STATEMENT OF NEED AND REASONABLENESS
FOR
8 MCAR §§ 1.9001 - 1.9023 [Temporary]

These rules for the rating of permanent partial disability are required by Laws of Minnesota 1983, ch. 290, section 86, codified as Minn. Stat. § 176.105, subd. 4. Section (a) of Minn. Stat. 176.105, subd. 4 requires that the schedules established by these rules shall in the aggregrate provide benefits approximately equal to those currently payable. Written actuarial testimony will be provided at the November 4 hearing to establish that this requirement is fulfilled by the proposed rules.

Minn. Stat. 176.105, subd. 4 (b) requires the commissioner to conduct an analysis of the current permanent partial disability schedule for the purpose of determining the number and distribution of permanent partial disabilities and the average compensation for various permanent partial disabilities. Written actuarial testimony will be introduced at the hearing to establish that the commissioner has complied with this legislative directive.

Minn. Stat. 176.105, subd. 4 (b) (1) - (7) list factors which the commissioner may consider in the promulgation of the disability schedules. The discussion of the rules in the balance of this statement of need and reasonableness indicates that these factors were considered in developing the schedules. In addition, the commissioner's written analysis of the disability schedules of other states will be made part of the hearing record on November 4.

On January 1, 1984, the current permanent partial disability schedule of Minn. Stat. § 176.101, subd. 3 is repealed. Laws of Minnesota 1983, ch. 290, section 173. The schedules set forth in these rules replace the current statutory schedule and are thus effective January 1, 1984.

8 MCAR § 1.9001 - General

The basic purpose of specifying disability for categories of impairment is to promote consistency and objectivity in the rating of permanent impairments, thereby reducing litigation regarding the rating of disabilities.

Section B provides rules for interpreting the schedules. One of the purposes of the interpretation rules is to ensure selection of the smallest number of categories necessary to fairly represent the disabling condition. Thus, cumulation and duplication are prohibited. A specific restriction on cumulation is included for the musculoskeleletal schedule. To avoid rating on a basis other than the categories of the schedules, averaging or prorating is prohibited.

That the schedules are the exclusive rating basis is stated in Section C. The disability rating assigned to each category includes a consideration of loss of function.

Section D lists the documents incorporated by reference. These documents are standard medical references which are in common use. The documents are incorporated only to the extent that they are specifically referenced or are necessary for definition.

8 MCAR § 1.9002 - Definitions

Most of the sections of this rule define medical terms. Although these terms are defined in Dorland's or other documents incorporated by reference, the definitions in those documents were not sufficiently specific for the purpose of these rules. These terms are thus defined in the context of their use in the rules.

8 MCAR § 1.9003 - Eye Schedule

The Minnesota Medical Association adapted the eye schedule from the Wisconsin schedule and from the A.M.A. Guides. The eye schedule of this rule is a significant improvement over the out-dated method used under the current schedule. With the current statutory schedule, only distance vision is used as a measure of impairment. Thus, there is no compensation for impairment of near vision, of field vision, or of ocular motility. The schedule set forth in this rule corrects these inadequacies and provides a method for determining visual impairment which is consistent with present medical practice.

The examination requirements of section B follow generally accepted ophthalmological practices.

Section C describes the three factors (central visual acuity, field vision, and ocular motility) used to measure vision and the possible range within which the measurement of each factor may fall. For central visual acuity, the maximum at C.1.a. and the minimum for distance vision at C.2.a.(1) are those of both the A.M.A. and Wisconsin schedules. The minimum for near vision at C.2.A.(2) follows the Wisconsin schedule. The A.M.A. Guides measure near vision to only 14/140. The use of the Wisconsin limit permits greater distinctions at the higher levels of impairment.

For the visual field, the A.M.A. Guides were followed in choosing the maximum limit of 500 degrees at C.1.b. This maximum differs from the Wisconsin limit of 420 degrees. The availability and general professional acceptance of the A.M.A. visual field charts supported the selection of the A.M.A. method. The effect of increasing the normative visual field is to slightly increase the disability rating, and thus

compensation. A visual field of 420 degrees is measured as unimpaired under the Wisconsin system, while the same visual field is impaired when measured against a 500 degree standard.

For ocular motility, the maximum limit at C.1.c. is consistent with that of Wisconsin and the A.M.A. Guides. The minimum limit at C.2.c. is adopted from the Wisconsin schedule.

