ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, FREDERICK Case# **11WC046390**

Employee/Petitioner

FLEXIBLE STAFFING INC

Employer/Respondent

On 7/24/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4442 TIMOTHY TAKASK
20 N CLARK ST
SUITE 1700
CHICAGO, IL 60602

1596 MEACHUM STARCK AND BOYLE
JASMER JANNISCH
225 W WASHINGTON ST SUITE 1400
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

FREDERICK WILLIAMS
Employee/Petitioner

Case # 11 WC 46390

v.

Consolidated cases: N/A

FLEXIBLE STAFFING, Inc.
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Lynette Thompson-Edwards, Arbitrator of the Commission, in the city of Chicago, on June 5, 2012. By stipulation, the parties agree:

On the date of accident, October 7, 2011, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $33,951.32, and the average weekly wage was $652.91.

At the time of injury, Petitioner was 45 years of age, married with no dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $10,073.36 for TTD, $0 for TPD, $ for maintenance, and $0 for other benefits, for a total credit of $10,073.36.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

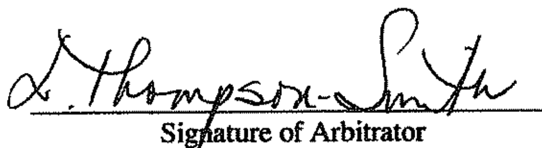
Respondent shall pay Petitioner temporary total disability from October 7, 2011 through March 7, 2012, for 23 & 1/7th weeks, in the amount of $435.27 per week pursuant to Sections 8(b) of the Act.

Respondent shall pay Petitioner the sum of $391.75/week for a further period of 75.9 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the Petitioner a 30% loss of use of his right arm.

Respondent shall pay Petitioner compensation that has accrued from October 7, 2011 through June 5, 2012, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS: Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.



Signature of Arbitrator

July 24, 2012

JUL 24 2012

FREDERICK WILLIAMS
11WC 46390

FINDINGS OF FACT

The petitioner was 45 years old at the time of the work accident on October 7, 2011. He was married, and he had no dependent children. The petitioner testified that he is right-hand dominant. He testified that, before the subject work accident on October 7, 2011 he had never had any medical problems or symptoms involving his right arm. He testified that, before the work accident, he had never received any medical treatment for right arm problems. The petitioner testified that he never re-injured his right arm after October 7, 2011.

The petitioner testified that he was a member of the United States Marine Corp from 1984 through 1988, and that he received an honorable discharge from the service. The petitioner testified that, after he left the service, he spent most or all of his professional life as a welder. He testified that welding has always been his passion and that he has his own welding equipment in the garage of his home. He testified that he began working for the respondent on June 19, 2011 and that the respondent was in the business of manufacturing boilers, shredders and conveyors at the time of the work accident. The petitioner always worked as a welder/fabricator and testified that his job duties were physically demanding in nature, requiring cutting, welding and carrying both tools and metal equipment and interpreting blueprints. The petitioner testified that he worked without any physical restrictions for the respondent at all times.

The petitioner testified that he worked 40 hours per week for the Respondent. He testified that he worked from 6:00 a.m. to 2:30 p.m. The petitioner testified that the work accident on October 7, 2011 occurred at approximately 9:00 a.m. He testified that he was working on a section of a rail, similar to a rail road track. The petitioner testified that the section of rail was approximately nine feet long, two inches wide, and weighed in excess of 400 pounds. The petitioner testified that the rail was positioned on a horse while he welded it. He testified that one end of the rail slipped off of the horse. The petitioner testified that his first reaction was to reach out and grab the rail, to keep it from falling on him. He testified that when the rail hit his hand, he felt a sharp pain in his right arm and he heard something snap. He testified that he immediately noticed that his arm was disfigured. The petitioner

testified that he reported the incident to his supervisor, Mr. Greg Herndon. The petitioner testified that his supervisor asked him if he needed an ambulance. The Petitioner testified that he declined the ambulance, and instead drove himself to Ingalls Occupational Health Clinic ("Ingalls") using only his left arm. The petitioner testified that his right arm was x-rayed at Ingalls, that he was given a sling, and that he was diagnosed with a distal biceps tendon rupture. The specialist at Ingalls immediately sent Petitioner home. Petitioner testified that he was off of work for one (1) week, in severe pain and was never contacted by Respondent's insurance carrier. Petitioner further testified that his right arm was wrapped in an Ace bandage for approximately one month until Respondent finally approved surgery.

Medical records from Southland Orthopaedic Associates, Ltd. ("Southland") show that petitioner's first visit with Dr. Arabindi took place on October 12, 2011. The petitioner complained of right arm and right elbow pain and the doctor immediately diagnosed a probable right distal biceps tendon rupture. Dr. Arabindi discussed a surgery to repair the tendon rupture at the completion of that first visit. The Southland records confirm that Dr. Arabindi kept the petitioner off work from that first visit through March 8, 2012. The doctor wrote that he was awaiting approval of the surgery during both office visits in October of 2011. Dr. Arabindi eventually performed the surgery at the Ingalls Same Day Surgery on November 7, 2011. The doctor performed a repair of the petitioner's right elbow distal biceps tendon rupture. Under a general anesthesia, the surgeon drilled two holes into the petitioner's right radius and used K-wire and metal anchors to pull and secure the tendon into place. The petitioner began attending physical therapy ("PT") at Southland on November 28, 2011. He continued to attend PT, at Dr. Arabindi's direction, through February 8, 2012. At the time of the last office visit on March 7, 2012, the doctor declared the petitioner to be at maximum medical improvement (:MMI") but noted that he still lacked approximately five to ten (5-10) degrees of full supination in his right forearm. *See,* PX1.

On May 8, 2012, petitioner was examined by Dr. Mark Levin of Barrington Orthopedic Specialists, at Respondent's request. During that examination, the petitioner complained of right arm pain which he had been suffering since the work accident. The petitioner

indicated that he also experienced pain when he tried to fully pronate and supinate the right forearm. The petitioner told Dr. Levin that he did not believe that he had full extension of his right elbow and that he experienced constant numbness over the ulnar aspect of that elbow. The petitioner stated that he was experiencing pain two or three times per week and that he was still taking narcotic pain medication, i.e. Norco, approximately two or three times a week because of pain in his elbow. Following his examination, Dr. Levin also noted that the petitioner lacked full extension with both pronation and supination of his right arm and then listed an AMA disability rating of 4% of a whole person or 5% loss of the right arm. *See*, RX1.

