


# Best Practices to AMA Guides Impairment Ratings

## AMA Guides Impairment Ratings

### Best Practices Approaches

Specific strategies to cost-effectively manage the challenge of incorrect ratings.



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- Author of several texts, and nearly 200 articles
- Founder of ABIME
- Performed and reviewed several thousand evaluations
- Taught physicians throughout the US, Canada, Australia and Asia skills in performing evaluations; Consultant

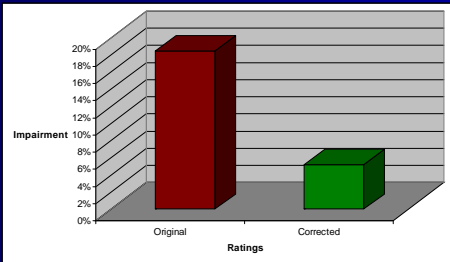
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### Corrected vs. Original Ratings

86% Error Rate    Average 18.5% vs. 5.2%



(874 cases July 2006 – February 2007)

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### What do erroneous ratings cost your client and what is the ROI for intervening?

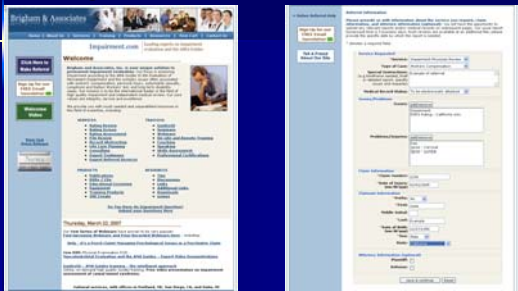
- What percentage of your ratings are erroneous? Do you really know?
- Of the erroneous ratings, what was the average erroneous WPI and what should it have been?
- What dollar value does this reflect?
- How successful are you in having physicians correct their ratings?
- How many impairment cases do you have per year?
- What is your opportunity?

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### Rating Review Process



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Online Referral

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### Rating Review Process

Web-based Data Management System – Specific for Impairment and Disability Ratings



