Subject: Guidelines for evaluation of various disabilities and procedure for certification.

No. 16-18/97-NI. I.- In order to review the guidelines for evaluation of various disabilities and procedure for certification as given in the Ministry of Welfare's O.M. No. 4-2/83-HW.-III, dated the 6th August, 1986 and to recommend appropriate modifications/alterations keeping in view the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, Government of India in Ministry of Social Justice and Empowerment vide Order No. 16-18/97-NI. I, dated 28-8-1998, set up four committees under the Chairmanships of Director General of Health Services-one each in the area of mental retardation, Locomotor/Orthopaedic disability, Visual disability and Speech & Hearing disability. Subsequently, another Committee was also constituted on 21-7-1999 for evaluation, assessment of multiple disabilities and categorization and extent of disability and procedures for certification.

2. After having considered the reports of these committees the undersigned is directed to convey the approval of the President to notify the guidelines for evaluation of following disabilities and procedure for certification:-
   1. Visual Impairment
   2. Locomotor/Orthopaedic disability
   3. Speech & hearing disability
   4. Mental retardation
   5. Multiple Disabilities

Copy of the Report is enclosed herewith as Annexure.

3. The minimum degree of disability should be 40% in order to be eligible for any concessions/benefits.

4. According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996 notified on 31.12.1996 by the Central Government in exercise of the powers conferred by sub-section (1) and (2) of section 73 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1of 1996), authorities to give disability certificate will be a Medical Board duly constituted by the Central and the State Government. The State government may constitute a Medical Board consisting of at least three members out of which at least one shall be a specialist in the particular field for assessing locomotor/visual including low vision/hearing and speech disability, mental retardation and leprosy cured, as the case may be.

5. Specified test as indicated in Annexure should be conducted by the medical board and recorded before a certificate is given.

6. The certificate would be valid for a period of five years for those whose disability is temporary. For those who acquire permanent disability, the validity can be shown as 'Permanent'.

7. The State Governments/UT Administrations may constitute the medical boards indicated in para 4 above immediately, if not done so far.

8. The Director General of Health Services Ministry of Health and
Family Welfare will be the final authority, should there arise any controversy/doubt regarding the interpretation of the definitions/classifications/evaluations tests etc.

ANNEXURE

Reports of the Committee set up to review the guidelines for evaluation of various disabilities and procedure for certification and to recommend appropriate modifications/alternations keeping in view the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995.

In order to review the definitions of various types of disability, the guidelines for evaluation of various disabilities and procedure for certification as given in the Ministry of Welfare's O.M.No.4-2/83-HW.III, dated the 6th August, 1983 and to recommend appropriate modifications/alternations keeping in view the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, five Sub-Committees were constituted in the areas of Mental Retardation, Orthopedic/Locomotor Disability, Visual Disability, Speech & Hearing and Multiple Disabilities, under the Chairmanship of Dr S.P. Agarwal, Director General of Health Services, vide the Ministry of Social Justice & Empowerment's Order No.16-18/97-N.I.I, dated 28.8.1998 and 21.7.1999. A copy each of the Order is at Appendix.I.

2. These Sub-Committees, after detailed deliberations, have submitted their reports. List of participants of the meetings taken by the Committee is at Appendix. II. The reports of the Committees set up to review the guidelines for evaluation of various disabilities and procedure for certification on each of the area of the disabilities are given in Appendix. III.

APPENDIX I

No 16-18/97-N.I.I
Government of India
Ministry of Social Justice & Empowerment

ORDER

In order to review the definitions of various types of disability, the guidelines for evaluation of various disabilities and procedure for certification as given in the Ministry of Welfare's O.M.No.4-2/83-HW.III, dated the 6th August, 1983 and to recommend appropriate modifications/alternations keeping in view the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, the following. Sub-Committees are hereby constituted in the areas of Mental Retardation, Orthopedic/Locomotor Disability, Visual Disability and Speech & Hearing disability:

1. Sub-Committee on Mental Retardation:
   1. Dr. S.P. Agarwal, Chairperson
      Director General
      Health Services
      Ministry of Health and Family Welfare,
      Nirman Bhawan
      New Delhi-11

   2. Dr. R. Srinivastava Murthy, Co-Chairperson
      Prof.&Head,
      Deptt. of Psychiatry,
      NIMHANS.
Bangalore-22.

3. Dr. G G Prabhu, Member
Workchil Court
Mysore.

4. Dr. (Mrs.) Neena Vohra, Member
Consultant & HOD,
Psychiatry,
Dr. R. M. I. Hospital, New Delhi.

5. Dr. Anand Pandit, Member
Hony. Prof & Director
KEM Hospital Pune-11.

6. Dr. D K Menon, Member-Secretary
Director
National Instt. for Mentally Handicapped Secunderabad

II. Sub-Committee on Locomotor / Orthopaedic Disability:

1. Dr. S P Aggarwal, Chairperson
DGHS.
Ministry of Health Nirman Bhavan New Delhi-11

2. Dr. K. K. Singh, Co-Chairperson
Prof. & Head.
AHMS New Delhi.

3. Dr. Balu Sankaran, Member
FX-DOHS FX-Chairman ALIMCO New Delhi

4. Dr. Suranjani Bhattacharji, Member
HOD Deptt. of PMR
CMC Hospital Vellore.

5. Dr. R K Srivastava Member
Medical Superintendent.
Safdarjung Hospital New Delhi.

6. Dr. B P Yadav Member
Ex-Chairman
Rehab Council of India
New Delhi

7. Dr. B R Avadhani Member - Secretary
Director IPH
New Delhi

III. Sub - Committee on visual Disability.

1. Dr. S P Aggarwal Chairperson
D.G.H.S.
Ministry of Health
New Delhi

2. Dr. V.K. Dada, Co-Chairperson
Head. Dr R.P. Centre.
Dr. Shireen K. Alme提高了 Member-\textit{Consultant}
Mohan Eve Institute.
Rajender Nagar.
New Delhi.

4. Shri Lal Advani Member
Consultant
Saket. New Delhi

5. Dr. Bhushabn Punani Member
Blind Men's Association
Ahmedabad

6. Shri S A Datrange Member
National Association for the Blind
Mumbai.

7. Dr. S R Shukla Member-Secretary
Director
NIVH.
Dehradun.

IV. Sub-Committee on Speech & Hearing Disability:

1. Dr. S P Aggarwal Chairperson
D.G.H.S. Ministry of Health.
New Delhi

2. Dr. S.K.Kacker. Co-Chairperson
Ex-Director.
AIIMS. New Delhi.

3 Dr S Nikam Member
Director AIIMS, Mysore.

4. Dr. J.M.Hans. Member
Sr.ENT Surgeon. Dr. RML Hospital. New Delhi

5. Dr. M Raghunath Member
Professor in Audiology
PGIMER. Chandigarh

6. Dr. (MRS) RekhaRoy Member-Secretary
Director
AYJNIH Mumbai-400050.

2. The terms of reference for the Committees are as follows:
   a) Providing uniform definitions and categorisation of degree and extent of the disability.
   b) Recommending authorities competent to give certification.
   c) The Committees will submit their report in two months.

