Designated Doctor Sample Certification Test Questions

This document contains 10 sample test questions retired from the designated doctor (DD) and certifying doctor certification tests (M.D./D.O. and D.C.) and provides test candidates with samples of the types of questions asked on the certification exams. This is for educational purposes only.

The document includes an:

- answer key with a description of the concept the test question evaluates
- explanation of the correct choice; and
- explanation of why the other choices are not correct.

The sample test questions are organized by the concept evaluated in the exam:

- impairment rating for upper extremity, lower extremity, and spine and torso: four questions;
- maximum medical improvement: three questions;
- extent of injury: one question;
- disability: one question; and
- return to work: one question.

If you have any questions, contact Designated Doctor Education at desdoc.education@tdi.texas.gov or 512-804-4765.

Sample Questions

Question 1

The injured employee sustained a crush injury to index finger. At maximum medical improvement (MMI), exam reveals range of motion (ROM) values of the index finger as follows: MP flexion 50°, extension (minus) 20°, PIP flexion 70°, extension (minus) 30°, DIP flexion 40°, extension (minus) 30°. There was 2-point discrimination of 8 mm along the radial aspect of index finger extending from the PIP joint distally, and 5 mm proximal to the PIP joint.

What is the whole person impairment rating (IR)?

a. 7%
b. 8%
c. 10%

Question 2

The injured employee sustained an injury with low back pain radiating to his right calf. EMG was positive for right L5 radiculopathy. The MRI demonstrated a grade 1 spondylolisthesis of L4-L5, and a right L4-L5 disc herniation. Flexion/extension X-rays showed 4 mm of translation of L4 on L5. Physical therapy and epidural steroid injections were provided, with resolution of his pain but ongoing numbness in the right calf. Surgery was offered but declined. Examination at MMI showed weakness in right EHL, sensory loss in the right L5 distribution, 1 cm atrophy of the right calf. The patellar reflex on the right side is absent, the Achilles reflex is decreased bilaterally, and the medial hamstring reflex is absent bilaterally. The injured employee is at MMI.

What is the whole person impairment rating?

a. 5%
b. 10%
c. 20%

Question 3

An employee sustained an injury to his left thumb. At MMI, he has the following thumb range of motion: Lack of adduction of 3 cm, Radial abduction of 20°, opposition of 4 cm, MP flexion is 50°, MP extension minus 20°, IP flexion is 40°, IP extension is 0°. He has greater than 15 mm of 2-point discrimination over the palmar surface of the left thumb from the IP joint distally.

What is the whole person impairment rating?

a. 10%
b. 16%
c. 18%

Question 4

The injured employee twisted his left knee. An arthroscopic partial medial meniscectomy was performed. The injured employee attended 16 visits of physical therapy followed by home exercise.

At MMI, the injured employee can walk without limping and sit and rise without hesitation. The knee appears to be in good alignment with 7° genu valgus. The injured employee can squat about halfway and arise without audible crepitus. There is no swelling or joint enlargement. The patella is well positioned in the trochlear groove. There are two small portal scars inferior to the patella. Palpation reveals no tenderness over the medial or lateral joint lines, or about the patellar tendon, and there is no swelling or mass in the popliteal space. Valgus and varus stress reveal no instability. Drawer test is negative for anterior and posterior instability. McMurray's test reveals no popping or clicking of the medial or lateral compartment, although the injured employee indicates discomfort deep in the knee. Pivot shift is negative but painful in the medial compartment. Active ROM of the left knee is 0° extension to 105° flexion compared to the right knee with 0° extension and 130° of flexion. There is end range mechanical block with left knee flexion.

What is the whole person IR?

a. 1%
b. 4%
c. 5%

Question 5

An injured employee tore his Achilles tendon. The injured employee had an open repair 10 days post injury, was casted for four weeks, then placed in a cast boot and started on physical therapy (PT) seven weeks post injury.

At seven months after the date of injury, 48 PT visits were completed. The discharge evaluation noted improved ROM but inability to stand on toes and heels with pain 4/10. The injured employee continued a home exercise program (HEP) and resumed normal activities.

At nine months post injury, the treating doctor (TD) noted continued improvement and the ability to walk on his heels and toes with pain 4/10. Gait was normal with ability to walk on heels and toes, ROM was "normal," and there was 5/5 lower extremity strength bilaterally.