The 50 percent minimum at C.2.c.prevents overcompensation of ocular motility impairment. The worst case of double vision should not be compensated to the same extent that total blindness is compensated. Without the 50 percent minimum, this could occur because of the calculation method employed.

Section D prescribes the methods for measuring the three factors of vision. D.1.a.-d. set forth standard testing and calculation procedures. Table 1 is taken from the Wisconsin schedule and its use is consistent with the selection of the Wisconsin standards for maximum and minimum central visual acuity efficiency.

D.1.e. and f. permit downward adjustments of the efficiency measurement for aphakia and pseudophakia, conditions resulting from the development of cataracts. These adjustments are intended to compensate for the increased fragility of the eye and the need for corrective lenses. In cases of severe impairment, the adjustment under these provisions may result in less compensation than an adjustment for glasses under E.2.b. or c. In order to permit a higher compensation for the injury, the adjustment is not made where an adjustment under Section E permits more compensation.

D.2. and D.2.a. describe standard procedures for measuring visual field efficiency. D.2.b. sets forth the standard procedure to be followed in cases of irregular impairment of field. The number of radii selected will depend on the nature and extent of the particular impairment. The divisor for calculating efficiency will vary from case to case, depending on the number of radii selected.

D.2.c. is also the standard procedure followed by ophthalmologists where field vision is severely impaired.

D.3., the measurement of ocular motility, follows the method set forth in the A.M.A. Guides. The A.M.A. ocular motility chart was selected because of its availability and general acceptance in the ophthalmological profession.

Section E prescribes the method for combining the three factors (central visual acuity, field vision and ocular motility) to determine the visual efficiency of one eye. The factors are simply multiplied together. The method chosen is that used by Wisconsin and is relatively uncomplicated. The A.M.A. method is considerably more complex and requires the use of comparative value tables.

Section E.2. permits adjustments to the efficiency calculation in certain cases. For most eye conditions, visual impairment is the most objective and significant aspect of symptomatology. In some cases, vision is not affected by the condition or visual impairment is not a fair measure of the disability. E.2.a. provides additional compensation for conditions of the eye where visual impairment due to the condition was considered an inadequate basis for compensation.

E.2.b. and c. permit additional compensation where corrective lenses are required as a result of the injury. The rationale for this adjustment is that dependence or increased dependence on corrective lenses is in itself an impairment, even where the correction gives 100 percent visual efficiency.

E.2.d. specifies the point in the calculation at which adjustments for pre-existing impairments are to be made.

Section F follows the A.M.A. Guides in prescribing the method for calculating visual system impairment from the impairment to each eye. Both the Wisconsin and A.M.A. systems use this method. Table 2 is taken from the A.M.A. Guides.

8 MCAR § 1.9004. - Ear Schedule

The ear schedule was promulgated by a Minnesota Medical Association's Otolaryngology Committee. Consistent with the A.M.A. Guides, the schedule is based on binaural rather than monaural hearing loss. Use of the binaural standard is premissed on the belief that hearing impairment should be compensated on impairment to the audiological system rather than to one ear in isolation. Thus, the effect on overall hearing determines the extent of compensable loss.

Sections B-D of the rule describe the medical and testing procedures which precede the calculation of disability. Generally accepted medical procedures are required in Sections B and D. For audiological testing, calibration at regular intervals is required in Section C to ensure accurate measurement of hearing loss. Equipment calibration requirements are the ANSI standards which are generally used in the profession. The requirement to keep records is included so that a reliable method is available to substantiate a claim of proper calibration.

Section E of the rule prescribes the methods for calculating disability. At E.1.a., four test readings are required. Some procedures delete the 3,000 hertz reading and require only three test readings. By including the fourth reading at 3,000 hertz, the rule permits compensation for hearing loss in the higher ranges.

The 25 decibel "fence" of E.1.c. is the level at which there is usually no impairment in the ability to hear normal speech under normal

conditions. The effect of the fence is that hearing in an ear is considered unimpaired if the average hearing level for that ear is 25 decibels or less.

The calculation procedure in E.1.d.-f. is consistent with that used in the A.M.A. Guides and is in common use among practicing otolaryngologists.

The ear schedule of E.3, translating binaural hearing loss to whole body disability, is taken from the A.M.A. Guides.