The Petitioner testified that, at the time that he was released to return to work by Dr. Arabindi, he was capable of lifting only 25 pounds. He testified that he told Dr. Arabindi, at the time of the last office visit on March 7, 2012, that his strength was diminished and that he had ongoing pain and numbness. The petitioner testified that, despite those complaints, Dr. Arabindi released him to return to work, without restrictions, as of March 8, 2012. The petitioner testified that, once he was released to return to work, he was told by the respondent that he does not have a job anymore.

Petitioner testified that he continues to experience pain in his right arm on a daily basis, and that he still lacks range of motion. The petitioner further testified that he still lacks strength in his right arm and that he still has tingling sensations in his right arm and his fingertips. And he testified that he still experiences numbness and a measurable amount of pain in his right arm. He continues to take Norco approximately three times per week. He testified that he continues to look for employment as a welder and that he has attempted to use his own welding equipment after he was released by Dr. Arabindi.

The petitioner testified that he finds welding difficult and that he experiences difficulty while playing with his three young grandchildren due to his ongoing symptoms in his right arm. He testified that he cannot perform garden work, mow his lawn, or play golf. The Petitioner testified that he experiences the numbness and tingling in his right arm and hand a few times a week and that he experiences some level of pain in his right arm on a daily basis.

CONCLUSIONS OF LAW

L. What is the nature and extent of the injury?

On October 7, 2011 the Petitioner suffered painful injuries to his right arm. All of the medical evidence conclusively established that the Petitioner suffered a right distal biceps tendon rupture while in the course of his employment for the Respondent on that date. I base my findings on the petitioner's credible testimony that his right arm was symptom-free all times prior to the work accident on October 7, 2011. All of the medical evidence supports Petitioner's testimony that he was working without any physical restrictions and that he was not under a doctor's care for any problems involving his right arm, at the time of the subject work accident.

The injuries to Petitioner's right arm and elbow lingered for more than seven months after the subject work accident. The Petitioner voiced the same complaints of pain, numbness and tingling to both his treating orthopedic surgeon and his physical therapist. The Petitioner described those same symptoms when he was examined by Dr. Mark Levin of Barrington Orthopedic Specialists on May 8, 2012. During that examination, the petitioner complained of right arm pain since the work accident. He indicated objectively, that he experienced pain when he tried to fully pronate and supinate the forearm. Petitioner told Dr. Levin that he did not believe that he had full extension of his right elbow and that he experienced constant numbness over the ulnar aspect of that elbow. The petitioner testified that he was suffering from lingering effects of the right arm injuries at the time of the hearing on June 5, 2012. The petitioner testified that he was experiencing pain two to three times a week and is taking pain medication in an attempt to ease his pain.

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment

that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment;
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by medical records.

With regards to (i) of Section 8.1(b) of the Act:
the level of impairment reported by Dr. Levin pursuant to the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment is 6% upper extremity impairment and "disability" rating of 4% of a whole person. The Arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act. Dr. Levin's reference to "an AMA disability rating" is misplaced; Dr. Levin is rating impairment only, not permanent partial disability. Dr. Levin does not specifically include loss of range of motion or any other measurements that establishes the nature and extent of the impairment pursuant to Section 8.1b. Dr. Levin used a physical examination grade modifier of 2 indicating a moderate problem. Dr. Levin did not consider a grade modifier for clinical studies in his impairment report, even though the surgical report could have been used in this way. Dr. Levin scored the QDASH report for functional history grade modifier as 23, however, does not include a copy of the QDASH in his impairment report so that the Arbitrator may review his findings.
With regards to (ii) of Section 8.1(b) of the Act:
the petitioner's occupation is welder/fabricator, which the Arbitrator takes judicial notice to be medium to heavy work and concludes that Petitioner's permanent partial disability will be larger than an individual who performs lighter work.

With regards to (iii) of Section 8.1(b) of the Act:
the age of the petitioner at the time of the injury was 44 years old. The Arbitrator considers the petitioner to be a somewhat younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual because he will have to live with the permanent partial disability longer.

With regards to (iv) of Section 8.1(b) of the Act:
the petitioner's future earning capacity, at the present time, appears to be undiminished as a result of his injuries, because he has medically been returned to his full-time duties. However, when he attempted to return to work, he was told that he no longer had a job. The Arbitrator concludes that this may negatively affect Petitioner's future earning capacity.

With regards to (v) of Section 8.1(b) of the Act:
the petitioner has demonstrated evidence of disability corroborated by his treating medical records. The petitioner has credibly testified that he currently experiences pain, numbness, tingling and loss of range of motion. The petitioner's complaints regarding his right arm are corroborated in the treating medical records of Dr. Arabindi, including but not limited to the diagnosis of distal biceps tendon rupture and the necessity of the subsequent surgery and course of treatment. The doctor also noted that the petitioner has disability of a permanent nature as, on Petitioner's last visit, he noted that Petitioner's condition was as good as it was going to get and that he still lacked approximately five to ten (5-10) degrees of full supination in his right forearm. The petitioner's complaints, supported by medical records, evidences a disability as indicated by Commission decisions regarded as precedents pursuant to Section 19(e).

The determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, 820 ILCS 305/8.1b, the petitioner has sustained accidental injuries that caused 30% loss of use of the right arm. The Arbitrator further

finds that the respondent shall pay the petitioner the sum of $391.75/week for a further period of 75.9 weeks, as provided in Section 8(e) of the Act

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, ZACHARY
Employee/Petitioner

Case# **11WC041328**

RECEIVED JUL 3 0 2012

CENTRAL TRANSPORT
Employer/Respondent

On 7/24/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
100 W MONROE ST SUITE 1410
CHICAGO, IL 60603

1622 HINSHAW & CULBERTSON LLP
ROBERT J FINLEY
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Zachary Johnson
Employee/Petitioner

v.

Central Transport
Employer/Respondent

Case # **11** WC **041328**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **June 5, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **October 17, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$6,507.33**; the average weekly wage was **$948.42**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $6,763.70 for TTD, **$0** for TPD, **$0** for maintenance, and $1,163.66 for over payment of TTD benefits, for a total credit of $7,927.36.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $632.28/week for 8 6/7 weeks, commencing October 18, 2011 through December 18, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 18, 2011 through December 18, 2011, and shall pay the remainder of the award, if any, in weekly payments.