Case Intake    Primary Reviewer    Physician Reviewer    Senior Reviewer

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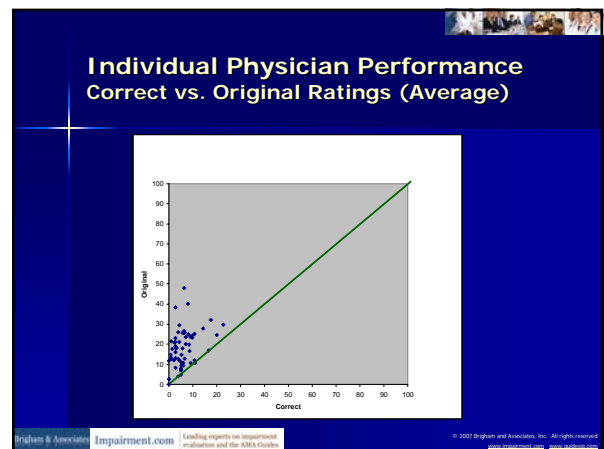
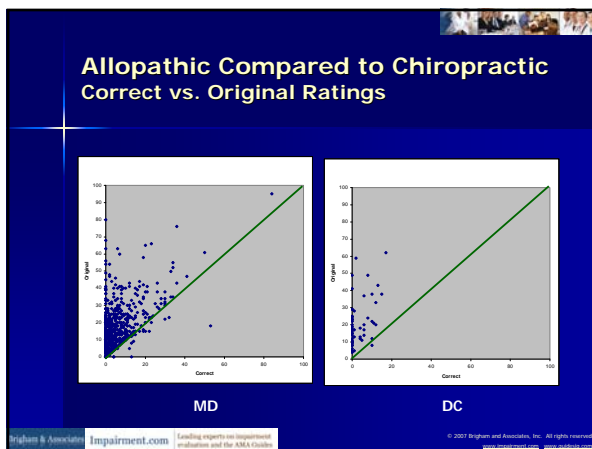
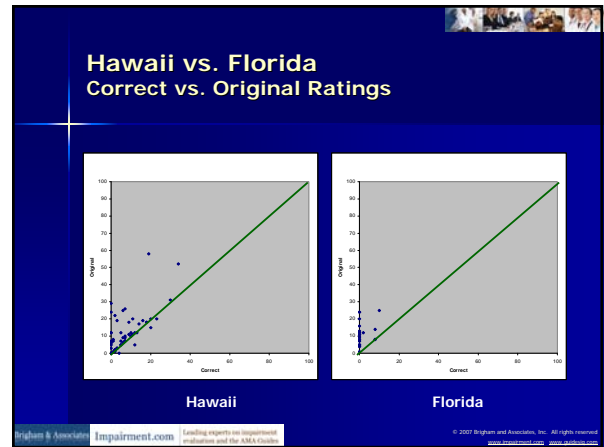
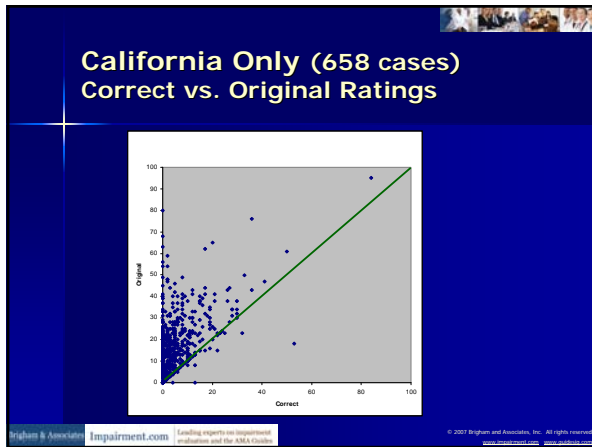
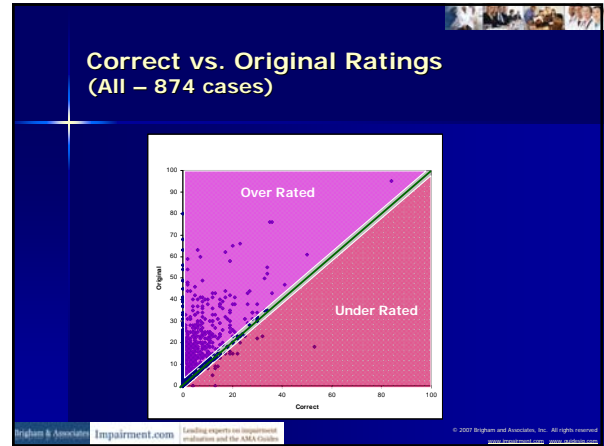
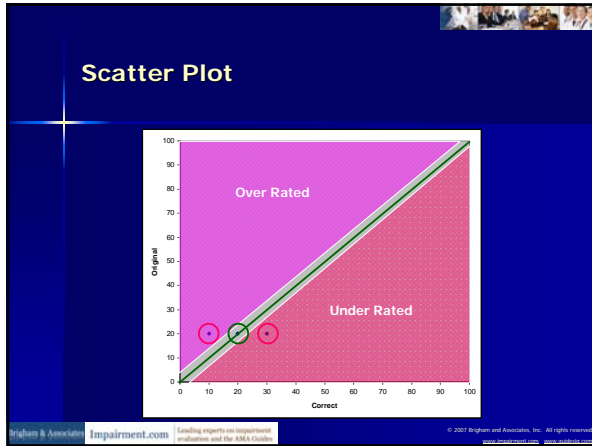
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# Best Practices to AMA Guides Impairment Ratings

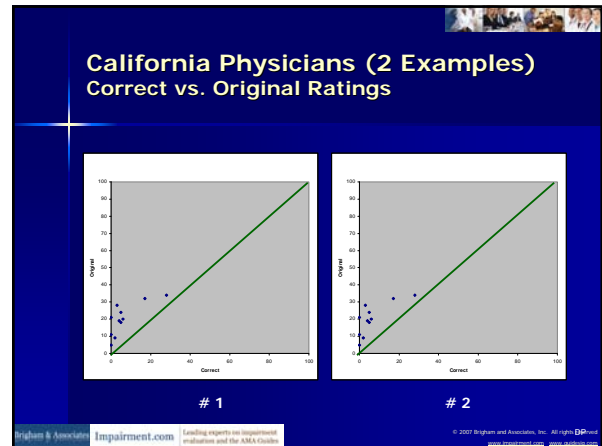
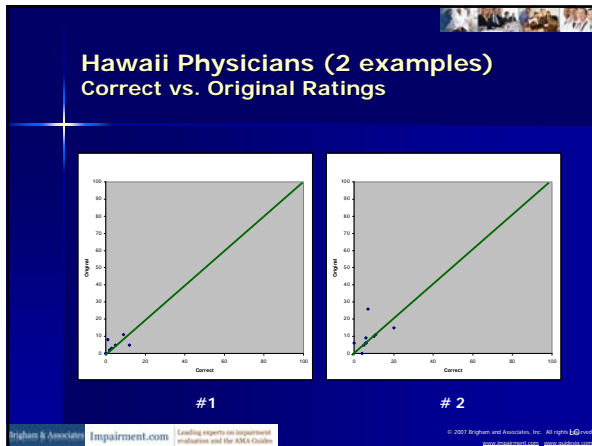
## Rating Data Collection