3. TA/DA to the members of the Committee will be borne by the concerned Institute whose Director is included as Member-Secretary of the Sub-Committee.
   (Gauri Chatterjee) Joint Secretary to Govt. of India
   Tele No. 3381641
ORDER

It has been decided to constitute a Sub-Committee in the sector of Multiple Disability, in order to have standard definitions and guidelines for evaluation and procedure for certification, and to make appropriate recommendations. Keeping in view the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Accordingly, a Sub-Committee is hereby constituted in the sector of multiple disability, with the following Members:

1. Dr. SP Aggarwal, Chairman
   Director General of Health Services
   Ministry of Health & Family Welfare Nirman Bhavan, New Delhi.

2. Smt. Aloke Guha, Member
   Director,
   Spastics Society of Tamil Nadu,
   Opp. TITI, Taramani Road,
   Chennai-13

3. Dr. H.C. Goyal, Member
   Consultant,
   Rehabilitation Department Safdarjung Hospital, New Delhi.

4. Dr. Uma Tull, Member
   General Secretary
   Amar Jyoti Charitable Trust, N-192, Greater Kailash -1 New Delhi - 110048.

5. Dr. DK. Menon, Member-Secretary
   Director,
   National Institute for the Mentally Handicapped, Manovikas Nagar, Secunderabad-500 009,

3. The terms of reference for the Committee are as follows:—
   (a) Providing uniform definitions and categorisation of degree and extent of the disabilities.
   (b) Recommending authorities competent to give certification.
   (c) The Committee will submit its report in two months.

4. TA/DA to the members of the Committee will be borne by the National Institute for the Mentally Handicapped, Secunderabad.
   (Gauri Chatterji)
   Joint Secretary to the Government of India.
   Tele No.338 1641.

To:
All Members of the Committees
Copy for information to:
PSs to Secretary (SJ&E)/AS (SJ&E)/JS(DD).
APPENDIX.II

List of participants of the meeting held on 29.2.2000 under the Chairmanship of Dr. S.P. Agarwal. Director General of Health Services with the Members of Subcommittee constituted vide Order No.16-18/96-NI.I (PWD). dated 28.8.1998 of Ministry of Social Justice & Empowerment.

1. Dr. R.K. Srivastava, Addl. Director General of Health Services.
2. Dr. V.K. Dada, Head, R.P. Centre, AIIMS, New Delhi.
3. Dr. R. Srinivasa Murthy, Prof. & HOD, Deptt. of Psychiatry, NIMHANS, Bangalore.
4. Dr. O.K. Menon, Director, NIMH, Hyderabad.
5. Dr. Rekha Roy, Director, NIH, Mumbai.
6. Dr. S.R. Shukla, Director, NIVH, Dehradun.
7. Dr. Dharmendra Kumar, Officiating Director, NIRTAR, Cuttack.
8. Dr. A.S. Bais, Deputy Director General (Medical).
9. Dr. S. Chug, Consultant in Medicine & Chairman, Medical Board, Dr. RML Hospital.
10. Dr. L.S. Chauhan, ADG (IH),
11. Dr. A.N. Sinha, CMO (HA).

List of participants of the meeting held on 17.8.2000 under the Chairmanship of Dr. S.P. Agarwal. Director General of Health Services with the Members of Sub-Committee constituted vide Order No.16-18/96-NI.I (PWD). dated 21.7.1999 of Ministry of Social Justice & Empowerment.

1. Dr. R.K. Srivastava, Addl. Director General of Health Services
2. Dr. H.C. Goyal, Consultant & HOD, Rehabilitation, S.J.Hospital, New Delhi.
3. Dr. O.K. Menon, Director, National Institute for the Mentally Handicapped, Secunderabad.
4. Smt. Aloka Guha, Director, Spastic Society of Tamil Nadu, Opp. TTTI, Taramani Road, Chennai-13.
5. Dr. A.N. Sinha, CMO (HA).

APPENDIX.III

A. MENTAL RETARDATION

1. Definition:- Mental retardation is a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the development period which contribute to the over all level of intelligence, i.e., cognitive, language, motor and social abilities.

2. Categories of Mental Retardation:-

2.1 Mild Mental Retardation:- The range of 50 to 69 (standardised IQ test) is indicative of mild retardation. Understanding and use of language tend to be delayed to a varying degree and executive speech problems that interfere with the development of independence may persist into adult life.

2.2 Moderate Mental Retardation: - The IQ is in the range of 35 to 49. Discrepant profiles of abilities are common in this group with some individuals achieving higher levels in visuo-spatial skills than in tasks dependent on language while others are markedly clumsy by enjoy social interaction and simple conversation. The level of development of language
in variable: some of those affected can take part in simple conversations while others have only enough language to communicate their basic needs.

2.3 Severe Mental Retardation: - The IQ is usually in the range of 20 to 34. In this category, most of the people suffer from a marked degree of motor impairment or other associated deficits indicating the presence of clinically significant damage to or mal-development of the central nervous system.

2.4 Profound Mental Retardation: - The IQ in this category estimated to be under 20. The ability to understand or comply with requests or instructions are severely limited. Most of such individuals are immobile or severely restricted in mobility, incontinent and capable at most of only very rudimentary forms of non-verbal communication. They possess little or no ability to care for their own basic needs and require constant help and supervision.

3. Process of Certifications:-

3.1 A disability certificate shall be issued by a Medical Board consisting of three members duly constituted by the Central/State Government. At least, one shall be a Specialist in the area of mental retardation, namely, Psychiatrist, Paediatrician and clinical Psychologist.

3.2 The examination process will consist of three components, namely, clinical assessment, assessment, of adaptive behaviour and intellectual functioning.

B. VISUAL DISABILITY
1. Definition: - Blindness refers to a condition where a persons suffers from any of the condition, namely,
 i) total absence of sight; or
 ii) visual acuity not exceeding 6/60 or 20/200(snellen) in the better eye with best correcting lenses; or
 iii) limitation of field of vision subtending an angle of 20 degree or worse;

2. Low Vision: - Persons with low vision means a person a with impairment of vision of less than 6/18 to 6/60 with best correction in the better eye or impairment of field in any one of the following categories:-
a) reduction of fields less than 50 degrees
b) Hemianopia with macular involvement
c) Altitudinal defect involving lower fields.

