



Impairment Ratings from a Claims Perspective

AMA Guides, Fifth Edition: Impairment Ratings from a Claims Perspective




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AMA Guides

- The AMA Guides (5th Edition) is complex, confusing, difficult to learn, includes errors and is not internally consistent
- Therefore significant challenges - and also opportunities, if you effectively manage erroneous ratings

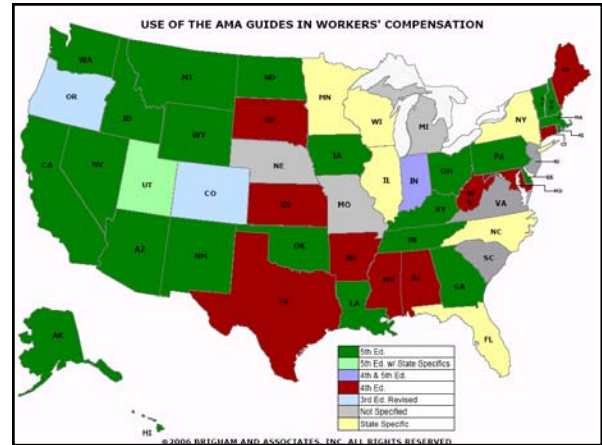


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AMA Guides Principles

- Most widely used basis for rating impairment, "loss of, loss of use of, or derangement of any body part, system or function"
- Procedure for obtaining and analyzing clinical data, and then applying to criteria to obtain a rating
- Average rating is 6% whole person (WPI); rare >30% WPI

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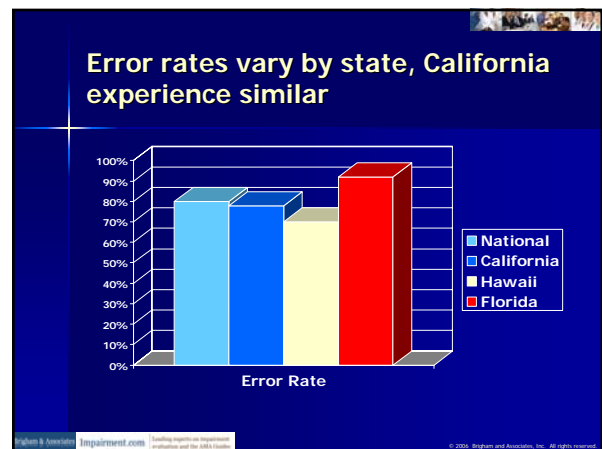


Musculoskeletal Ratings

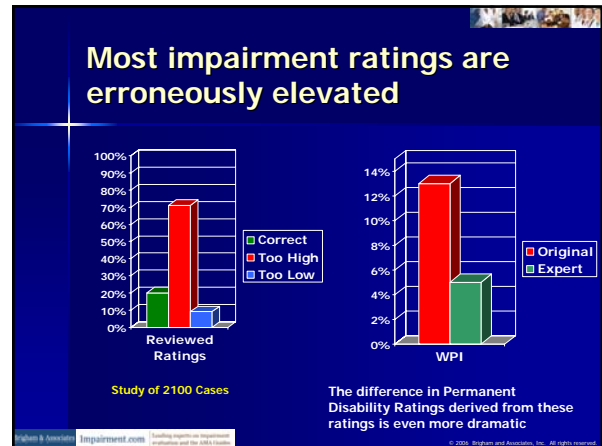
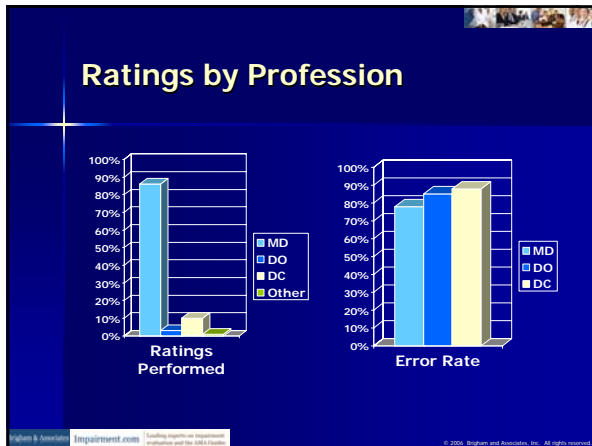
- 98% of all ratings are musculoskeletal
- Spine – 36%
- Upper extremity – 31%
- Lower extremity – 21%
- Multiple – 12%
- Lumber spine most common – 17% of all ratings

Category	Percentage
Spine	36%
Upper Extremity	31%
Lower Extremity	21%
Multiple	12%

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Impairment Ratings from a Claims Perspective



What does that mean to you and your organization?

- 80% of ratings erroneous
- Average original impairment assessment for California cases was 13% WPI vs. correct impairment of 5% WPI

What does this mean?