Section F of the rule disallows an adjustment for presbycusis. Some schedules from other states decrease the whole body disability rating where presbycusis is diagnosed. Because presbycusis generally affects the higher ranges of hearing, some compensation for presbycusis may occur through the inclusion of the 3,000 hertz testing level. The difficulties of diagnosis and the desire to maintain simplicity in the calculations support the reasonableness of the prohibition against adjusting disability for presbycusis. To the extent that presbycusis is documented as a pre-existing impairment, an adjustment pursuant to Minn. Stat. § 176.101, subd. 4 (a) may be made.

Section G of the rule disallows an adjustment for tinnitus. The disallowance is based on the subjective nature of the complaint. In most cases of complaints objectively substantiated, the tinnitus impairs hearing and is thus indirectly compensated by increased impairment readings.

8 MCAR § 1.9005 - Skull Defects

The skull defects schedule was developed by the Minnesota Medical Association's Neurology Task Force to standardize the disability ratings for damage to the cranial bones of the head. In considering skull defects, the Task Force concluded that skull fractures, when not associated with skull defects, are usually not a permanent partial disability and thus did not include fractures under this rule. The rule distinguishes between filled defects, in which bone or artificial substances are used to replace the damaged skull, and unfilled defects. With unfilled defects, the brain remains unprotected by a rigid covering and the compensation for these defects is therefore higher.

8 MCAR § 1.9006 - Central Nervous System

The organization of the central nervous system schedule follows that of the A.M.A. Guides in addressing central nervous system impairments in terms of disorders of the cranial nerves, the spinal cord, and the brain.

Sections B through G of the rule categorize disabilities due to impairment of the cranial nerves. The percentages of disability generally follow the A.M.A. Guides, but provide greater detail and specificity. No compensation is provided for olfactory nerve impairments because of the negligible impact of these impairments on whole body functioning. To the extent that hearing is affected, impairments of the cochlear nerve are compensated under the Ear Schedule, 8 MCAR § 1.9004. Impairments of the oculomotor, trochlear and abducens nerves, which are responsible for eyeball motility and regulation of pupil size, are compensated by the Eye Schedule, 8 MCAR § 1.9003.

Section H categorizes disorders due to spinal cord impairment. For upper extremity impairments at H. 2, the disability rating for relatively minor impairments varies depending on whether the preferred or nonpreferred extremity is affected. The distinction between preferred and nonpreferred is not made for the more severe impairments. This is because with severe impairments the ability to perform self cares is minimal, and the distinction between preferred and nonpreferred extremities becomes meaningless.

Urinary bladder and anorectal impairments due to spinal cord injury are categorized at paragraphs 4 and 5 of Section H. The distinction among categories is based on degree of continence and voluntary control.

Sexual function impairment due to spinal cord injury is categorized at Section H. 6, using the same categories as are used in 8 MCAR § 1.9022 E. and H.

Impairments due to brain injury are categorized in Section I. The categories generally follow the A.M.A. Guides in classifying the impairments under communication disturbances, cerebral function disturbances, emotional disturbances, consciousness disturbances, and epilepsy. The rule goes beyond the A.M.A. Guides in distinguishing expressive and receptive communication disturbances and in providing categories for psychotic disorders, paralysis, and headaches.

A major contribution to objectivity in rating under this rule is the incorporation of the Kenny scale for self cares. The Kenny scale provides an objective procedure for rating independence in self cares. Each of the self care factors is rated on a 0 to 4 scale. The numbers translate to medical judgment terminology as follows:

A composite score of 24 to 28 or a single factor score of 4 means totally independent.

A composite score of 16 to 24 or a single factor score of 3 means minimally or mildly dependent.

A composite score of 10 to 16 or a single factor score of 2 means moderately or markedly dependent.

A composite score of 0 to 10 or a single factor score of 1 or 0 means severely or totally dependent.

In most cases, the subjective medical judgment should suffice for a rating; a formal evaluation pursuant to the Kenny system will be unnecessary. In questionable cases, however, the use of the Kenny evaluation procedure should practically eliminate dispute regarding the degree of dependence in self cares. Incorporation of the Kenny rating system thus significantly contributes to objectivity and the reduction of litigation in the application of this rule.