3. Categories of Visual Disability
All with correction

<table>
<thead>
<tr>
<th>Category</th>
<th>Better eye</th>
<th>Worse eye</th>
<th>% age impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 0</td>
<td>6/9-6/18</td>
<td>6/24 to 6/36</td>
<td>20%</td>
</tr>
<tr>
<td>Category I</td>
<td>6/16-6/36</td>
<td>6/60 to Nil</td>
<td>40%</td>
</tr>
<tr>
<td>Category II</td>
<td>6/40-4/60 or field of vision 10°-20°</td>
<td>3/60 to Nil</td>
<td>75%</td>
</tr>
<tr>
<td>Category III</td>
<td>3/60 to 1/60 or field of vision 10°</td>
<td>F.C. at 1 ft. to Nil</td>
<td>100%</td>
</tr>
<tr>
<td>Category IV</td>
<td>F.C. at 1 ft. to Nil or</td>
<td>F.C. at 1 ft. to Nil</td>
<td>100%</td>
</tr>
</tbody>
</table>
One eyed persons & F. C. at 1 ft to nil or field of vision 10° 30%

Note: F.C. means Finger Count

4. Process of Certification
A disability certificate shall be issued by a Medical Board duly constituted by the Central/State Government having, at least three members. Out of which, at least one member shall be a specialist in ophthalmology.

8. SPEECH & HEARING DISABILITY

1. Definition of Hearing: - A persons with hearing impairment having difficulty of various degrees in hearing sounds is an impaired person.

2. Categories of Hearing Impairment:

<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Impairment</th>
<th>D B Level</th>
<th>Speech discrimination</th>
<th>% age of Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Mild hearing</td>
<td>DB 26 to 40 dB in better ear</td>
<td>80 to 100% in better ear</td>
<td>Less than 40% to 50%</td>
</tr>
<tr>
<td>II (a)</td>
<td>Moderate hearing</td>
<td>41 to 60 dB in better ear</td>
<td>50 to 80% in better ear</td>
<td>40% to 50%</td>
</tr>
<tr>
<td>II (b)</td>
<td>Severe hearing</td>
<td>61 to 70 dB hearing Impairment in better ear</td>
<td>40 to 50% in better ear</td>
<td>51% to 70%</td>
</tr>
<tr>
<td>III</td>
<td>a) Profound hearing Impairment</td>
<td>71 to 90 dB</td>
<td>Less than 40% in better ear</td>
<td>71% to 100%</td>
</tr>
<tr>
<td></td>
<td>c) Total deafness</td>
<td>91 dB and above/in better ear/to hearing</td>
<td>Very Poor discrimination</td>
<td>100%</td>
</tr>
</tbody>
</table>

i) Pure tone average of learning in 500, and 2000 HZ, 4000 HZ by conduction (AC and BC) should be taken as basis for consideration as per the test recommendations.

ii) When there is only an island of hearing present in one or two frequencies in better ear, it should be considered as total loss of hearing.

iii) Wherever there is no response (NR) at any of the 4 frequencies (500, 1000, 2000 and 4000 HZ), it should be considered as equivalent to 100 dB loss for the purpose of classification of disability and in arriving at the average.

3. Process of Certification

A disability certificate shall be issued by a Medical Board duly constituted by the Central and the
C. Locomotor Disability

1 Definition

1) Impairment: An impairment in any loss or abnormality of psychological, physiological or anatomical structure or function in a human being.
2) Functional Limitations: Impairment may cause functional limitations which are partial or total inability to perform those activities, necessary for motor, sensory or mental function within the range or manner of which a human being is normally capable.
3) Disability: A disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.
4) Locomotor Disability: Locomotor disability is defined as a person's inability to execute distinctive activities associated with moving both himself and objects, from place to place and such inability resulting from affliction of musculoskeletal and/or nervous system.

2. Categories of Locomotor Disability

The categories of locomotor disabilities are enclosed at Annexure-A.

3. Process of Certification

A disability certificate shall be issued by a Medical Board of three members duly constituted by the Central and the State Government, out of which, at least, one member shall be a specialist from either the field of Physical Medicine and Rehabilitation or Orthopaedics.

Two specimen copies of the disability certificate for mental retardation and others (visual disability, speech and hearing disability and locomotor disability) are enclosed at Annexure-B.

It was also decided that whenever required the Chairman of the Board may co-opt other experts including that of the members constituted for the purpose by the Central and the State Government.

On representation by the applicant, the Medical Board may review its decision having regard to all the facts and circumstances of the case and pass such order in the matter as it thinks fit.

ANNEXURE-A LOCOMOTOR DISABILITY

REVISED GUIDELINES FOR EVALUATION OF THE PERMANENT PHYSICAL IMPAIRMENT

1.1 Guidelines for Evaluation of Permanent Physical Impairment of Upper Limb

1. The estimation of permanent impairment depends upon the measurement of functional impairment and is not expression of a personal opinion.

2. The estimation and measurement should be made when the clinical condition has reached the stage of maximum improvement from the medical treatment. Normally the time period is to be decided by the medical doctor who is evaluating the case for issuing the PPI Certificate as per standard format of the certificate.

3. The upper limb is divided into two component parts; the arm component and the hand component.

4. Measurement of the loss of function of arm component consists of measuring the loss of motion, muscle strength and co-ordinated activities.
5. Measurement of loss of function of hand component consists of determining the prehension, sensation and strength. For estimation of prehension opposition, lateral pinch cylindrical grasp, spherical grasp and hook grasp have to be assessed as shown in Hand Component of Form A Assessment Proforma for upper extremity.

6. The impairment of the entire extremity depends on the combination of the functional impairments of both components

2 ARM COMPONENT
Total value of arm component is 90%

1.2.1 Principles of evaluation of range of motion (ROM) of joints

1. The value of maximum ROM in the arm component is 90%
2. Each of the three joints of the arm is weighed equally (30%);

Example:

The intra articular fractures of the bones of right shoulder joint may affect range of motion even after healing. The loss of ROM should be calculated in each arc of motion as envisaged in the Assessment Form A (Assessment Proforma for Upper Extremity).