At 10 months after the date of injury, the DD examination noted maintained ROM/heel-toe walking, 1 cm of calf atrophy, 15° of dorsiflexion, 30° of plantar flexion, and 6/10 pain.

Which MMI certification is correct?

a. MMI was reached nine months post injury.
b. MMI was reached 10 months post injury.
c. The injured employee is not at MMI, which is estimated to be reached 13 months post injury.

Question 6

The injured employee injured his right knee three and half months ago when he was in a frontal collision with vehicles traveling approximately 40 m.p.h. His right tibia struck the dashboard. X-rays done that day revealed no fractures. The injured employee attended two PT visits with increased pain.

At three weeks post injury, an MRI revealed a contusion of the patellar tendon, a ~~posterior~~ anterior medial tibial plateau contusion with posterior horn medial meniscus tear of the right knee. Each of these findings were determined to be compensable.

At four weeks post injury, the injured employee underwent an arthroscopic partial meniscectomy. Following surgery, the injured employee was started in PT.

At eight weeks post-injury, the injured employee completed 12 visits of PT with minimal improvement. The injured employee returned to work with restrictions of limited weight bearing, limited standing and walking with no climbing stairs, ladders, or hills.

At 12 weeks post injury, the DD examination revealed right knee pain with prolonged standing or walking. The right knee shows no effusion and mild tenderness. The right knee range of motion is 0° to 70° actively and passively with a firm endpoint. The injured employee states the right knee is stiff and he has had some episodes of giving way.

Which MMI certification is correct?

a. The injured employee reached MMI 8 weeks post injury.
b. The injured employee reached MMI 12 weeks post injury.
c. The injured employee has not yet reached MMI.

Question 7

An injured employee was diagnosed with a crush injury and sprain/strain to the right foot/ankle. The injured employee was referred to an orthopedic surgeon who diagnosed a Lisfranc injury. The injured employee was treated conservatively with a rigid post-op shoe and crutches. A CT scan was performed and demonstrated no fracture or subluxation.

At three months post injury, the injured employee started PT and was sent back to work on restricted duty.

At five months post injury, the injured employee had completed a series of nine PT visits. The injured employee had less pain and swelling. Active ROM was plantar flexion 20°, dorsiflexion 10°. The injured employee was able to walk with normal shoes but with a slight limp favoring the right foot.

Additional PT was prescribed but initially denied by the carrier. The injured employee returned to work regular duty by six months post injury. The injured employee later completed three more sessions of PT and was discharged from PT seven months post injury.

At seven months post injury, the injured employee's therapist measured active ROM to be plantar flexion 40°, dorsiflexion 20°.

At eight months post injury, the injured employee returned to the orthopedic surgeon. The injured employee was noted to complain of some pain and swelling after prolonged standing and walking but demonstrated "normal" ROM.

At nine months post injury, the DD exam reveals normal gait in the hallway to the exam room. Active ROM measures plantar flexion 40° and dorsiflexion 15°. The injured employee complains of some pain and swelling after prolonged standing and walking.

Which MMI certification is correct?

a. MMI seven months post injury.
b. MMI eight months post injury.
c. MMI nine months post injury.

Question 8

As the designated doctor, you have been assigned a case with instructions only to determine the extent of the injured employee's (IE) compensable injury. Review of the medical records indicate the injury includes at least an elbow contusion and wrist sprain. The disputed conditions in Box 31C of the DWC-32 include neck sprain/strain and lumbar radiculopathy. During the designated doctor evaluation, the IE also claimed a knee contusion. Your opinion is that the elbow contusion, wrist sprain and knee contusion should be included, but not the neck sprain/strain or the lumbar radiculopathy.

In addition to a statement and explanation why you consider the neck sprain/strain and lumbar radiculopathy not to be compensable, your report should include:

a. an explanation of why you think the elbow contusion, wrist sprain and knee contusion should be included.
b. a statement that the knee contusion should be considered in a Benefit Review Conference.
c. multiple certifications of MMI and IR, including all conditions on the DWC 32 and the knee contusion.

Question 9

The injured employee was performing a heavy job classification and suffered a low back injury at work. The injured employee was diagnosed with a lumbar strain and an L4-L5 disc protrusion with an L5 radiculopathy. The IE completed PT for the sprain/strain six weeks after the date of injury (DOI). Following the unsuccessful trial of conservative treatment, a lumbar discectomy was performed eight weeks after the DOI. At the time of the designated doctor (DD) examination eight weeks after the DOI, the injured employee stated that he had not returned to work in any capacity since the injury.