8 MCAR § 1.9007 - 1.9017 - Musculo-Skeletal Schedule

The musculo-skeletal schedule of 8 MCAR §§ 1.9007 -1.9017 follows the A.M.A. Guides in dividing impairments into those of the back (8 MCAR § 1.9007), the upper extremities (8 MCAR § 1.9008 -1.914), and the lower extremities (8 MCAR § 1.915 -1.917). In addition to the A.M.A. Guides, the Manual for Orthopaedic Surgeons in Evaluating Permanent Physical Impairment was also used in the development of the musculo-skeletal schedule.

8 MCAR § 1.9007 - Back Schedule

Disorders of the back are divided generally into those of the lumbar spine, Section A, and those of the cervical spine, Sections B and C. While the back schedule is consistent with the Orthopaedic Manual, the departures from the manual improve the objectivity and workability of the rule. Sections A - C clarify the various levels of disability while remaining consistent with the Orthopaedic Manual.

8 MCAR § 1.9008 - Upper Extremity Amputation Schedule

This rule is adopted from the A.M.A. Guides. Some categories were added to increase the specificity of the rule. The rating for amputation includes a consideration of motor and sensory loss. Pursuant to 8 MCAR § 1.9001.B., there cannot be an additional rating under 8 MCAR § 1.909 or 1.9010 for motor or sensory loss where this amputation schedule is used.

8 MCAR § 1.9009 - Sensory Loss - Upper Extremities

The A.M.A. Guides are used as the basis for this rule. The schedule departs from the Guides to simplify the levels of impairment, and to provide objectivity to the specific percentages applied. Pursuant to 8 MCAR § 1.9001 B., this schedule is not to be used where either the motor loss schedule or the amputation schedule is used.

8 MCAR § 1.9010 Motor Loss - Upper Extremities

The A.M.A. Guides are used as the basis for this rule. The schedule departs from the Guides to simplify the levels of impairment, and to provide objectivity to the specific percentages applied. Pursuant to 8 MCAR § 1.9001 B., this schedule should not be used where either the sensory loss or the amputation schedule is used.

8 MCAR § 1.9011 - Shoulder Schedule

8 MCAR § 1.9012 - Elbow Schedule

8 MCAR § 1.9013 - Wrist Schedule

8 MCAR § 1.9014 - Fingers Schedule

These schedules are adopted from the Orthopaedic Manual. Each schedule is broken into two basic sections: range of motion and other conditions. The section entitled "Procedures and Conditions" provides workable evaluation procedures and is an improvement on the Orthopaedic Manual. Pursuant to 8 MCAR § 1.9001.B., a disability should be rated under either the range of motion section or the procedures section; it should not be rated under both sections.

8 MCAR § 1.9015 - Amputations of Lower Extremities

The amputation of lower extremities schedule is adopted from the A.M.A. Guides. The schedule is specific and provides objectivity in its application. Pursuant to 8 MCAR § 1.9001.B., an injury cannot be rated under both this rule and 8 MCAR § 1.9016.

8 MCAR § 1.9016 - Sensory Loss - Lower Extremities

This rule was adopted from the A.M.A. Guides. The percentages of disability are within the ranges provided by the Guides. Pursuant to 8 MCAR § 1.9001 B., this schedule does not apply where the amputation schedule is used.

8 MCAR § 1.9017 - Joints Schedule

This schedule is adapted from the Orthopaedics Manual and the A.M.A. Guides. As with the upper extremities schedule, the body part is rated in one of two sections: range of motion or conditions and procedures. As provided by 8 MCAR § 1.9001 B., it is the intent of this rule to rate under only one of these sections. Thus, where a procedure or condition results in a loss of range of motion, the disability should be rated under the procedures or condition section only.

8 MCAR § 1.9018 - Respiratory System

The respiratory system schedule is a modification of the A.M.A. Guides. The classification of impairment is based primarily on the degree of dyspnea and the degree of impairment of ventilatory function. These factors are more easily evaluated than general characteristics such as malaise, fatigability, and excessive cough. Diffusing capacity studies are necessary when the patient's statement about the severity of dyspnea is inconsistent with forced spirometric measurement results. Diffusing capacity studies do not require subject cooperation, and are therefore useful as objective diagnostic tools.

The evaluation procedures listed in Section A are the accepted medical procedures applicable to respiratory system dysfunction.

The 0, 15 and 30 percent classes of Table 1 in Section B correspond to classes 1 through 3 of the A.M.A. Guides. The roentgenogram appearance factor is eliminated. The roentgenogram test result for each class in the A.M.A. Guides is equivocal, and thus not as definitive as the other criteria.