<table>
<thead>
<tr>
<th>Arc of ROM</th>
<th>Normal value</th>
<th>Active ROM</th>
<th>Loss of ROM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder Flexion-</td>
<td>0-220</td>
<td>110</td>
<td>50%</td>
</tr>
<tr>
<td>Rotation</td>
<td>0-180</td>
<td>90</td>
<td>50%</td>
</tr>
<tr>
<td>Abduction-Adduction</td>
<td>0-180</td>
<td>90</td>
<td>50%</td>
</tr>
</tbody>
</table>

Hence the mean loss of ROM of shoulder will be 50+50+50/3 = 150/3 = 50%  
Shoulder movements constitute 30% of the motion of the arm component, therefore the loss of motion for arm component will be 50 X 0.3 = 15% If more than one joint of the arm is involved the loss of percentage in each joint is calculated separately as above and then added together.

1.2.2. Principles of evaluation of strength of muscles:

1. Strength of muscles can be tested by manual method and graded from 0-5 as advocated by Medical Research Council of Great Britain depending upon the strength of the muscles.

2. Loss of muscle power can be given percentages as follows:

<table>
<thead>
<tr>
<th>Manual muscle Strength grading percentage</th>
<th>Loss of Strength in percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>80%</td>
</tr>
<tr>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>3</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>0%</td>
</tr>
</tbody>
</table>
3. The mean percentage of loss of muscle strength around a joint is multiplied by 0.30.

4. If loss of muscle strength involves more than one joint the mean loss of percentage in each joint is calculated separately and then added together as has been described for loss of motion.

1.23 Principles of evaluation of coordinated activities:

1. The total value for coordinated activities is 90%
   Ten different coordinated activities should be tested as given in
   Form A. (Appendix I of Annexure A)

2. Each activity has a value of 9%

1.2.4 Combining values for the Arm Component:

The total value of loss of function of arm component is obtained by combining the value of loss of ROM, muscle strength and coordinated activities, using the combing formula:

$$a + b(90-a)$$

$$90$$

where

- $a$ = higher value
- $b$ = lower value

Example

Let us assume that an individual with an intra articular fracture of bones of shoulder joint in addition to 16.5% loss of motion in arm has 8.3% loss of strength of muscles and 5% loss of coordination. These values should be combined as follows:

Loss of ROM - 16.5% $\quad 16.5 + 8.3(90-16.5)$

$$\frac{90}{90} = 23.3\%$$

Loss of strength of muscles - 8.3% $\quad 23.3 + 5(90-23.3) = 27.0\%$

To add

Loss of coordination - 5% $\quad \frac{27.0}{90} = 27.0\%$

So the total value of loss of function in Arm component will be 27.0%

1.3 HAND COMPONENT:

1. Total value of hand component is 90%
2. The functional impairment of hand is expressed as loss of prehension, loss of sensation and loss of strength

1.3.1 Principles of evaluation of prehension:

1. Total value of prehension is 30%
   It includes

   a) Opposition - 8%
      Tested against - Index finger -2%
- Middle finger - 2%
- Ring - 2%
- Little finger - 2%

b) Lateral pinch -5% - Tested by asking the patient to hold a key between the thumb and lateral side of index finger.

c) Cylindrical grasp - 6% Tested for
   i) Large object of 4 inches size - 3%
   ii) Small object of 1 inch size - 3%

d) Spherical grasp -6% Tested for
   i) Large object of 4 inches size - 3%
   ii) Small object of 1 inch size - 3%

e) Hook grasp - 5% - Tested by asking the patient to lift a bag

1.3.2. Principles of Evaluation of sensation:

1. Total value of sensation in hand is 30%
2. It should be assessed according to the distribution given below:
   i) Complete loss of sensation
      Thumb ray 9%
      Index finger 6%
      Middle finger 5%
      Ring finger 5%
      Little finger 5%

   ii) Partial loss of sensation: Assessment should be made according to percentage of loss of sensation in thumb/finger(s)

1 33. Principles of Evaluation of strength

1. Total value of strength is 30%
2. It includes:
   i) Grip strength 20%
   ii) Pinch strength 10%

Strength of hand should be tested with hand dynamo-meter or by clinical method (grp method).

Additional weightage - A total of 10% additional weightage can be given to following accompanying factors if they are continuous and persistent despite treatment

1. Pain
2. Infection
3. Deformity
4. Mal-alignment
5. Contractures
6. Cosmetic disfigurement
7. Dominant extremity-4%
8. Shortening of upper limb

First 1" - No weightage
For each 1" beyond first 1" -2%

The extra points should not exceed 10% of the total Arm Component and total PPI should not exceed 100% in any case.

1.3.4. Combining values of hand component:

The final value of loss of function of hand component is obtained by summing up values of loss of prehension, sensation and strength.

1.3.5. Combining values for the Extremity:

Values of impairment of arm component and impairment of hand component should be added by using combining formula:

\[
\frac{a+b}{90} = \frac{(90-a)}{90} = \text{higher value}
\]

\[
\frac{b}{90} = \text{lower value}
\]

Example:

Impairment of Arm - 27%       \[64 + \frac{27(90 - 64)}{90}\]
Impairment of hand - 64%       \[= 71.8\%\]

The total value can also be obtained by using the Ready Reckoner table for combining formula given at

Appendix.II of Annexure.A.

2. Guidelines for Evaluation of permanent physical Impairment in Lower Limb.

The measurement of loss of function in lower extremity is divided into two components: Mobility and standing components

2.1 Mobility Component:-

1. Total value of mobility component is 90%
2. It includes range of movement (ROM) and muscle strength

2.1.1. Principles of Evaluation of Range of Movement:

1. The value of maximum range of movement in mobility component is 90%
2. Each of three joints i.e. hip, knee and foot-ankle component is weighed equally - 30%.

Example:

A fracture of right hip joint bones may affect range of motion of the hip joint. Loss of ROM of the
affected hip in different are should be assessed as given in Form B (Assessment Proforma for lower extremity). (Appendix.I of Annexure.A)

<table>
<thead>
<tr>
<th>Affected Joint - Rt. Hip:</th>
<th>Normal ROM</th>
<th>Active ROM</th>
<th>Loss in percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion-Extension</td>
<td>0-140</td>
<td>70</td>
<td>50%</td>
</tr>
<tr>
<td>Abduction-Adduction</td>
<td>0-90</td>
<td>60</td>
<td>33%</td>
</tr>
<tr>
<td>Rotations</td>
<td>0-90</td>
<td>30</td>
<td>66%</td>
</tr>
</tbody>
</table>

Mean loss of ROM of Rt Hip = 50 + 33 + 66 = 50%

Since the hip constitute 30% of the total mobility component of the lower limb the loss of motion in relation to the lower limb will be 50 x 0.30 = 15%

If more than one joint of the limb is involved the mean loss of ROM in percentage should be calculated in relation to individual joint separately and then added together as follows to calculate the loss of mobility component in relation to that particular limb.