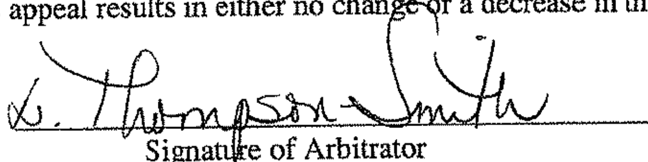
Respondent shall be given credits of $6,763.70 for temporary total disability ("TTD") benefits that have been paid and a TTD overpayment of $1,163.66.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $569.05/week for 20.50 weeks, because the injuries sustained caused the 10% loss of the right hand, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS: Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.



Signature of Arbitrator

July 24, 2012

JUL 24 2012

FINDINGS OF FACT

The disputed issues are 1) casual connection; and 2) nature and extent of the injury. See, AX1.

Petitioner's Testimony at Hearing

Petitioner, Zachary Johnson, is claiming an accidental right hand injury on October 17, 2011. Temporary total disability and medical bills are not in dispute. The parties have stipulated that Respondent is entitled to a temporary total disability overpayment credit of $1,163.60. Petitioner sustained accidental injuries on October 17, 2011 while employed by Central Transport as a local truck driver and loader. At the time of the accident, Petitioner was 28-year old and a journeyman truck driver employed by Central Transport, since August 10, 2011. Petitioner's employment duties included loading the truck trailer and driving city trucking routes. On the day of injury, he had completed loading the trailer and was conducting a pre-trip inspection when he encountered a problem with the trailer door. The trailer door operates on a bearing system by which the door rolls up/down. Petitioner testified that the bearings malfunctioned preventing the trailer door from completely closing. Petitioner attempted to close the trailer door with the assistance of a forklift but was unsuccessful. He then tried to close the trailer door manually by placing his left hand on the trailer door handle and his right hand on an attached rope. Petitioner pushed and pulled the door which eventually gave way, falling onto Petitioner's right hand. Timely notice was given to Central Transport and he proceeded to complete his shift.

Petitioner continued working regular duties as truck driver with Central Transport. These were the same duties as before the accident. In February 2012, Petitioner ceased working for Central Transport and went to a new trucking company, i.e., JF Freight; for an increase in salary. Petitioner testified that his decision to quit Central Transport had nothing to do with his with his right hand injury. Petitioner remains employed as an over-the-road driver with JF Freight. Petitioner's trucking routes while at Central Transport, consisted of short, urban routes. Petitioner did not travel long distances while employed with Central Transport. Petitioner testified his current routes with JF Freight have him driving from Chicago to Texas and Florida several times per week and he is driving much longer distances compared to Central Transport. Petitioner testified that he is right hand dominant and that currently, his right hand stiffens in the cold and he experiences periodic pain throughout the day, especially while driving over bumpy roads and when his hand strikes the stick-shift.

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's current right hand condition is a healed metacarpal fracture with angulations. This diagnosis is confirmed by his treating physicians, diagnostic studies, and examining physician Dr. Vender.

L. What is the nature and extent to Petitioner's injury?

Pursuant to Section 8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment;

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of injury;

(iv) the employee's future earning capacity; and

(v) evidence of disability corroborated by medical records.

With regards to paragraph (i) of Section 8.1(b) of the Act:

(i) Dr. Vender's AMA report was admitted into evidence. Dr. Vender concludes that Petitioner's hand impairment is 1%. Petitioner provided no evidence or argument rebutting Dr. Vender's 1% impairment rating.

Medical Records

On October 18, 2011, the day after the accident, Petitioner sought treatment at Concentra Medical Center. X-rays of the right hand revealed a closed right small finger metacarpal fracture. Petitioner was discharged the same day with a right hand ulnar gutter splint. He was then referred to Advanced Medical Specialists and presented for examination on October 21, 2011; and was placed on restricted left-hand work. Petitioner returned to Advanced Medical Specialist for follow-up examinations on November 8th and 29th of 2011. X-rays taken on or about November 29, 2011, found Petitioner's small finger metacarpal fracture was healing.

On December 13, 2011, approximately eight (8) weeks after the date of injury, Petitioner was released to full duty work, without restrictions, starting on December 19, 2011. On January 12, 2012, Petitioner was examined by Dr. Cohen, the Director of the Hand and Elbow section at Midwest Orthopaedics at Rush, by request of Respondent. Dr. Cohen noted that Petitioner's right small finger metacarpal fracture had been treated conservatively. Dr. Cohen commented that Petitioner's susceptibility to cold weather should resolve over time and was not permanent. Petitioner's records also show that he underwent right hand surgery at the age of 5 due to a hereditary hand deformity and the arbitrator observed the disfigurement and surgical scarring at trial. Petitioner has not seen a treating physician, had any treatment, or been prescribed medication since his release in December 2011.

AMA Impairment Examination

On April 6, 2011, Dr. Michael Vender performed an AMA Impairment Examination and his report was admitted into evidence. Dr. Vender's examination found 1% impairment in Petitioner's right hand. Petitioner provided Dr. Vender with a history and filled out an evaluation which was utilized in determining an impairment rating. Dr. Vender noted that Petitioner sustained a work injury on October 17, 2011 when the rear door of his trailer fell onto his right hand causing a fracture which was treated conservatively. Upon examination, Petitioner complained of sporadic numbness in his right palm and sporadic soreness in the ulnar aspect of his right hand. Congenital deformities related to both ring fingers were noted with surgical scars on the volar aspect of the ring finger. Petitioner demonstrated normal range of motion of the right small finger. Petitioner was diagnosed with a healed right small finger metacarpal fracture with angulations. *See,* RX1. Petitioner did not offer an AMA impairment rating or write proposed findings that considered the AMA guides.

With regards to paragraph (ii) of Section 8.1(b) of the Act:

(ii) Petitioner continues to be employed as a truck driver and now drives over-the-road rather than locally.

With regards to paragraph (iii) of Section 8.1(b) of the Act:

(iii) Petitioner was 28-years old on the date of accident. The Arbitrator considers the petitioner to be a younger individual and concludes that Petitioner's permanent partial disability may not be more extensive than that of an older individual.

