence.

Recommended Research

As indicated in the body of this article, the evidence-based process is somewhat fluid in that it is based on labor code, statutes, case law, Workers' Compensation Appeals Board (WCAB) decisions, and court rulings. While it appears that scientifically based factual information presented with a reasonable foundation will be accepted, interpretation of the law may modify specific sections. Therefore, we recommend that every vocational expert stay abreast of potential changes. Having a definite level of communication with attorneys will often result in being informed of changes required by law or the triers-of-fact.

Many of our professional organizations publicize changes. The authors subscribe to Lexis Nexis eNewsletter online for weekly news about workers' compensation (LexisNexis, robin.e.kobayashi @lexisnexis.com), for example.

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