A zero percent class is included to clarify the fact that not all normal individuals will score one hundred percent on the forced spirometry measurement. Since there is a wide variation among normal individuals, no impairment is recognized until the test shows 85 percent of normal or less. The forced spirometry tests are administered three times to eliminate misleading results, with the highest test result determined as most representative of the subject's ability.

A new 85 percent class of severe impairment is added to the A.M.A. Guide's four classes. The diffusing capacity and forced spirometry measurement ranges in the 60 percent class are thus reduced to smaller, more specific categories. The individual confined to bed and requiring oxygen in the 85 percent class is clearly more disabled than the 60 percent person who is ambulatory, even if only for short distances. The severe loss of organ function and restriction of almost all normal daily activities justify the creation of this class.

8 MCAR § 1.9019 - Organic Heart Disease

The organic heart disease schedule is a simplification of the classifications used in the A.M.A. Guides. Permanent impairment due to heart disease most commonly results from failure of myocardial function, or impairment of coronary circulatory function, or both. A definite percentage of disability, within the range given by the A.M.A. Guides, is assigned to each class. The specificity of this schedule is superior to Minn. Stat. § 176.101, subd. 3 (40), which offered no guidelines for setting the percent of disability suffered from injury to internal organs.

Section B prescribes procedures to be followed in the diagnostic analysis. A detailed history is an established medical practice and is important in heart disease cases. Psychological responses to physical processes and physical responses to psychological processes are not uncommon in heart disease patients. Hence, it is essential that objective tests including x-rays and electrocardiograms be performed. Other standard tests, including echo-cardiography, exercise testing, and radionuclide studies, may be indicated by the symptoms present. Categorization is appropriate only after maximum medical and surgical therapy and rehabilitation, plus a reasonable period of time to permit maximum circulation and other adjustments.

Each category of disability in Section B requires a diagnosis of organic heart disease. In the category of least impairment, organic heart disease is present according to diagnostic tests, but is asymptomatic. The remaining categories are distinguished by the effects of the activities of daily living, as defined in 8 MCAR § 1.9002 E., and other specified activities.

8 MCAR § 1.9020 - Vascular Disease

No separate schedule for vascular disease affecting the extremities previously existed, although Minn. Stat. § 176.101, subd. 3 contained values assigned for loss of limbs. The vascular disease schedule is a simplification of the A.M.A. Guides. These impairments are most commonly the result of diseases of the arteries, veins, or lymphatics.

Prior to classification by this schedule, a diagnosis of vascular disease, using accepted medical standards, is necessary. A complete history and physical exam, as well as imaging examination, volume studies, or flow studies are required to establish the diagnosis.

Classification in this schedule depends upon the severity and extent of lesions on the extremities. When amputation due to peripheral vascular disease is present, evaluation using the amputation of lower extremities schedule in 8 MCAR § 1.9015 is proper.

The categories of the vascular disease schedule are based upon the physical symptoms present and the resulting effect upon the activity of walking. An individual with a zero percent disability experiences rare and transient edema, but no other physical symptoms or pain upon walking. This minor condition is uncompensated.

A ten percent disability is characterized by intermittent pain upon walking approximately one city block at an average pace and persistent, incompletely controlled edema. No active ulcers or stumps are present.

The 30, 60 and 90 percent categories each require either an active ulcer or signs of activity in a stump; pain upon walking short distances; and severe or marked edema. Choice of class is based upon the

physician's observance of signs of ulceration, diseased limbs, and degree of edema present. The pain reported by the patient is also considered. The 60 and 90 percent classifications both include advanced signs of disease, but are easily distinguished by the number of limbs affected.

8 MCAR § 1.9021 - Gastrointestinal Tract

The gastrointestinal tract schedule parallels the A.M.A. Guides and assigns percentages within the ranges given in the Guides. This schedule replaces the very indefinite rule of Minn. Stat. § 176.101 subd. 3 (40), which gave no guidelines for assigning percentages of disability. The specificity of the schedule promotes objectivity, consistency, and workability in the rating of disability.

Section A follows the accepted medical practice of requiring a thorough history and physical exam, and recommends basic diagnostic tests.

Section B classifies disorders of the upper digestive tract according to symptoms or signs of disease, anatomic loss or alteration, and weight variations. These factors may be objectively evaluated by the examining physician.

A class 1 symptom may be premissed on purely subjective complaints of the patient. A rating in this category thus relies on the physician to judge the reliability of the complaints.