With regards to paragraph (iv) of Section 8.1(b) of the Act:

(iv) There is no evidence that Petitioner's future earning capacity has diminished as a result of this right hand injury. Petitioner is currently 29 years old and continues driving a truck. He is now driving longer distances with a different employer for more pay. Petitioner's age increases the likelihood of a long career as a truck driver.

With regards to paragraph (v) of Section 8.1(b) of the Act:

(v) Evidence of disability in Petitioner's treating medical records finds that Petitioner's metacarpal fracture with angulations was treated conservatively and has now healed. Dr. Cohen reported that Petitioner's susceptibility to cold would resolve over time, his grip strength was relatively symmetrical and functional difficulties associate with this type of mal-union of the small finger metacarpal are minimal. Dr. Vender noted complaints of sporadic numbness in Petitioner's right palm and sporadic soreness in the ulnar aspect of his right hand. Petitioner demonstrated normal range of motion of the right small finger. Petitioner returned to work full duty about eight (8) weeks after the accident.

The Arbitrator also finds persuasive Commission decisions which clearly differentiate the extent of Petitioner's disability and lend support to the conclusion that a minimal PPD award is appropriate. In *Waggaman v. Freight Car Services*, that petitioner, a freight production line supervisor, fractured the midshaft of the second metacarpal (07 I.W.C.C. 41359). Petitioner treated conservatively with therapy and returned to work three months after the accident with 50% strength loss in his hand. Petitioner was awarded 7.5% loss of use of the left hand. In the subject case, the petitioner has suffered

no loss of strength and is driving longer, more demanding routes than before the accident.

The determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, including Dr. Vender's AMA impairment rating, the Arbitrator concludes that Petitioner has sustained a 10% permanent loss of his right hand or 20.50 weeks of loss of use of the right hand.

Barrington Orthopedic Specialists

Mark N. Levin, M.D.

May 8, 2012

RE: Frederick Williams
DOB: 06/20/196
Patient ID: WC0145990

I had the pleasure of seeing Mr. Frederick Williams in my Elk Grove Village office on May 08, 2012, for the purpose of Independent Medical Exam. Mr. Williams did fill out a Quick DASH questionnaire and did confirm that he filled it out.

Mr. Williams is a 45-year-old, right-hand dominant African-American male who reports that he worked through the flexible staffing temporary agency since June 2011 at the Maren Engineering Company as a welder/fabricator. This company makes balers, shredders and other machinery. He relates that, initially, he went to Maren Engineering to apply for his full-time duties back in June 2011 and they had him work through this flexible staff agency. He was working full duty, when on October 07, 2011, there was a nine foot railroad track that was up on a horse. He states it weighed between 300-400 pounds. It slipped off the end of the horse and, as he was welding, he tried to catch it with his right hand. As he tried to catch the end of the track, he felt a snap in his upper arm area and let go and the track fell to the ground. He had immediate severe pain over his biceps area and reported the episode. He went to Ingalls Occupational Health who did x-rays, gave him a sling and diagnosed him with a distal biceps rupture. He was taken off of work. He

Respondent's Exhibit #1

had several followups and no MRI was done because he has a pacemaker in place. He eventually was referred to an orthopedic surgeon, Dr. Ram Aribinidi, and underwent surgery on November 17, 2011, at Ingalls Surgery Center for a distal biceps tendon repair. Postoperatively, he was placed in a posterior mold and a sling and then began physical therapy through Dr. Aribindi's office, two times a week for two months. He states that he never totally got full extension of his elbow and has had problems with what he calls wrist mobility, but upon questioning him, it is actually pronation and supination of the forearm. He subsequently was last seen by Dr. Aribinidi on March 08, 2012, where he was released and told he was at the best he was going to be and to go back to work full duty. He relates that when he tried to go back to full duty, he was fired. At this point in time, he would like to return back to a welding job and feels he can do it. He, though, does have some discomfort since the injury. Specifically, he gets pain when he tries to fully pronate and supinate the forearm and feels he does not have full extension of the elbow. He has had some numbness over the ulnar aspect of the right elbow, which is constant. He does note he is able to lift to at least 35 pounds in therapy. His pain that he gets around the elbow varies in intensity and occurs about 2-3 times a week and could be as much as a 5/10. Most of the time, there is no pain. He is having no pain directly over his hand, wrist or shoulder. The only problem that he has is when he describes pronation and supination.

He denies any previous right elbow injury or upper extremity injuries. He denies seeing doctors for right elbow or upper extremity problems in the past.

His current medications are occasional Norco on a p.r.n. basis approximately 2-3 times a week if he has elbow pain. He is also on Glyburide, metformin and Enalapril. Allergies are none. Social history reveals he is married and has one child. Review of systems is positive for hypertension and a history of diabetes. There is no lung, liver, kidney or stomach disease. Past hospitalization was for a pacemaker in February 2005. He is a nonsmoker. He quit drinking 12 years ago. Family history reveals mother is alive and well. Father is deceased and had squamous cell carcinoma. He denies any previous work injuries.

Orthopedic physical exam demonstrates a cooperative, African-American male who weighs 258 pounds and is 5'9-1/4" tall. His cervical spine exam showed there is no cervical spasm or tenderness. He has full range of motion of his cervical spine with the ability to touch his chin to his chest and extend back fully. He has normal right and left lateral deviation with no pain. He is noted to have tattoos over his cervicothoracic area as well as over the scapula. He has tattoos over the bilateral forearms and arms bilaterally. He has no pain over the trapezius or medial borders of the scapula.

His shoulder exam shows no pain over the AC or SC joints. He has full range of motion of his shoulders with forward flexion to 170 degrees bilaterally. Abduction is to 170 degrees bilaterally. Internal rotation is to T12 bilaterally. External rotation is 90 degrees bilaterally.

Rotator cuff strength is 5/5 bilaterally. His elbow exam shows he does have a scar over the antebrachial cutaneous fossa on the right elbow measuring 3 cm. He also has a proximal radius scar of the forearm measuring 3 cm. His elbow range of motion shows, on the right side, he lacks 3 degrees of full extension. He can flex to 125 degrees. His pronation lacks 15 degrees of full pronation on the right and 15 degrees of full supination on the right. The left elbow has full extension and he flexes to 125 degrees. The left elbow has full pronation and full supination. His wrist exams show that he has flexion of the wrist that is 75 degrees on the right compared to 80 degrees on the left. Extension is 85 degrees on the right and 90 degrees on the left. He has radial deviation of 40 degrees bilaterally and ulnar deviation on the right is 30 degrees and the left is 45 degrees. He has normal motion of all the digits of his hands bilaterally. His mid-arm circumference measures 34.5 cm bilaterally. His mid-forearm circumference measures 26 cm on the right compared to 26.5 on the left. Wrist circumference is symmetrical at 17 cm. His motor strength shows he has 5/5 motor strength to all groups of the upper extremities to individualized testing, including the biceps with normal biceps reflex bilaterally.