For example:

Mean loss of ROM of Rt. Hip 50%
Mean loss of ROM Rt. Knee 40%
Loss of mobility component of Rt. Lower Limb will be
\[
(50 \times 0.30) + (40 \times 0.30) = 27\%
\]

2.1.2. Principle of Evaluation of Muscle Strength:

1. The value for maximum muscle strength in the limb is 90%
2. Strength of muscles can be tested by Manual Method and graded 0-5 as advocated by MRC of Great Britain depending upon the residual strength in the muscle group.

3. Manual muscle grading can be given percentage like below:

<table>
<thead>
<tr>
<th>Power Grade of Ms</th>
<th>Loss of strength in percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>80%</td>
</tr>
<tr>
<td>2</td>
<td>60%</td>
</tr>
<tr>
<td>3</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>0%</td>
</tr>
</tbody>
</table>

4. Mean percentage of muscle strength loss around a joint is multiplied by 0.30 to calculate loss in relation to limb

5. If there has been a loss muscle strength involving more than one joint the values are added as has been described for loss of ROM

2.1.3. Combining values for mobility component:

1. The values of loss of ROM and loss of muscle strength should be combined with the help of
combining formula: \( a + b(90-a) \)
\[ \frac{90}{90} \]
(a = higher value, b = lower value)

Example: Let us assume that the individual with a fracture of right hip bones has in addition to 16% loss of motion, 8% loss of muscle strength also.

Combined values

Motion-16% \[ \frac{16 + b(90-16)}{90} \]

Strength-8% \[ \frac{-22.6}{90} \]

2.2 Stability component:

1. Total value of the stability component is 90%

2. It should be tested by clinical method as given in From B (Assessment Proforma for lower extremity). There are nine activities, which need to be tested, and each activity has a value of ten per cent (10%). The percentage valued in relation to each activity depends upon the percentage of loss stability in relation to each activity.

2.3 Extra points:
Extra points have been given for pain, deformities, contractures, loss of sensations and shortening. Maximum points to be added are 10% (excluding shortening). Details are as following.

i) Deformity
   In functional position 3%
   In non-functional position 6%

ii) Pain
   Sever (grossly interfering with function) 9%
   Moderate (moderately interfering with function) 6%
   Mild (mildly interfering with function) 3%

iii) Loss of sensation
   Complete Loss 9%
   Partial Loss 6%

iv) Shortening
   First 1/2" Nil
   Every 1/2" beyond first 1/2" 4%

v) Complications
   Superficial complications 3%
   Deep complications

3. Guidelines for Evaluation of Permanent Physical Impairment of Trunk (Spine)
Basic guidelines:

1. As permanent physical impairment caused by spinal deformity tends to change over the years, the certificate issued in relation to spine should be reviewed as per the standard format of the certificate given at Annexure - B of Appendix. III.

2. Permanent physical impairment should be awarded in relation to spine and not in relation to whole body.

3. Permanent physical impairment due to neurological deficit in addition to spinal impairment should be added by combining formula. The local effects of the lesions of the spine can be conventionally divided into traumatic and non-traumatic. The percentage of PPI in relation to each situation should be valued as follows:

3.1.1 Cervical spine injuries

<table>
<thead>
<tr>
<th>Percentage of PPI in relation to Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) 25% or more compression of one or two adjacent vertebral bodies with No involvement of posterior elements, No nerve root involvement, moderate Neck rigidity and persistent Soreness.</td>
</tr>
<tr>
<td>ii) Posterior element damage with radiological Evidence of moderate parties dislocation/subluxation including whiplash injury.</td>
</tr>
</tbody>
</table>

A) With fusion healed, No permanent motor or sensory changes. 10%

b) Persistent pain with radiologically demonstrable instability. 25%

iii) Severe Dislocation:

a) Fair to good reduction with or without fusion with no residual motor or sensory involvement; 10%
b) Inadequate reduction with fusion and persistent radicular pain 15%

3.1.2. Cervical Intervertebral Disc Lesions Spine

<table>
<thead>
<tr>
<th>Percentage of PPI In relation to Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Treated case of disc lesion with persistent pain and no neurological deficit</td>
</tr>
<tr>
<td>ii) Treated case with pain and instability</td>
</tr>
</tbody>
</table>

3.1.3. Thoracic and Thoracolumbar Spine Injuries:

<table>
<thead>
<tr>
<th>Percentage of PPI In relation to Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Compression of less than 50% involving one vertebral body with no neurological manifestation</td>
</tr>
<tr>
<td>ii) Compression of more than 50% involving single vertebra</td>
</tr>
</tbody>
</table>
or more with involvement of posterior elements, healed, no neurological manifestations persistent pain, fusion indicated

iii) Same as (b) with fusion, pain only on heavy use of back 15%

iv) Radiologically demonstrable instability with fracture or fracture dislocation with persistent pain. 30%

3.1.3. Thoracic and Thoracolumbar Spine Injuries:

i) Compression of less than 50% involving one vertebral body with no neurological manifestation 10%

ii) Compression of more than 50% involving single vertebra or more with involvement of posterior elements, healed, no neurological manifestations persistent pain, fusion indicated 20%

iii) Same as (b) with fusion, pain only on heavy use of back 15%

iv) Radiologically demonstrable instability with fracture or fracture dislocation with persistent pain. 30%

3.1.4 Lumbar and Lumbosacral Spine: Fracture

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Compression of 25% or less of one or two adjacent vertebral bodies, No definite pattern or neurological deficit</td>
<td>15%</td>
</tr>
<tr>
<td>b</td>
<td>Compression of more than 25% with disruption of Posterior elements, persistent pain and stiffness, healed With or without fusion, inability to lift more than 10 kgs</td>
<td>30%</td>
</tr>
<tr>
<td>c</td>
<td>Radiologically demonstrable instability in low lumbar or Lumbosacral spine with pain</td>
<td>35%</td>
</tr>
</tbody>
</table>

3.1.5 Disc lesion:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Treated case with persistent pain</td>
<td>15%</td>
</tr>
<tr>
<td>b</td>
<td>Treated case with pain and instability</td>
<td>20%</td>
</tr>
<tr>
<td>c</td>
<td>Treated case of disc disease with pain activities of lifting moderately modified</td>
<td>25%</td>
</tr>
<tr>
<td>d</td>
<td>Treated case of disc disease with persistent pain and stiffness, aggravated by heavy lifting necessitating modification of all activities requiring heavy weight lifting</td>
<td>30%</td>
</tr>
</tbody>
</table>

3.2 NON TRAUMATIC LESIONS:
3.2.1 Scoliosis:

Basic guidelines - following modification is suggested.
- The largest structural curve should be accounted for while calculating the PPI and not the compensatory curve or both structural curves.