# Best Practices to AMA Guides Impairment Ratings



# Best Practices to AMA Guides Impairment Ratings



### Best Practices Approach: Expert Review of All Ratings

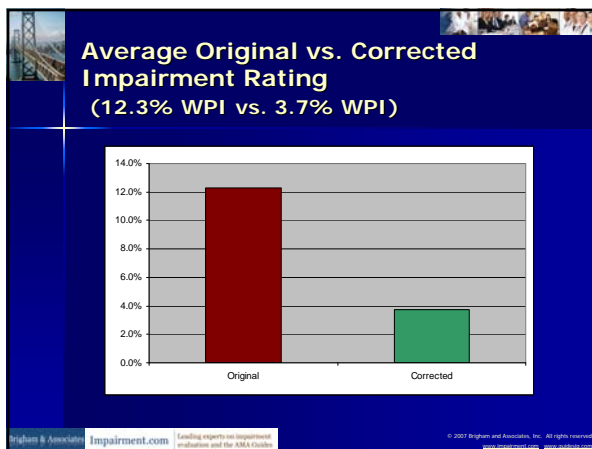
- Best practices approach is to review every rating.
- Initial review is a low-cost impairment screen (cost of \$95 if rating correct and typically \$195 if incorrect) with more detailed analysis and reports available on those with significant errors (fee based on complexity of case and time involved, and whether rater only or physician review)

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### Best Practices Approach of a California Self-Insured Client

Review of all reports by California client reviewed 82% error rate

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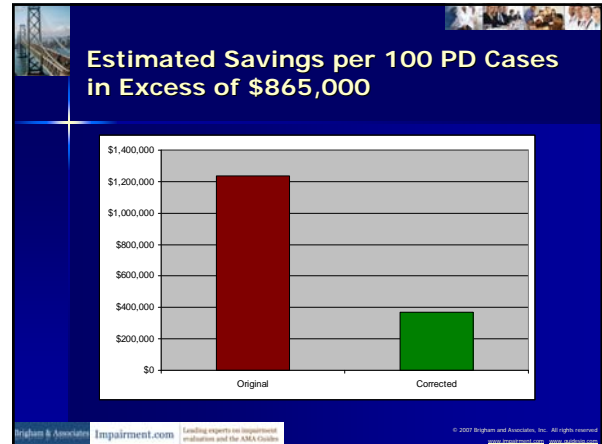
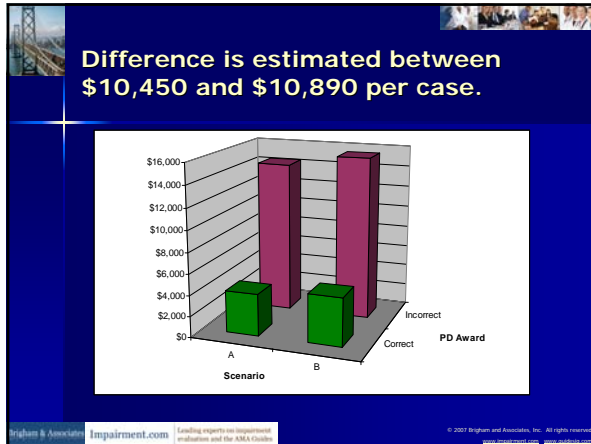


### Impact of Erroneous Impairment Ratings – Significant Financial Costs

- Converts to PD ratings in the range of 18% to 19% PD and corrected PD ratings of 6% to 7% PD.
- Assuming a January 2005 date of injury and maximum weekly wages, the California PD benefit award based on the original ratings would be between \$14,410 and \$15,510 and the corrected ratings between \$3,960 to \$4,620

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# Best Practices to AMA Guides Impairment Ratings



- Use of Critiques and Reports**
- Case management and strategy
  - Feedback to the treating physician (most often they will correct rating)
  - Negotiation
  - Preparation for effective cross-examination
  - Evidence
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- Most impairment evaluation reports do not meet the standards defined in the Guides**
- Reference Criteria in Section 2.6, Section \*.1, and text (useful content for review and preparation of cross-examination)
  - Substantial medical evidence challenges are probable in most AMA Guides impairment ratings.
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- Use of Data**
- Quality improvement
  - Profiling physician performance
  - Selecting an AME physician
  - Case reserving (defining impairment values for specific diagnoses)
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**Data capture and analysis essential to claims management**