Pinprick sensation, he reports, is decreased over the ulnar aspect of the right elbow, but otherwise normal on the right upper extremity.

X-rays of the right elbow, AP, lateral and oblique views, show the postoperative changes consistent with a fixation of the distal biceps tendon into the proximal radius. The elbow joint is otherwise normal.

I have subsequently reviewed medical records that have been supplied to us, which include records from Occupational Health Program at Ingalls with a visit from October 07, 2011. The diagnosis was a right elbow strain.

There is a followup on October 11, 2011. Again, diagnosis was a right elbow strain.

There is a consultation on October 12, 2011, by Dr. Aribinidi, where the patient was diagnosed with a right elbow distal biceps tendon rupture.

There is a record from Dr. Aribinidi on October 26, 2011.

There is an operative report on November 17, 2011, where he underwent a right elbow distal biceps tendon repair by Dr. Aribinidi.

There are then Southland Orthopedic therapy records from January and February 2012. There is a followup by Dr. Aribinidi on February 08, 2012, with additional therapy records after that followup.

There is then a followup by Dr. Aribinidi on March 08, 2012. He was returned to full duty work as of March 08, 2012. No additional medical records are available for our review.

Based upon this patient's history, physical exam, radiographic studies and medical records, Mr. Williams did sustain a right distal biceps tendon rupture from his work injury in October 07, 2011. He has had appropriate surgical and postoperative treatment. At this point in time, he has obtained maximum medical improvement. Functionally, from his clinical exam and from the records, he would appear to be capable of returning back to work as a welder, full duty.

At this point, I have reviewed your fax correspondence dated May 03, 2012. To specifically answer the questions:

This patient's diagnosis was status post right distal biceps tendon rupture and had appropriate surgical intervention. The patient has reached maximum medical improvement and, per your request, an AMA rating will be given below. The patient has no history of any comorbid condition.

As per request for an AMA rating, using the AMA Guides to Evaluation of Permanent Impairment, 6th edition, this gentleman's class of impairment, based on diagnosis (CDX), would be that of a distal biceps tendon rupture, which according to table 15-4, would place this patient at a CDX class 1. Using the adjustment grid, the grade modification for functional history (GMFH), based on the Quick DASH, would give him a Quick DASH score of 23, where based on table 15-7, would give a grade modifier of 1 (GMFH=1). The grade modifier for physical exam (GMPE), based on table 15-8, would be a grade modifier 2, based on range of motion of his pronation/supination of the forearm. In regards to the grade modification for clinical studies (GMCS), this is not applicable since the patient's diagnosis was biceps tendon rupture.

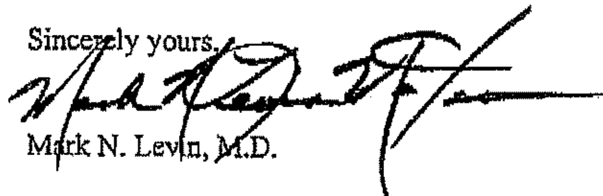
Therefore, the calculation for net adjustment, based on grade modification, would show that the patient's CDX=1, GMFH=1, GMPE=2. The (GMFH-CDX) would equal 1-1=0. (GMPE-CDX) would equal 2-1=1. The (GMCS-CDX) is not applicable. Therefore, adding up the three net adjustments would be 0+1+ not applicable would give a net adjustment of 1. Therefore, this patient's final AMA rating, based on table 15-4, would place him in a class 1 grade D, which would be equal to a 6% upper extremity impairment.

Therefore, using table 15-11, a 6% upper extremity impairment would place this gentleman in an AMA disability rating of 4% of a whole person.

This completes the report on Mr. Frederick Williams and I am a Certified Evaluator for Disability and Impairment Rating (CEDIR).

If you have any questions regarding Mr. Williams, please feel free to contact my office.

Sincerely yours,



Mark N. Levin, M.D.

MNL:ji

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April 9, 2012

MR ROBERT J FINLEY
HINSHAW & CULBERTSON LLP
ATTORNEYS AT LAW
222 N LASALLE ST, SUITE 300
CHICAGO IL 60601-1081

RE: ZACHARY JOHNSON
V CENTRAL TRANSPORT
DOI: 10/2011
DOE: 4/6/2012
IWCC #: 11 WC 041328

Dear Mr. Finley:

On April 6, 2012 I evaluated Mr. Zachary Johnson for an Independent Medical Evaluation. Mr. Johnson is a 28-year-old male who reports an injury to his right hand in October, 2011. He describes the rear door of a trailer falling onto his right hand. Mr. Johnson was subsequently evaluated and found to have a fracture of the hand. He was treated conservatively with a splint. He continues to note some degree of residual symptoms.

Mr. Johnson states at times there is numbness in his right palm. At times, there is soreness in the dorsal ulnar aspect of his hand.

PHYSICAL EXAMINATION: There are congenital deformities related to both ring fingers, more prominent on the right than the left. There are surgical scars on the volar aspect of the right ring finger. Range of motion of the right small finger is normal. MP range of motion is approximately 0/90, PIP is 0/110 and DIP is 0/60. There is a decreased prominence of the small finger metacarpal head dorsally. There is no significant A1 pulley tenderness. Light touch of the fingers is normal.

X-RAY EXAMINATION: X-rays of the right hand are obtained. These demonstrate a healed right small finger metacarpal neck fracture. There is apex dorsal angulation of approximately 35 degrees.

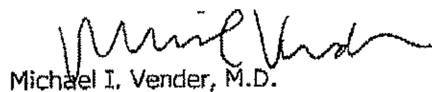
DIAGNOSIS AND IMPRESSION: Status post right small finger metacarpal neck fracture with angulation.