According to the maximum value provided in the MDGuidelines Disability Duration Tables, in what job class (Physical Demand Level = PDL) is the injured employee able to perform at the time of the DD exam?

a. Sedentary PDL
b. Light PDL
c. Medium PDL

Question 10

The injured employee (IE) sustained an injury to the right knee. The IE underwent arthroscopic surgery, which consisted of both a partial lateral meniscectomy and a medial meniscus repair. The IE was taken off work after surgery. Physical therapy started the second week after surgery and was completed consistent with ODG treatment guidelines. The IE has not yet returned to work and now presents for evaluation regarding ability to return to work.

Following surgery, what is the maximum number of days after which it is anticipated that the IE should be able to return to very heavy physical demand level per the MDGuidelines?

a. 84
b. 112
c. 140

Answer Key

1. b.
2. a.
3. a.
4. b.
5. a.
6. c.
7. a.
8. a.
9. a.
10. c.

Explanation of Each Question

Question 1
(IR – Upper Extremity)

Objective

The candidate should demonstrate minimum competency in applying the AMA Guides, 4th Edition, Chapter 3, Upper Extremity concepts in determining accurate IRs.

Outcomes

- Demonstrate understanding of ROM measurements and concepts in terms of proper calculation of digital impairment.

- Apply correct tables, figures, and processes for determining ROM and sensory findings in calculating impairment.

- Demonstrate accurate use of the Combined Values Chart.

- Correctly convert regional impairments from digit to whole-person impairment.

Rationale for the correct answer and incorrect response options

- Response a. is not correct. This answer uses Table 8, Longitudinal Sensory Loss Impairment for the Thumb and Little Finger instead of Table 9, Longitudinal Sensory Loss Impairment of Index, Middle and Ring Fingers.

- **Response b. is the correct answer.** The candidate should look at Sections 3.1c, Evaluating Sensory Loss and 3.1d, Evaluating Abnormal Motion to review proper considerations. Section 3.1g covers finger impairment for ROM loss and sensory abnormality. Add impairments within a joint and combine impairments of different joints within a digit, for digits II – V. When there is more than one impairment of a digit, such as abnormal motion, sensory loss, and amputation, the impairments must be combined (Section 3.1e).

    - ROM Impairment: Finger ROM Figures 19, 21, and 23. MP flex 22% + extension 10% = 32%; PIP flexion 18% + extension 11% = 29%; DIP flexion 15% + extension 12% = 27%. 32 combined with 29 = 52%, combined with 27 = 65% digit ROM impairment.

- Sensory Impairment: Digit 2-point discrimination Page 21: 2-point discrimination of 15 through 7 mm is a partial loss. From Figure 17, determine that the sensory deficit involves 80% of the finger length (PIP to tip). Using Table 9, determine that a 12% impairment exists for a partial sensory loss involving 80% of the digit length on the radial side of the digit.

- Using the combined values chart, 65% digit for ROM combines with 12% partial sensory loss for a 69% index digit impairment.

- Sixty-nine percent index impairment yields 14% hand impairment (Table 1, Page 18). Fourteen percent hand impairment converts to 13% upper extremity impairment (Table 2, Page 19). Thirteen percent upper extremity converts to 8% whole person (Table 3, Page 20).

- Response c. is not correct. This answer is reached by adding the ROM impairments from DIP, PIP, and MP ROMs instead of combining them. ROMs within the finger joint are added (i.e., DIP flexion and extension) but ROMs of separate joints are combined. See "Distal interphalangeal (DIP) Joint: Flexion and Extension" example on Page 31, "Abnormal Motion of more Than One Finger" on Page 34, and "When there is more than one impairment of a member [digit], such as abnormal motion, sensory loss, and amputation, the impairments must be combined" on Page 24.

Question 2
(IR – Spine and Torso)

Objective

The candidate should demonstrate minimum competency in applying the AMA Guides, 4th Edition, Chapter 3, Spine Concepts in determining appropriate spinal ratings.

Outcomes

- Demonstrate understanding of the Lumbar diagnosis related estimates (DRE) categories and qualifiers.

- Apply jurisdictional nuance and Appeals Panel decisions to determine the proper DRE category selection.

- Apply correct clinical correlation considerations to imaging studies.

- Demonstrate accurate knowledge of spinal nerve root levels and how they relate to clinical findings.