Classes 2 through 4 describe impairments resulting in increasing weight loss and decreasing responsiveness to treatment by drugs and dietary restrictions. The divisions among classes are based upon evidence of disease and loss of function of the upper digestive tract organs.

Colonic and rectal impairments are classified in Section C. The basis for the division into classes of impairment is objective evidence of disease or anatomic loss or alteration. The physician notes the presence or absence of constitutional manifestations such as fever, anemia, and weight loss. The level of restriction in normal activities and diet is similarly graduated by class. These categories are specifically delineated, thereby reducing the likelihood of litigation.

Section D contains classes of anal impairment due to disease or local injury. Classification of disturbances in fecal continence resulting from neurological disorders are found in Rule 1.9006 H.5.

Classes 1 through 3 each require objective signs of organic anal disease. The evaluator rates the degree of incontinence, frequency of symptoms, and amenability of the symptoms to treatment. There should be little difficulty quantifying the required treatment and the patient's response to treatment. Each class is distinguished by the response to and results of treatment.

The five percent impairment classification of Section E.1. is based upon objective evidence of persistent liver disease when no symptoms of liver disease are present. It is an accepted medical fact that liver disease may be present in the absence of symptoms or physical findings. The requirement that biochemical studies indicate at least a minimal disturbance in liver function avoids reliance on complaints which are not objectively substantiated. The remaining classifications detail the physical manifestations of progressive liver disease.

Biliary tract impairments are rated in Section F according to the frequency of the impairment and the type of obstruction present. These classifications follow the A.M.A. Guides.

8 MCAR § 1.9022 - Reproductive And Urinary Tract Schedule

This rule provides criteria for evaluating disability due to impairment of the reproductive and urinary systems. Section B describes standard medical procedures to be followed in evaluating the impairment. Because of the diversity of potential impairments and injuries to these systems, tests which would apply to all conditions could not be specified. The listing of test procedures at paragraph 2 is thus not mandatory. It is included to give guidance to the pratitioner in selecting appropriate tests and procedures.

Section B contains the upper urinary tract schedule. The disability rating for a solitary kidney at paragraph B.1 applies even where there is no impairment of function. The rationale for this rating is that reliance on only one kidney represents the loss of a normal safety factor. Dependence on a solitary kidney is thus a disability regardless of the present funtional ability of the renal system. When impairment of function is combined with a solitary kidney, the disability should be higher than the same functional impairment occuring with both kidneys. For this reason the rule provides for an increase in the disability rating for a class when a solitary kidney is present.

Section B. 2.-5. divides the upper urinary tract impairment into four classes. This division is essentially that of the A.M.A. Guides. As the creatine clearance test should be adequate in nearly all cases, the PSP test recommended by the A.M.A. Guides is not required.

Section C sets forth classes of bladder impairment. The extent of bladder reflex activity is the basis for distinguishing among the classes.

Section D provides two classes of urethral impairment. The class distinctions are those of the A.M.A. Guides and depend on the extent to which the disorder is controlled by treatment.

Sections E, F and G classify disorders of the male reproductive organs, and sections H, J and K classify parallel disorders of the female organs. The classification generally follows the A.M.A. Guides, except at Sections E and H, which deal with loss of sexual function. The standards set forth in sections E and H are simpler and more objective than those of the A.M.A. Guides.

8 MCAR § 1.9023 - Skin Disorders

The skin schedule is based on the A.M.A. Guides. The disability is evaluated according to the effect of the disorder on the ability to function and perform activities of daily living, and according to the degree of treatment required. The classes represent a logical progression and offer a workable and simplistic guide for the practitioner.

Each class requires the presence of signs or symptoms of a skin disorder. A Class 1 disorder, a two percent disability, must be supported by objective skin findings, thus eliminating cases involving vague complaints which cannot be objectively substantiated. The remaining classes are divided according to treatment and the effect of the disorder on activities of daily living, as defined at 8 MCAR § 1.9002 E.

No provision of 8 MCAR § 1.9023 specifically provides compensation for disfigurement or scarring. Some types of scarring may cause skin disorders. Any functional impairment due to disfigurement or scarring will be evaluated under this schedule according to the degree of treatment required and the effect on activities of daily living. In addition, if the loss of function from scarring or disfigurement is to a body part or system other than the skin, that loss will be evaluated in accordance with the applicable schedule for that body part or system.