April 9, 2012
Re: Zachary Johnson
Page 2

COMMENTS AND RECOMMENDATIONS: Mr. Johnson presents with residual complaints and findings after his reported injury. In addition to his history provided today, he also filled out a Quick Dash evaluation. This was information utilized in determining his impairment rating. Mr. Johnson was rated utilizing sixth edition AMA guidelines. Enclosed please see documentation of his rating.

If you have any further questions regarding Mr. Zachary Johnson, please feel free to contact me.

Sincerely,



Michael I. Vender, M.D.

MIV/all

cc: Patrick Keene – Cherokee Insurance

Impairment Rating:

Patient: Zachary Johnson

Date of Evaluation : 4/6/2012

Diagnosis: Healed Right Small Finger Metacarpal Fracture

Diagnosis Class = Class 1: Metacarpal fracture with consistent objective findings. Digit Regional Grid (Table 15-2 P.391 "Guides to the Evaluation of Permanent Impairment" 6th ed.)

Grade Modifier Functional History (GMFH):

QuickDASH score = 50

Grade Modifier = 2 (Table 15-7 P.406)

Grade Modifier Physical Examination (GMPE):

Moderate alignment deformity present - 35 degree apex dorsal angulation.

Grade modifier = 2 (Table 15-9 p.408)

Clinical Studies Adjustment (CDX):

No evidence of arthritis present on x-ray

Grade modifier = 0 (P 40 table 15-9)

Summary

Class of Diagnosis = CDX = 1

Grade Modifier of functional history = GMFH = 2

Grade Modifier of Physical Exam = GMPE = 2

Grade Modifier Clinical Studies = GMCS = 0

Net adjustment Formula= (GMFE – CDX) + (GMPE – CDX) + (GMCS –CDX)

Net adjustment = (2-1) + (2-1) + (0-1) = 1

Impairment Rating Grade Assignment = D = 7% of Index Finger = 1% of hand = 1% Upper Extremity = 0% whole person (Table 15-12 page 421)

TABLE 15-4 Elbow Regional Grid: Upper Extremity Impairments

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES (upper extremity %)	0	1%–13% UE	14%–25% UE	26%–49% UE	50%–100% UE
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
MUSCLE/TENDON*					
Epicondylitis: Lateral or medial*	0 No significant objective abnormal findings at MMI	0 1 1 2 2 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) 3 4 5 6 7 s/p surgical release of flexor or extensor origins with residual symptoms			
Distal biceps tendon rupture*	0 No residual findings: +/− surgical treatment	3 4 5 6 7 Residual loss of strength, functional with normal motion			
LIGAMENT/BONE/JOINT*					
Collateral ligament injury: medial, ulnar or lateral*	0 No residual findings: +/− surgical treatment	3 4 5 6 7 Recurrent instability: occasional 8 9 10 11 12 Recurrent instability: frequent; resulting in functional limitation			
Persistent elbow subluxation or dislocation*	0 No residual findings: +/− surgical treatment	8 9 10 11 12 Mild: can be completely reduced manually	16 18 20 22 24 Moderate: cannot be completely reduced manually	34 37 40 43 46 Severe: cannot be reduced	
Fracture*	0 No residual findings: +/− surgical treatment	1 2 3 4 5 Residual symptoms, consistent objective findings and/or functional loss, with normal motion			
Loose bodies or osteochondral lesions*	0 No residual findings: +/− surgical treatment	3 4 5 6 7 Residual loss, functional with normal motion			

(continued)

TABLE 15-8

Physical Examination Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Observed and Palpatory Findings (tenderness, swelling, mass, or crepitance)	No consistent findings	Minimal palpatory findings, consistently documented, without observed abnormalities	Moderate palpatory findings, consistently documented, and supported by observed abnormalities	Severe palpatory findings, consistently documented, and supported by observed moderate or greater abnormalities	Very severe palpatory findings, consistently documented, and supported by observed severe abnormalities
Stability	Stable	Grade 1 (slight) instability	Grade 2 (moderate) instability	Grade 3 (serious) instability	Gross instability
Hand/finger/ thumb		Pain with stressing of ligament, but no opening of joint with stress	Pain and slight opening	Pain and >5 mm of joint opening with stress	Severe instability
Wrist		Clicking or clunking by history, but not reproducible	Clicking or clunking by history, and reproducible on physical examination		
Wrist excessive passive/active mediolateral joint deviation degrees compared to normal		<10° passive <20° active	10°–20° passive 20°–30° active	>20° passive >30° active	
Shoulder		Grade 1 (slight) instability; subluxable	Grade 2 (moderate) instability; easily subluxable	Grade 3 (serious) instability; dislocatable with anesthesia or sedation	
Alignment/ Deformity	Normal for individual with symmetry to opposite side	Mild	Moderate	Severe	Very severe
Range of Motion (reference Section 15.7)	None	Mild decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment <20% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of <12% upper extremity impairment.	Moderate decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 20% to 39% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 12% to 23% upper extremity impairment.	Severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 40% to 70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 24% to 42% upper extremity impairment.	Very severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment >70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment >42% upper extremity impairment.
Muscle Atrophy (asymmetry compared to opposite normal)	<1 cm	1.0–1.9 cm	2.0–2.9 cm	3.0 cm–3.9 cm	4.0 cm +

Note: ROM indicates range of motion; GH indicates Glenohumeral.

TABLE 15-9

Clinical Studies Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Imaging Studies	No available clinical studies or relevant findings	Clinical studies confirm diagnosis, mild pathology	Clinical studies confirm diagnosis, moderate pathology	Clinical studies confirm diagnosis, severe pathology	Clinical studies confirm diagnosis, very severe pathology
Shoulder			Clinical studies confirm one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology		Clinical studies confirm more than one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology. The most significant diagnosis is the only one rated.
X rays					
Arthritis		Cartilage interval normal or mild joint space narrowing and/or osteophytes	Cartilage interval: moderate joint space narrowing with cystic changes on 1 or both sides of joint and/or osteophytes; radiographic evidence of mild posttraumatic arthrosis; avascular necrosis without collapse	Cartilage interval severe joint space narrowing with cystic changes on both sides of joint and/or osteophytes; or avascular necrosis with bony collapse/fragmentation	No cartilage interval; radiographic evidence of severe posttraumatic arthrosis
Stability					
Joint laxity (based on stress testing)		<10° Instability	10°–20° Instability	20°–30° Instability	>30° Instability
Wrist (see text for explanation)		Radiolunate angle 11°–20° Scapholunate angle 61°–70° Scapholunate gap 3–5 mm Triquetrolunate stepoff >1 mm Ulnar translation mild	Radiolunate angle 21°–30° Scapholunate angle 71°–80° Scapholunate gap 6–8 mm Triquetrolunate stepoff >2 mm Ulnar translation moderate	Radiolunate angle >30° Scapholunate angle >80° Scapholunate gap >8 mm Triquetrolunate stepoff >3 mm Ulnar translation severe	
Nerve Conduction Testing	Normal	Conduction delay (sensory and/or motor)	Motor conduction block	Partial axonal loss	Total axonal loss/denervation