3.2.2 Measurement of Spine Deformity:

Cobb's method for measurement, of angle of curve in the radiograph taken in standing position should be used. The curves have been divided into following groups depending upon the angle of major structural scoliotic deformity.

<table>
<thead>
<tr>
<th>Group</th>
<th>Cobb's Angle</th>
<th>PPI in relation to Spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>0-20</td>
<td>NIL</td>
</tr>
<tr>
<td>II</td>
<td>21-50</td>
<td>10%</td>
</tr>
<tr>
<td>III</td>
<td>51-100</td>
<td>20%</td>
</tr>
<tr>
<td>IV</td>
<td>101 &amp; above</td>
<td>30%</td>
</tr>
</tbody>
</table>

3.2.3 Torso Imbalance:

In addition to the above PPI should also be evaluated in relation the torso imbalance. The torso imbalance should be measured by dropping a plumb line from C7 spine and measuring the distance of plumb line from gluteal crease.

<table>
<thead>
<tr>
<th>Deviation of Plumb line</th>
<th>PPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 1.5 Cm</td>
<td>4%</td>
</tr>
<tr>
<td>1.6 - 30 Cm</td>
<td>8%</td>
</tr>
<tr>
<td>3.1 - 50 Cm</td>
<td>16%</td>
</tr>
<tr>
<td>5.1 and above</td>
<td>32%</td>
</tr>
</tbody>
</table>

3.2.4 Head Tilt over C7 spine PPI

<table>
<thead>
<tr>
<th>Upto 15</th>
<th>More than 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>4%</td>
<td>10%</td>
</tr>
</tbody>
</table>

3.2.5 Cardiopulmonary Test

In cases with scoliosis of severe type cardiopulmonary function tests and percentage deviation from normal should be assessed by one of the following method whichever seems more reliable clinically at the time of assessment. The value thus obtained may be added by combining formula.

a. Chest Expansion

<table>
<thead>
<tr>
<th>PPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>5% for each cm</td>
</tr>
</tbody>
</table>

4 - 5 Cm.
Less than 4 cm reduction in chest expansion
No expansion 25%

b counting in one breathe:

Breathe Count PPI
More than 40 Normal
0-40 5%
0-30 10%
0-20 15%
0-10 20%
Less than 5 25%

3.2.6 Associated Problems: To be added directly but the total value of PPI in relation to spine should not exceed 100%.

a) Pain
   -mildly interfering with ADL 4%
   -moderately restricting ADL 6%
   -severely restricting ADL 10%

b) Cosmetic Appearance:
   -No obvious disfigurement with clothes on Nil
   -mild disfigurement 2%
   -severe disfigurement 4%

c) Leg Length Discrepancy.
   -First½ " shortening Nil
   -Every½" beyond first½" 4%

d) Neurological deficit - Neurological deficit should be calculated as per established method of evaluation of PPI in such cases. Value thus obtained should be added telescopically using combining formula.

3.3 KYPHOSIS
Evaluation should be done on the similar guidelines as use for scoliosis with the following modifications:

3.3.1 Spinal Deformity PPI
Less than 20 Nil
21-40 10%
41-60 20%
Above 60 30%

322 Torso Imbalance - Plumb line dropped from external ear normally falls at ankle level. The deviation from normal should be measured from ankle anterior joint line to the plumb line.

Less than 5 cm in front of ankle 4%
5 to 10 cm in front of ankle 8%
10 to 15 cm in front of ankle 16%
More than 15 cm in front of ankle 32%
(Add directly)

Miscellaneous conditions:
Those conditions of the spine which cause stiffness and pain etc. are rated as follows.
<table>
<thead>
<tr>
<th>Conditions</th>
<th>Percentage PPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Subjective symptoms of pain, no involuntary muscle spasm, not substantiated by demonstrable structural pathology</td>
<td>-0%</td>
</tr>
<tr>
<td>B Pain, persistent muscles spasm and stiffness of spine, substantiated by mild radiological change.</td>
<td>-20%</td>
</tr>
<tr>
<td>C Same as B with moderate radiological changes</td>
<td>-25%</td>
</tr>
<tr>
<td>D Same as B with severe radiological changes involving any one of the regions of spine</td>
<td>-30%</td>
</tr>
<tr>
<td>E Same as D involving whole spine</td>
<td>-40%</td>
</tr>
</tbody>
</table>

4. Guidelines for Evaluation of PPI in cases of Short Stature/Dwarftsm:

1. Recumbent length or longitudinal height below 3rd percentile or less than 2 Standard Deviation from the mean is considered to have short stature.

2. The evaluation of a Short Statured person should be considered only when it is of disproportionate variety and is accompanied by an underlying pathological conditions, e.g., Achondroplasia, Chandrodysplasia Punctata, spondyloepiphysial dysplasia, mucopoly and acrhydosis, etc.

3. The ICMR norms as enclosed at Appendix III of Annexure. A should be used as a guideline for the height.

4. Every 1" vertical height reduction should be valued as 4% permanent physical impairment.

5. Associated skeletal deformities should be evaluated, separately and total percentage of both should be added by combining formula.

5. Guidelines for Evaluation of Permanent Physical Impairment in Amputees:

   Basic Guidelines:

1. In cases of multiple amputees if the total sum of permanent physical impairment is above 100%, it should be taken as 100% only.

2. If the stump is unfit for fitting the prosthesis additional weightage of 5% should be added to the value.

3. In case of amputation in more than one limb percentage of each limb is added by combining formula and another 10% will be added but when only toes or fingers are involved only 5% will be added.

4. Any complication in form of stiffness of proximal joint, neuroma infection, etc., should be given up to a total of 10% additional weightage.
5. Dominant upper extremity should be given 4% additional weightage.