Rationale for the correct answer and incorrect response options

- **Response a. is the correct answer.** The injured employee has clinical radiculopathy but does not meet the threshold for a "ratable" radiculopathy under the requirements for a DRE III. The injured employee has non-verifiable radicular complaints and fits DRE II. The 1 cm of atrophy does not meet the requirement for ≥2 cm atrophy for radiculopathy. While there is a loss of patellar reflex, the patellar reflex is consistent with the L4 level and does not correlate with the imaging and EMG findings of L5 involvement. While there is diminished sensation and muscle weakness, which may represent a clinical radiculopathy, according to Appeals Panel Decisions (APDs), to reach the level of a ratable radiculopathy in Texas, there must be loss of relevant reflex or 2 or more centimeters of atrophy at the level that correlates with the imaging findings. Electrodiagnostic studies may be used to verify radiculopathy as stated in page 102, DRE III and in Table 71, page 109, but are insufficient alone to rate as DRE III. See APDs, 040924, 091039, 111710, 072220-S, 080375 and 051456 available at:
  www.tdi.texas.gov/wc/dd/documents/apddd.pdf

- Response b. is not correct because there is no DRE II threshold ratable atrophy and no loss of relevant reflex. Although there is loss of L4 reflex on the right, this does not correlate with the L5 level on imaging findings. While there is loss of Achilles reflexes bilaterally, loss of the S1 reflex is not consistent with the level indicated on imaging. It is a bilateral finding, while the disc herniation is only to the right. Loss of the relevant reflex is an appropriate differentiator for DRE III. Bilaterally absent Achilles reflexes do not represent a loss of relevant reflexes but likely represent baseline reflexes.

- Response c. is not correct because there is 4 mm of translation, not the required 5 mm of translation for loss of motion segment integrity for the lumbar spine, so the injured employee does not qualify for DRE IV.

Question 3
(IR – Upper Extremity)

Objective

The candidate should demonstrate minimum competency in applying the AMA Guides, 4th Edition concepts from Chapter3 in determining accurate impairment ratings.

Outcomes

- Demonstrate understanding of ROM measurements and concepts in terms of proper calculation of digital impairment.

- Apply correct tables, figures, and processes for determining ROM and sensory findings in calculating impairment.

- Demonstrate accurate use of the Combined Values Chart.

- Correctly convert regional impairments from digit to whole-person impairment.

Rationale for the correct answer and incorrect response options.

- **Response a. is the correct answer**. The transverse sensory loss at IP distally = 25% of thumb; ROM as follows: 3 cm lack of adduction = 3%, 20° of radial abduction = 7%, 4 cm opposition = 9%, MP flexion 50° = 1%, MP extension minus 20° = 1%, IP flexion 40° = 3%, IP extension 0° = 1%; ROM = 25% thumb. The 25% for sensory loss cw 25% for ROM = 44% for the thumb, which converts to 18% for the hand, which converts to 16% for the upper extremity, which converts to 10% WP impairment**.**

- Response b is not correct. 16% is the impairment rating for the upper extremity and must be converted to the whole person impairment rating using Table 3.

- Response c is not correct. 18% is the impairment rating for the hand and must be converted to the upper extremity impairment rating, then the whole person impairment rating using Table 3.

Question 4
(IR – Lower Extremity)

Objective

The candidate should demonstrate minimum competency in applying the AMA Guides, 4th Edition, Chapter 3, Lower Extremity in determining accurate impairment ratings. Specifically, the concept of "only one evaluation method should be used to calculate a specific impairment." Text on pages 75 and 85 of the AMA Guides.

Outcomes

- Demonstrate proper selection of lower extremity impairment ratings, considering the 13 anatomic, diagnostic, and functional methods in Section 3.2 of the AMA Guides.

- Recognize effects of pain or other motivational factors during examination findings, which invalidate those findings. Text on pages 8,14, 76, and 77 of the AMA Guides.

- Identify the most relevant method of impairment for the lower extremity.

Rationale for the correct answer and incorrect response options

- Response a. is not correct. Table 64, Partial Medial Meniscectomy qualifies for 1% whole person impairment (WPI). This should not be used because there is a greater impairment for ROM.

- **Response b. is the correct answer.** Table 41 for Active ROM would give a mild impairment for 4% WPI. The AMA Guides state that you should use the section providing the greater impairment estimate. The ROM impairment percentage is greater than the Table 64 method.