Assumptions 50 year old truck driver with 2005 back injury, earning \$500 / week

- 13% Impairment Standard (Erroneous)
 - 15.03.01.00-13-[5]17-350G-19-22
 - \$18,810.
- 5% Impairment Standard (Correct)
 - 15.03.01.00-5-[5]6-350G-7-6
 - \$5,280.
- Saving by Correcting Rating
 - \$13,520

Causes of Erroneous Ratings

1. Bias
2. Inexperience and lack of interest
3. Errors in clinical and causation analysis
4. Applicant/Plaintiff oriented physicians attempting to misapply *Guides* to inflate ratings (physician profiling supports this observation)
5. Misapplication of *Guides* criteria
6. Physicians typically unskilled in causation and disability assessment
7. False reliance on software systems (without understanding the principles of assessment)

Nature of errors is such that most erroneous ratings will be higher

Spine Impairment Evaluation

Chapter 15

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Spinal examination findings may also be questionable

- "Spasm"
- "Guarding"
- "Non-verifiable radicular complaints"
- "Radiculopathy"
- Need to assess the reliability of all ratable criteria – compare to other available data

Spinal Impairment Errors

- Use of wrong method; most ratings by Diagnosis-Related Estimates (DRE), not Range-of-Motion (ROM)
 - Multilevel degenerative disease not adequate basis to use ROM method
- Assignment to incorrect DRE category
- Assignment of wrong value in DRE range
- Errors in measuring and rating motion

Upper Extremity Impairment Evaluation

Chapter 16

Upper Extremity Impairment Errors

- Inadequate examination and failure to compare to opposite extremity
- Erroneous sensory assessment
- Rating for non-verifiable CRPS
- Rating strength loss
 - "Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of maximal force in the region being evaluated." (5th ed., 508)

UE Impairment Evaluation

- Hand dominance not accounted for but can have a significant impact on the ability to perform ADLs, so should be discussed
- Confusing re: what can be added and what should be combined
- If the total combined WPI does not seem to adequately reflect the actual extent of alteration in ADLs, this should be noted
- In compression neuropathies, additional impairment values are not given for decreased grip strength

CTS Impairment Rating (page 495)

- Do not use grip strength
- Only individuals with an *objectively verifiable diagnosis* should qualify for a permanent impairment rating
- The diagnosis is made not only on believable symptoms but, more important, on the presence of *positive clinical findings and loss of function*
- Impairment evaluated 1 year post surgery

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Tendinitis, Fasciitis, or Epicondylitis

(page 507, 16.7d)

- May be persistent for some time, but not given a permanent impairment rating unless there is some other factor that must be considered
- May use grip strength if grip weakness due to tendon rupture or surgical release of the flexor or extensor origins or medial or lateral epicondylitis, or has had excision of the epicondyle

Lower Extremity Impairment Evaluation

Chapter 17

Lower Extremity Impairment Errors

- Combining duplicative impairments inappropriately
- Rating for gait derangement or muscle strength
- Rating for arthritis without adequate radiographic imaging studies.

Table 17-2 Guide to the Appropriate Combination of Evaluation Methods

Table 17-2 Guide to the Appropriate Combination of Evaluation Methods

Open boxes indicate impairment ratings derived from these methods can be combined.

	Link Length Abnormality	Link Derangement	Gait Derangement	Muscle Atrophy	Muscle Strength	ROM Flexion	Arthritis (MRI)	Arthritis (X)	Arthritis (Clinical)	Diagnosis Based on MRI	Skin Les	Arthritis Bone Injury	Complete Medical History (CPI)	Neurology
Link Length Abnormality														
Link Derangement	X													
Muscle Atrophy			X		X	X	X	X	X	X			X	X
Muscle Strength			X	X						X			X	O
ROM Flexion			X	X	X			X		X				O
Arthritis (MRI)			X	X	X	X								
Arthritis (X)			X	X	X	X								
Arthritis (Clinical)			X	X	X	X								
Diagnosis Based on MRI			X	X	X	X	X							
Skin Les			X											
Arthritis Bone Injury			X	X	X									X
Complete Medical History (CPI)			X	X	X	O	O						X	X
Neurology			X											X

X = Do not use these methods together for evaluating a single impairment.
O = Use specific instructions for CPI of the lower extremity.