<table>
<thead>
<tr>
<th>Upper Limb Amputations</th>
<th>PPI &amp; loss of</th>
</tr>
</thead>
<tbody>
<tr>
<td>physical function of each limb</td>
<td></td>
</tr>
<tr>
<td>1. Fore-quarter amputations</td>
<td>100%</td>
</tr>
<tr>
<td>2. Shoulder Disarticulation</td>
<td>90%</td>
</tr>
<tr>
<td>3. Above Elbow upto upper 1/3 of arm</td>
<td>85%</td>
</tr>
<tr>
<td>4. Above Elbow upto lower 1/3 of forearm</td>
<td>80%</td>
</tr>
<tr>
<td>5. Elbow disarticulation</td>
<td>75%</td>
</tr>
<tr>
<td>6. Below Elbow upto upper 1/3 of forearm</td>
<td>70%</td>
</tr>
<tr>
<td>7. Below Elbow upto lower 1/3 of forearm</td>
<td>65%</td>
</tr>
<tr>
<td>8. Wrist disarticulation</td>
<td>60%</td>
</tr>
<tr>
<td>9. Hand through carpal bones</td>
<td>55%</td>
</tr>
<tr>
<td>10. Thumb through C.M. or though 1st MC joint</td>
<td>30%</td>
</tr>
<tr>
<td>11. Thumb disarticulation through metacarpophalangeal joint or through proximal phalanx.</td>
<td>25%</td>
</tr>
<tr>
<td>12. Thumb disarticulation through interphalangeal joint or through distal phalanx.</td>
<td>15%</td>
</tr>
<tr>
<td>(15%)</td>
<td></td>
</tr>
<tr>
<td>(5%)</td>
<td></td>
</tr>
<tr>
<td>(3%)</td>
<td></td>
</tr>
<tr>
<td>(2%)</td>
<td></td>
</tr>
<tr>
<td>13. Amputation through Proximal phalanx or Disarticulation through M.P. Joint</td>
<td>15% 5% 3% 2%</td>
</tr>
</tbody>
</table>
14. Amputation through Middle phalanx or Disarticulation through PP joint. 10%  
4% 2% 1%

15. Amputation through Distal phalanx or disarticulation through DIP joint. 5%  
2% 1% 1%

1.3 Lower Limb Amputations:

1. Hind quarter 100%  
2. Hip disarticulation 90%  
3. Above knee upto upper 1/3 of thigh 85%  
4. Above knee upto lower 1/3 of thigh 80%  
5. Through knee 75%  
6. B.K. upto 8 cm 70%  
7. B.K. upto lower 1/3 of leg 60%  
8. Through ankle 55%  
9. Syme's 50%  
10. Upto mid-foot 40%  
11. Upto fore-foot 30%  
12. All toes 20%  
13. Loss of first toe 10%  
14. Loss of second toe 5%  
15. Loss of third toe 4%  
16. Loss of fourth toe 3%  
17. Loss of fifth toe 2%

deficiencies of the limbs.  
6.1 Transverse Deficiencies-

1. Functionally congenital transverse limb deficiencies are comparable to acquired amputations  
and can be called synonymously as congenital amputation, however, in some cases revision of  
amputation is required to fit in a prosthesis.

2. The transverse limb deficiencies therefore should be assessed on basis of the guidelines  
applicable to the evaluation of PPI in cases of amputees as given in the preceding chapter.

For example:

Transverse deficiency Rt. Arm complete (shoulder disarticulation)  PPI 90%
(shoulder disarticulation)
Transverse deficiency at thigh complete (hip disarticulation)  PPI 90%
Transverse deficiency Proximal Upper arm (Above elbow Amp.)  PPI 85%
(Above elbow Amp.)
Transverse deficiency at lower thigh (Above knee Amp. Lower 1/3)  PPI 80%
(Above knee Amp. Lower 1/3)
Transverse deficiency forearm complete (elbow disarticulation)  PPI 75%
Transverse deficiency lower forearm (Below Elbow Amp.)  PPI 65%
(Below Elbow Amp.)
Transverse deficiency carpal complete  PPI 60%
(wrist disarticulation)  
Transverse deficiency Metacarpal complete  
(Disarticulation through carpal bones)  

55% 

6.2 Longitudinal Deficiencies:  

6.2.1 Basic Guidelines  

1. In cases of longitudinal deficiencies of limbs due consideration should be  
given to functional impairment  

2. In upper limb, loss of ROM loss muscular strength and hand functions  
like prehension, etc should be tested while assessing the case for PPI  

3. In lower limb clinical method of stability component and shortening of lower limb should be  
given due weightage.  

4 Apart from functional assessment the lost joint/part of body should also be valued as per  
distribution Given in chapter Guidelines for Evaluation of PPI in upper extremity and lower  
limb. The values so obtained should be added with the help of combining formula  

Example:  
Congenital Absence of humerus where forearm bones directly articulate with scapula.  

There will be milled reduction in ROM and strength of muscles in the existing joints apart from  
loss of body part.  

Loss of shoulder joint can be given - 30%  
Loss of ROM of Elbow/Shoulder & Wrist  

All the components should be added together by the combining formula of  

\[ a + b \times (90 - a) \]  

90  

6.2.2 In cases of loss of single bone in forearm the evaluation should be based on the principles  
of evaluation of Arm component which include Evaluation of ROM, Muscle strength and  
coordinated activities. The values so obtained should be added together with the help of  
combining formula.  

6.2.3 In cases of loss of single bone in leg the evaluation should be based on the principles of  
evaluation of mobility component and stability components of the lower extremity. The values  
obtained should be added together with the help of combining formula.  


1.1 Basic Guidelines:  

1. Assessment in neurological conditions is not the assessment of disease but the assessment of  
its effects, i.e. clinical manifestations.  

2. These guidelines should only be used for central and upper motor neurone lesions.
3. Proformas (form A & B) will be utilized for assessment of lower motor neurone lesions, muscular disorders and other locomotor conditions.

4. Normally any neurological assessment for the purpose of certification has to be done six months after the onset of disease however exact time period is to be decided by the Medical Doctor who is evaluating the case and has to recommend the review of certificate as given in the standard format of certificate.

5. Total percentage of physical impairment in any neurological condition should not exceed 100%

6. In mixed cases the highest score will be taken into consideration. The lower score will be added telescopically to it by the help of combining formula $a+b(90-a)\div 90$

7. Additional rating of 4% will be given for dominant upper extremity.

8. Additional weightage up to 10% can be given for loss of sensation in each extremity but the total physical impairment should not exceed 100%.

### 7.2 Table-I

<table>
<thead>
<tr>
<th>Neurological Status</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered sensorium</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 7.3 Table-II

**Intellectual Impairment (to be assessed by Clinical Psychologist)**

<table>
<thead>
<tr>
<th>Degree of Mental Retardation</th>
<th>IQ Range</th>
<th>Intellectual Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Border line</td>
<td>70-79</td>
<td>25%</td>
</tr>
<tr>
<td>Mild</td>
<td>50-69</td>
<td>50%</td>
</tr>
<tr>
<td>Moderate</td>
<td>35-49</td>
<td>75%</td>
</tr>
<tr>
<td>Serve</td>
<td>20-34</td>
<td>90%</td>
</tr>
<tr>
<td>Profound</td>
<td>Less than 20</td>
<td>100%</td>
</tr>
</tbody>
</table>

### 7.4 Table - III

<table>
<thead>
<tr>
<th>Speech defect</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild dysarthria</td>
<td>Nil</td>
</tr>
</tbody>
</table>
### 7.5 Table - IV