    - Section 3.2 states, "in general only one evaluation method should be used to calculate a specific impairment." The candidate should consider the best or maximal impairment of the anatomic, diagnostic, and functional methods in 3.2. The candidate should understand that ROM should not be combined with atrophy (Page 78) or with diagnosis-based estimates (DBE) (pages 81 and 84), and atrophy should not be combined with DBE (Page 84). There are exceptions to combining methods, such as combining an intraarticular

fracture as per Table 64 with the appropriate radiographic cartilage interval according to Table 62.

- When there are limitations of ROM or manual muscle testing strength due to pain, fear of pain, or other motivational factors, those are not valid methods to use.

- Response c. is not correct because it combines a 1% DBE from Table 64 with a 4% ROM from Table 41.

Question 5
(MMI – Lower Extremity)

Objective

The candidate should demonstrate minimum competency in applying the Official Disability Guidelines (ODG) and clinical evaluation when assessing MMI.

Outcomes

- Demonstrate the ability to use the ODG when assessing the need for continued treatment.

- Assess clinical findings on anticipated future material recovery.

- Distinguish the difference between subjective and objective limitations of function.

Rationale for the correct answer and incorrect response options

- MMI is determined when there is no anticipation of further material recovery within a degree of reasonable medical probability. This determination is based on ODG-recommended treatment and case-specific details. There does not have to be a change in condition, just the anticipation of a change.

- **Response a. is the correct answer.** ODG-recommended treatment after an Achilles tendon rupture and repair was completed at seven months. With the continued HEP and resumption of normal activities, there was objective improvement in his condition at nine months. MMI has to be at least nine months after the DOI.

- Response b. is not correct. The injured employee's condition was the "same" or similar between nine and 10 months. At nine months, ROM was "normal" and by formal measurements, they were normal at 10 months as well. He could heal and toe-walk both at nine months and 10 months.

  The only difference between nine and 10 months is that the DD performed all the formal ROM measurements to determine the IR during his examination at 10 months. MMI is the *"earliest date at which there is no anticipation of further material improvement,"* and there was none at 9 months. The DD may use the earlier date for the date of MMI, and if the condition is the same or similar on the

date of the DD exam, the DD may use their measurements from the DD exam date to reflect the condition as of the date of MMI.

- Response c. (not at MMI) is not correct. An increase in subjective pain without some objective or functional parameter to change or improve from is not reasonable, especially when the injured employee returned to essentially normal function. Although it is possible, atrophy that is persistent at nine or 10 months is not likely to change over time with formal PT or additional time for an HEP.

Question 6
(MMI – Lower Extremity)

Objective

The candidate should demonstrate minimum competency in applying the ODG and clinical evaluation when assessing MMI.

Outcomes

- Demonstrate the ability to use the ODG.
- Recognize potential clinical red flags and require more clinical consideration.
- Apply the ODG, Appendix D when assessing MMI.

Rationale for the correct answer and incorrect response options

- Response a. is not correct. The ODG would support PT. Lack of improvement after 12 visits means poor prognosis of improvement with additional PT, unless there has been a complication of injury or treatment. In this case, the concern is post-traumatic arthritis or possibly post-op infection. In other cases that are post-op, this lack of improvement could be due to re-rupture of a repaired ACL for a knee. For a shoulder, it could be adhesive capsulitis or retear of a repaired rotator.
- Response b. is not correct. While this might be a normal time frame to reach MMI after a meniscectomy at three weeks, in this case, there are red flags for some other complication or sequelae of the injury.
- **Response c. is the correct answer.** The injured employee has not reached MMI because there needs to be further investigation of the residual symptoms of stiffness and "give way" episodes of the knee and objective decrease in ROM. This would not normally be expected at 14 weeks post injury. This would require more evaluation.

Question 7
(MMI – Feet)

Objective

The candidate should demonstrate minimum competency in applying the ODG and clinical evaluation when assessing MMI.

Outcomes

- Demonstrate anticipation of change in the condition when determining MMI.
- Recognize objective clinical MMI versus subjective complaints.
- Apply ODG to clinical cases to determine the date of MMI.