TABLE 15-6
Adjustment Grid: Summary

	Specific Adjustment Grid	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Functional History	Table 15-7	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Physical Examination	Table 15-8	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Clinical Studies	Table 15-9	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem

(eg, soft-tissue findings, stability, and alignment) that are attributable to the condition being rated and use the highest class modifier as the value for that adjustment in the Net Adjustment Calculation. For example, on physical examination, soft-tissue findings may be characterized as grade modifier 0 and stability findings may be grade modifier 2. The class modifier for physical examination would then be grade modifier 2, because it is the higher of the 2 grades. If any of these factors are determined by the examiner to be unreliable or inconsistent, they should be disregarded in the grading adjustment. The examiner should explain the basis for grade assignment or discounting of a specific adjustment for lack of reliability in the evaluation report.

15.3a Adjustment Grid: Functional History

Grade assignment for functional symptoms is based on subjective reports that are attributable to the impairment. Grading is based on the extent to which functional symptoms interfere with different level of activities, as summarized in Table 15-7, Functional History Adjustment. As explained in Section 1.8e, History of Clinical Presentation, in general, individuals with no symptoms will be assigned grade modifier 0, and those with constant symptoms that persist despite treatment and are unable to perform self-care activities, will be assigned grade modifier 4.

Functional history grade modifier should be applied only to the single, highest diagnosis-based impairment (DBI). Specific jurisdictions may modify this process such that functional history adjustment is considered for each DBI or not considered at all as a grade modifier.

The evaluating physician may use the *Quick*DASH functional assessment outcome questionnaire as part of the process of evaluating functional symptoms; the *Quick*DASH and functional assessment measures are provided in Appendix 15-A to this chapter. The inventory is used only to assist the examiner in defining the grade modifier for functional history and does not serve as a basis for defining further impairment, nor does the score reflect an impairment percentage.

The examiner must assess the reliability of the functional reports, recognizing the potential influence of behavioral and psychosocial factors. If the grade for functional history differs by 2 or more grades from that described by physical examination or clinical studies, the functional history should be assumed to be unreliable. *If the functional history is determined*

TABLE 15-7
Functional History Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; +/− medication to control symptoms	Pain/ symptoms with normal activity; +/− medications to control symptoms	Pain/symptoms with less than normal activity (minimal); +/− medications to control symptoms	Pain/symptoms at rest; +/− medications to control symptoms
		AND able to perform self-care activities independently	AND able to perform self-care activities with modification but unassisted	AND requires assistance to perform self-care activities	AND unable to perform self-care activities
*Quick*DASH Score	0–20	21–40	41–60	61–80	81–100

TABLE 15-11

Impairment Values Calculated From Upper Extremity Impairment

% Impairment					
Whole Person	Upper Extremity	Hand	Thumb	Index and Middle Finger	Ring and Small Finger
0	**0**	0	0	0	0
Mild					
1	**1**	1	3	6	11
1	**2**	2	6	11	22
2	**3**	3	8	17	33
2	**4**	4	11	22	44
3	**5**	6	14	28	56
4	**6**	7	17	33	67
4	**7**	8	19	39	78
5	**8**	9	22	44	89
5	**9**	10	25	50	100
6	**10**	11	28	56	
7	**11**	12	31	60	
7	**12**	13	33	65	
8	**13**	14	36	70	
Moderate					
8	**14**	16	39	80	
9	**15**	17	42	85	
10	**16**	18	44	90	
10	**17**	19	47	95	
11	**18**	20	50	100	
11	**19**	21	53		
12	**20**	22	56		
13	**21**	23	58		
13	**22**	24	61		
14	**23**	26	64		
14	**24**	27	67		
15	**25**	28	69		
Severe					
16	**26**	29	72		
16	**27**	30	75		
17	**28**	31	78		
17	**29**	32	81		
18	**30**	33	83		
19	**31**	34	86		
19	**32**	36	89		
20	**33**	37	92		
20	**34**	38	94		
21	**35**	39	97		
22	**36**	40	100		
22	**37**	41			
23	**38**	42			
23	**39**	43			
24	**40**	44			
25	**41**	46			
25	**42**	47			
26	**43**	48			
26	**44**	49			
27	**45**	50			
28	**46**	51			
28	**47**	52			
29	**48**	53			
29	**49**	54			
Very Severe					
30	**50**	56			
31	**51**	57			
31	**52**	58			
32	**53**	59			
32	**54**	60			
33	**55**	61			
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56	**93**				
56	**94**				
57	**95**				
58	**96**				
58	**97**				
59	**98**				
59	**99**				
60	**100**				

TABLE 15-2 Digit Regional Grid: Digit Impairments

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES (digit)	0	1%–13% Digit	14%–25% Digit	26%–49% Digit	50%–100% Digit
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
Joint dislocation or sprain*					
Thumb CMC*	0 No residual findings		14 14 15 16 17 <10° Instability 21 23 25 25 25 10°–20° Instability	29 32 35 38 41 >20° Instability	
Finger DIP*	0 No residual findings	3 4 5 6 7 <10° Instability 8 9 10 11 12 10°–20° Instability	14 14 15 16 17 >20° Instability		
Finger PIP*	0 No residual findings	8 9 10 11 12 <10° Instability	14 14 15 16 17 10°–20° Instability 21 23 25 25 25 >20° Instability		
Finger MCP*	0 No residual findings		14 14 15 16 17 <10° Instability 16 18 20 22 24 10°–20° Instability 21 23 25 25 25 >20° Instability		
Fractures*					
Thumb metacarpal, intra-articular*	0 No residual findings	8 9 10 11 12 Residual symptoms, consistent objective findings and/or functional loss, with normal motion			
Distal phalanx*	0 No residual findings	2 3 4 5 6 Residual symptoms, consistent objective findings and/or functional loss, with normal motion			
Proximal phalanx, middle phalanx, metacarpal*	0 No residual findings	4 5 6 7 8 Residual symptoms, consistent objective findings and/or functional loss, with normal motion			
Metacarpal head*	0 No residual findings	6 7 8 9 10 Residual symptoms, consistent objective findings and/or functional loss, with normal motion			