Novel, wrong approaches

- "Grazing" through the *Guides* rating for any symptoms similar to the patient
- Chapters 2 – 4: Erroneous rating of unrelated vascular and pulmonary disease
- Chapter 8 (Skin): Rating for scars when no interference with activities of daily living
- Chapter 9 (Hematopoietic System): Rating alleged inflammatory response as a white blood cell disease

Novel, wrong approaches

- Chapter 13 (Central and Peripheral Nervous System): Rating subjective complaints (including sleep) when no neurological injury or illness, and rating subjective chronic pain complaints
- Chapter 15 (Spine): Rating for corticospinal tract injury when none exist

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Novel, wrong approaches

- Chapter 16 (The Upper Extremities): Rating for doubtful diagnosis of CRPS (the diagnosis of "tendonitis" appears to be decreasing, and CRPS appears to be increasing)
- Chapter 18 (Pain): Rating for pain when impairment encompassed by Conventional Impairment Rating System and double dipping

Reviewing Reports: Inside Perspective

Review Process: Inside Look of Rating Critique Process

1. Go to the end of the report
2. Review and assess the report
3. Review and assess other documentation
4. Define clinical and other key issues
5. Apply criteria to independently assess impairment
6. Critique prior rating

1. Go to the end of the report

- Who did the rating?
 - Treating vs. unbiased
- What was the rating?
 - Consistent with anticipated rating?
- What was the rating procedure?
 - Was the title "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition" referenced correctly?
 - Were specific Tables, Figures and page numbers referenced?

2. Review the report and assess

- Quality
- Clinical information: history, subjective and objective
- Clinical analysis
- Criteria application

Report Review: Clinical information

- Date of evaluation versus date of injury should be greater than 6 months (need to be at maximum medical improvement – MMI)
- Clinical history adequately documented
- Current symptoms and activities of daily living adequately documented

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Report Review: Clinical Information

- Physical examination appropriate
 - Negative, positive, and non-physiological problems appropriately documented?
 - Findings specific, objective, consistent, and (where applicable) quantitative? Versus non-specific (“cervical spasm”), not objective (“tenderness” – a report), inconsistent (compared to other documentation), and vague (“some atrophy”)
 - Caution with multiple positive “named” tests, e.g. chiropractic jargon

Report Review: Clinical Analysis

- Diagnoses specific, supportable and causally related to event? Versus non-specific diagnoses “Strain, sprain, subluxations”
- Subjective complaints supported by objective findings?
- Other explanation for complaints? (including behavioral and litigation related)

Report Review: Criteria application

- Are specific Tables, Figures and page numbers referenced?
- Is the rating process appropriate based on the clinical information presented?
- Is apportionment applicable?
- If rating process inappropriate, what is the probable impairment?

3. Review and assess other documentation

- Injury (mechanism of injury and documented problems, e.g. review accident reports, initial records)
- Pre-existing status (identify prior injuries, treatment, difficulties, litigation)
- Assess causation and determine if apportionment is applicable (for causation to exist must have a cause, an effect, and relationship between cause and effect)

Review and assess other documentation

- Clinical course (determine if appropriate for condition)
- Diagnostic studies (significance of findings, vs. unrelated findings)
- Treatment (appropriate vs. unneeded passive modalities, manipulations, medications and surgeries)

4. Define clinical and other key issues

- Reassess diagnoses and relationship, if any, to injury
- Determine if apportionment appropriate or problems due to unrelated conditions
- Assess appropriateness of care
- Assess consistency of findings

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5. Apply criteria to independently assess impairment

- Based on clinical information provided, determine ratable impairment, referencing Tables, Figures and page numbers in the *Guides*

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6. Critique prior rating

- Critique prior rating
- Compare rating based on review with that of prior evaluator
- Assess quality of prior report (history, physical examination, clinical analysis, criteria application, and report quality)

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Conclusion

- Define a standard process for reviewing a report
- Critique every impairment rating

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Cross Examination Issues and Techniques

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Attacking and Defending Reports

1. Doctor's training and qualifications
2. Doctor's experience in working with the *Guides*
3. Material reviewed
4. AMA *Guides* title
5. Report elements

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Attacking and Defending Reports


6. Doctor bias
7. Steps of evaluation
8. Criteria application
9. Pain rating
10. Specificity

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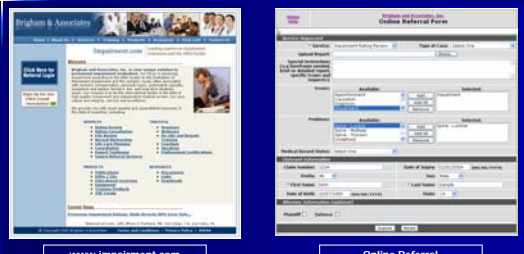
Options for Verifying Correctness of Rating

- Calculate Impairment
- State appointed Rater
- Computerized software
- 3rd Party Rater



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Rating Review Process



www.impairment.com Online Referral

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Rating Review Process




Report Database

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Resources www.impairment.com

- eZine
- GuidesIQ™
- Webinars – web-based seminars on the *Guides*
- DVDs – *Guides* seminars on DVD
- AMA *Guides* training CD
- ePublications

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