<table>
<thead>
<tr>
<th>Type of Cranial Nerve Involvement</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor cranial nerve</td>
<td>20% for each nerve</td>
</tr>
<tr>
<td>Sensory cranial nerve</td>
<td>10% for each nerve</td>
</tr>
</tbody>
</table>

Sensory cranial nerve 10% for each nerve

### 7.6 Table-V

**Motor system Disability**

<table>
<thead>
<tr>
<th>Neurological Involvement</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemiparesis:</td>
<td></td>
</tr>
<tr>
<td>- Mild</td>
<td>25%</td>
</tr>
<tr>
<td>- Moderate</td>
<td>50%</td>
</tr>
<tr>
<td>- Severe</td>
<td>75%</td>
</tr>
</tbody>
</table>

### 7.7 Table-VI

**Sensory System Disability**

<table>
<thead>
<tr>
<th>Extent of Sensory Deficit</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesia</td>
<td>Upto 10% for each limb</td>
</tr>
<tr>
<td>Hypoaesthesia</td>
<td>Depending upon % of</td>
</tr>
<tr>
<td>Paraesthesia</td>
<td>Loss of sensation up to 30% depending</td>
</tr>
<tr>
<td>Hands/feet sensory loss</td>
<td>Upon % of loss sensation</td>
</tr>
</tbody>
</table>

### 7.8 Table - VIII

Bladder disability due to neurogenic involvement

<table>
<thead>
<tr>
<th>Bladder Involvement</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (Hesitancy/Frequency)</td>
<td>25%</td>
</tr>
<tr>
<td>Moderate (precipitancy)</td>
<td>50%</td>
</tr>
<tr>
<td>Frequency/Severity of Convulsions</td>
<td>Physical Impairment</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Mild – occurrence of one convolution Only</td>
<td>Nil</td>
</tr>
<tr>
<td>Moderate 1-5 Convulsions/month on Adequate – Medication</td>
<td>25%</td>
</tr>
<tr>
<td>Severe 6-10 Convulsions/month on Adequate medication</td>
<td>50%</td>
</tr>
<tr>
<td>Very Severe more than 10 fits/months On adequate – Medication</td>
<td>75%</td>
</tr>
</tbody>
</table>

7.10 Table - IX
Ataxia (Sensory or Cerebellar)

<table>
<thead>
<tr>
<th>Severity of Ataxia</th>
<th>Physical Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (Detected on examination)</td>
<td>25%</td>
</tr>
<tr>
<td>Moderate</td>
<td>50%</td>
</tr>
<tr>
<td>Severe</td>
<td>75%</td>
</tr>
<tr>
<td>Very Severe</td>
<td>100%</td>
</tr>
</tbody>
</table>

8 Guidelines for Evaluation of Physical Impairment due to Cardiopulmonary Diseases.

8.1 Basic Guidelines:-

1. Modified New York Heart Association subjective classification should be utilised to assess the functional disability.

2. The assessing physician should be alert to the fact that patients who come for disability claims are likely to exaggerate their symptoms. In case of any doubt patients should be referred for detailed physiological
3. Disability evaluation of cardiopulmonary patients should be done after full medical, surgical and rehabilitative treatment available, because most of these diseases are potentially treatable.

4. Assessment of cardiopulmonary impairment should also be done in diseases which might have associated cardiopulmonary problems, e.g., amputees, myopathies, etc.

5. For respiratory assessment, routine respiratory functions test should be done, however, in cases of interstitial lung diseases, diffusion studies may be done.

6. In cases of Angina pectoris (chest pain) base line studies in resting ECG should be done. When there is persistence of symptoms, exercise or stress test should be done.

8.2 The proposed classification with loss of function is as follows:-

Group 0: A patient with cardiopulmonary disease who is asymptomatic (i.e. has no symptoms of breathlessness, palpitation, fatigue or chest pain).

Group 1: A patient with cardiopulmonary disease who becomes symptomatic during his ordinary physical activity but has mild restriction (25%) of his physical activities.

Group 2: A patient with cardiopulmonary disease who becomes symptomatic during his ordinary physical activity and has 25-50% restriction of his ordinary physical activities.

Group 3: A patient with cardiopulmonary disease who becomes symptomatic during less than ordinary physical activity so that his ordinary physical activities are 50-75% restricted.

Group 4: A patient with cardiopulmonary disease who is symptomatic even at rest or on mildest exertion so that his ordinary physical activities are severely or completely restricted (75-100%).

Group 5: A patient with cardiopulmonary disease who gets intermittent symptoms at rest (i.e. patients with bronchial asthma, paroxysmal nocturnal dyspnoea, etc.)

1. Definition of Multiple Disabilities:
Multiple disabilities means a combination of two or more disabilities as defined in clause (1) of Section (2) of the Persons with Disabilities. (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, namely -

I. Locomotor disability including leprosy cured
II. Blindness/low vision
III. Speech and hearing impairment
IV. Mental retardation
V. Mental illness.

2. Guidelines for Evaluation:
In order to evaluate the multiple disability, the same guidelines shall be used as have been developed by the respective sub-committees of various single disability, viz. Mental retardation, locomotor disability, visual disability, and speech and hearing disability and recommended in the meeting held on 29.2.2000 under the Chairmanship of Dr. S.P. Agarwal, Director General of Health Services, Government of India, with reference to Order No.16-18/96-N.I.I. dated 28th August, 1998 and communicated to Ministry of Social Justice & Empowerment, Government of India, vide letter No.S-13020/4/98-MH, dated 16th March, 2000.
However, in order to arrive at the total percentage of multiple disability, the combining formula

\[ a + \frac{b}{90-a} \times 90 \], as given in the “Manual for Doctors to Evaluate Permanent Physical Impairment, Developed by Expert Group meeting on Disability Evaluation”, shall be used, where “a” will be the higher score and “b” will be the lower score. However, the maximum total percentage of multiple disabilities shall not exceed 100%.

For example, if the percentage of hearing disability is 30% and visual disability is 20%, then by applying the combining formula given above, the total percentage of multiple disability will be calculated as follows:-

\[ \frac{30 + \frac{20(90-30)}{90}} = 43\% \]

3. Procedure for Certification of Multiple Disability:
   The procedure will remain the same as has been developed by the respective sub-committees on various single disabilities and finalized in a meeting under the Chairpersonship of Dr. S.P. Agarwal held on 29.2.2000. The final disability certificate for multiple disability will be issued by Disability Board which has given higher score of disability by combining the score of different disabilities using the combining formula, i.e., \( a + \frac{b}{90-a} \). In case, where two scores of disability are equal, the final certificate of multiple disability will be issued by any one of them as decided by Local authority.