(continued)

TABLE 15-12

Impairment Values Calculated From Digit Impairment

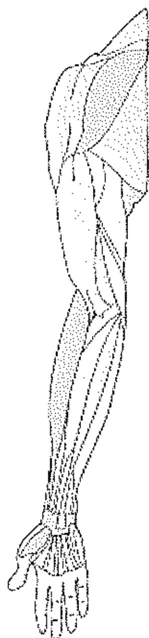
Note: To convert digit impairment to other units, identify the digit impairment value in the left-hand column, identify the digit (thumb, index, middle, ring, or little) in the top columns and the converted impairment values are shown based on unit (hand, upper extremity [UE], or whole person [WP]). Follow directions for combining, as directed in the text.

The conversion factor for upper extremity to whole person is 60%, for hand to upper extremity is 90%, thumb to hand is 40%, index and middle finger to hand is 20%, and ring and little finger to hand is 10%.

Digit Impairment Value	Thumb			Index or Middle Finger			Ring or Little Finger		
Digit Conversion Multiplier (digit to specified unit)	Hand	UE	WP	Hand	UE	WP	Hand	UE	WP
	40%	36%	22%	20%	18%	11%	10%	9%	5%
1	0	0	0	0	0	0	0	0	0
2	1	1	0	0	0	0	0	0	0
3	1	1	1	1	1	0	0	0	0
4	2	1	1	1	1	0	0	0	0
5	2	2	1	1	1	1	1	0	0
6	2	2	1	1	1	1	1	1	0
7	3	3	2	1	1	1	1	1	0
8	3	3	2	2	1	1	1	1	0
9	4	3	2	2	2	1	1	1	0
10	4	4	2	2	2	1	1	1	1
11	4	4	2	2	2	1	1	1	1
12	5	4	3	2	2	1	1	1	1
13	5	5	3	3	2	1	1	1	1
14	6	5	3	3	3	2	1	1	1
15	6	5	3	3	3	2	2	1	1
16	6	6	3	3	3	2	2	1	1
17	7	6	4	3	3	2	2	2	1
18	7	6	4	4	3	2	2	2	1
19	8	7	4	4	3	2	2	2	1
20	8	7	4	4	4	2	2	2	1
21	8	8	5	4	4	2	2	2	1
22	9	8	5	4	4	2	2	2	1
23	9	8	5	5	4	2	2	2	1
24	10	9	5	5	4	3	2	2	1
25	10	9	5	5	5	3	3	2	1
26	10	9	6	5	5	3	3	2	1
27	11	10	6	5	5	3	3	2	1
28	11	10	6	6	5	3	3	3	2
29	12	10	6	6	5	3	3	3	2
30	12	11	6	6	5	3	3	3	2
31	12	11	7	6	6	3	3	3	2
21	8	8	5	4	4	2	2	2	1
33	13	12	7	7	6	4	3	3	2
34	14	12	7	7	6	4	3	3	2
35	14	13	8	7	6	4	4	3	2
36	14	13	8	7	6	4	4	3	2
37	15	13	8	7	7	4	4	3	2
38	15	14	8	8	7	4	4	3	2
39	16	14	8	8	7	4	4	4	2

The DASH OUTCOME MEASURE

Disabilities of the Arm, Shoulder and Hand



Conditions of Use

- Use of the DASH and *Quick*DASH, inclusive of translated versions of the DASH and *Quick*DASH on this website, without charge is limited to, a clinician using them only for treatment or assessment of a patient or a researcher using them only for non-commercially related research.
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Development Information

The DASH Outcome Measure and the *Quick*DASH are the property of the **Institute for Work & Health** (IWH). These instruments were jointly developed by the Institute for Work & Health and the American Academy of Orthopaedic Surgeons (AAOS). The project was supported by the American Association for Hand Surgery, the American Orthopaedic Society for Sports Medicine, the American Shoulder & Elbow Surgeons, the American Society for Surgery of the Hand, the Arthroscopy Association of North America and the American Society of Plastic and Reconstructive Surgeons.

The DASH is currently administered by the Institute for Work & Health.

If you have read and understand these conditions, please click on the links below to download the documents

DASH Outcome Measure (PDF - 127k)

***Quick*DASH** (PDF - 118k)

www.orthopaedicscores.com

Date of completion
August 2, 2012

The Disabilities of the Arm, Shoulder and Hand Score(QuickDash)

Clinician's name (or ref) ____________________ **Patient's name (or ref** ____________________

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer *every question* , based on your condition in the **last week**. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on you ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week.

1. Open a tight or new jar	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
2. Do heavy household chores (eg wash walls, wash floors)	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
3. Carry a shopping bag or briefcase	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
4. Wash your back	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
5. Use a knife to cut food	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	Not at all	Slightly	Moderately	Quite a bit	Extremely
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	Not limited at all	Slightly limited	Moderately limited	Very limited	Unable

Please rate the severity of the following symptoms in the last week

9. Arm, shoulder or hand pain	None	Mild	Moderate	Severe	Extreme
10. Tingling (pins and needles) in your arm, shoulder or hand	None	Mild	Moderate	Severe	Extreme
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	So much difficulty I can't sleep

Thank you very much for completing all the questions in this questionnaire.

Print page | Close Window | Reset

To save this data please print or Save As CSV

Nb: This page cannot be saved due to patient data protection so please print the filled in form before closing the window.

The Disabilies of the Arm, Shoulder and Hand (quickdash) Score 0

(**NB.** A DASH score may not be calculated if there are greater than 1 missing items.)

There are two further small sections to this score. They are both optional. Just click below to select

WORK MODULE **SPORTS/PERFORMING ARTS MODULE**

Reference for Score: Hudak PL, Amadio PC, Bombardier C. Development of an upper extremity outcome measure: the DASH (disabilities of the arm, shoulder and hand) [corrected]. The Upper Extremity