Rationale for the correct answer and incorrect response options

- **Response a. is the correct answer.** There is no change in the condition and no anticipation of a change in the condition after seven months. Most soft tissue healing occurs by three months. Despite no fractures, the Lisfranc injury was appropriately managed with a rigid post-op shoe and limited weightbearing to aid in tissue healing. He completed the initial round of PT by five months, but with only a few more sessions of PT, return to normal activities of daily living and continuation of an HEP, his objective function had improved by seven months. In addition, by six months after the injury, he returned to work (RTW) without restrictions. While RTW does not define MMI, it is a measure of function.
- Response b. is not correct because at eight months after the injury, the injured employee's condition is the same or similar to the condition at seven months. The orthopedist did not discuss or order any additional treatments. There is no anticipation of additional improvement, especially from the "normal" objective parameters that were determined at the earlier date.
- Response c. is not correct because there is no anticipation of improvement in the condition at nine months. While the measurements have "declined" some, these are still within normal limits. There is nothing in the ODG to anticipate improvement of his condition to be better than it was at seven months.

Question 8
(EOI)

Objective

The candidate should demonstrate minimum competency in addressing extent of injury (EOI). The candidate should also demonstrate understanding that when asked to address EOI only, the candidate assesses the evidence in the records (including what the records might say about insurance carrier accepted conditions), the additional claimed conditions from the DWC-32, Box 31 C, and evidence from the certifying examination to determine the extent of the compensable injury.

Outcomes

- Analyze clinical information when determining EOI

- Demonstrate understanding of applicable forms and submission requirements for EOI examinations.

Rationale for the correct answer and incorrect response options

The candidate should understand that they are only to provide their own opinion of the extent of injury when EOI is the only issue they are asked to address by a DWC-032 form. The extent of injury as they define it should be conveyed on the DWC-68 and in their narrative report. Multiple certifications are only to be provided when a designated doctor receives a Presiding Officer's Directive (POD) ordering multiple certifications, following the instructions provided in the POD.

- **Response a. is the correct answer.** The DD should use the DWC form 032, Box 31 C as a starting place and consider the medical records and certifying exam including the IE's interview, in forming an opinion as to the conditions which should be included as compensable.

- Response b. is not correct. There was failure to consider anything beyond the conditions listed on the DWC 032, Box 31 C, and does not fully understand the role of the DD.

- Response c. is not correct. The DD assignment was to determine EOI only and did not request multiple certifications.

Question 9
(RTW – Spine and Torso)

Objective
The candidate should demonstrate minimum competency in interpreting the MDGuidelines in determining physical demand level (PDL) and RTW ability.

Outcomes

- Accurately determine the PDL level using the MDGuidelines.

- Determine an appropriate RTW date based on clinical information and MDGuidelines.

- Use the appropriate date range (date of surgery) for determining the RTW date.

Rationale for the correct answer and incorrect response options
The injured employee had not returned to work at the time of the DD exam, and you are determining what job class the injured employee would be expected to perform in at the time of exam. This question tests the DD to ensure they use the date of surgery and not the date of injury when using the disability duration tables for the situation described in this question. An important concept for RTW is that the TD's actions are not relevant to the question because the TD may not have used evidence-based medicine and case-specific details in their determination to not return the injured employee to work.

- **Response a. is the correct answer.** The date of the DD exam was 13 weeks after the DOI, but five weeks after the date of the surgery. At five weeks post a discectomy for an HNP causing radiculopathy, the injured employee would still be at a sedentary PDL.

- Response b. is not correct. Light would be chosen for an RTW date six weeks after the DOI or at the completion of the PT for the lumbar sprain/strain.

- Response c. is not correct. Medium PDL would be chosen if they used the DOI rather than the date of surgery to reset the RTW calendar (for a discectomy).

Question 10
(RTW)

Objective

The candidate should demonstrate minimum competency in the knowledge of the DWC adopted Return to Work guidelines (MDGuidelines) tempered with the evidence in the records and other potential evidence-based medicine.

Outcomes

- Demonstrate knowledge of navigating the MDGuidelines and locate applicable information; Job title / Physical Demand Levels and the Disability Duration tables.

Rationale for the correct answer and incorrect response options.

- Response a is an incorrect answer. 84 days would be chosen if the candidate incorrectly chose the Heavy classification from the Meniscectomy table.

- Response b is not correct. 112 days would be if the candidate incorrectly chose the Very Heavy classification from the Meniscectomy table or if they chose the Heavy classification from the Meniscal repair table. If there is more than one diagnosis / procedure, the candidate would consider the diagnosis / procedure that has the longer disability duration.

- **Response c is the correct answer.** Per MD Guides V8.4 (2021 Q4) Maximum Disability Duration for Very Heavy Job Classification for Meniscus Repair (longer than for meniscectomy) is 140 days.