Example from ICD-9 Report (data also provided by Impairment Number)

ICD9Code	Diagnosis	Original Rating	Corrected Rating	Cases
354.0	CARPAL TUNNEL SYNDROME	10.5 %WP	3.2 %WP	91
354.2	ULNAR NERVE LESION	11.6 %WP	2.1 %WP	8
802.9	SPRINTERSON NOS	21.0 %WP	12.7 %WP	7
717.3	DERANG MED MENISCUS NEC	6.2 %WP	1.2 %WP	5
717.7	CHONDROCALCIA PATELLAE	3.8 %WP	0.5 %WP	6
717.89	INT DERANGEMENT KNEE NEC	4.7 %WP	2.8 %WP	7
717.9	INT DERANGEMENT KNEE NOS	7.9 %WP	3.3 %WP	13
722.0	CERVICAL DISC DISPLACMENT	19.4 %WP	15.9 %WP	7
722.15	LUMBAR DISC DISPLACEMENT	14.6 %WP	9.0 %WP	23

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# Best Practices to AMA Guides Impairment Ratings

## Example of Physician Critique Data

Name	State	Rating - Average		Quality Scores - Average					# of Cases
		Original	Revised	History	Exam	Analysis	Rating	Report	
Dr. Dennis	M.D.	24.0 %	9.8 %	3.5	3.3	3.3	2.8	3.5	4
Dr. Steven	M.D.	7.0 %	5.5 %	2.7	2.7	3.0	2.7	2.7	3
Dr. Mark	M.D.	12.0 %	2.0 %	2.8	2.5	2.5	2.3	2.5	4
Dr. Jeffrey	M.D.	26.7 %	6.3 %	3.0	3.7	3.0	2.0	2.7	3
Dr. Robert	M.D.	48.0 %	6.3 %	2.7	2.3	2.3	2.0	2.3	3
Dr. James	M.D.	0.0 %	0.0 %	3.7	3.3	2.7	4.0	3.7	3
Dr. Steven	M.D.	20.0 %	7.0 %	2.6	2.2	2.1	2.0	2.1	10
Dr. John	M.D.	16.0 %	2.7 %	2.2	2.2	2.0	2.0	2.1	9
Dr. Stephen	M.D.	24.3 %	10.0 %	3.3	3.7	3.0	3.0	3.0	3
Dr. Thomas	M.D.	7.7 %	5.0 %	3.3	3.3	3.3	0.7	2.0	3
Dr. Paul	M.D.	9.5 %	5.3 %	2.8	2.5	2.0	2.0	2.5	4
Dr. Leonard	M.D.	18.0 %	3.7 %	4.0	3.0	2.3	2.3	3.0	3
Dr. Richard	M.D.	16.3 %	4.3 %	2.7	2.7	2.3	2.3	2.3	3
Dr. Brian	M.D.	26.0 %	3.8 %	2.5	2.5	2.0	2.0	2.3	4
Dr. Nicholas	D.C.	11.8 %	0.0 %	2.8	2.8	2.3	2.0	2.3	4

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## Root Causes of Incorrect Ratings

1. Resistance to change (from old to new Permanent Disability Rating Schedule)
2. Inexperience and lack of interest
3. Applicant oriented physicians attempting to misapply *Guides* to inflate ratings (physician profiling supports this observation)
4. Errors in clinical and causation - apportionment analysis
5. False reliance on software systems (without understanding the principles of assessment)

## Bias – a problem especially for the treating physician

- "An impairment evaluation is a medical evaluation performed by a physician, using a standard method as outlined in the *Guides* to determine permanent impairment associated with a medical condition. . . . The physician's role in performing an impairment evaluation is to provide an **independent, unbiased assessment** of the individual's medical condition, including its effect on function, and identify abilities and limitations to performing activities of daily living as listed in Table 1-2." (5<sup>th</sup> ed., 18)

## Errors in Clinical Analysis

- Rating an incorrect diagnosis (ex. CRPS)
- Rating prior to maximal medical improvement (MMI)
  - "a condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment." (5<sup>th</sup> ed., 601)
  - Most conditions 6 months to 1 year, often longer with CTS with residuals, neurological injury, hand injuries, and head injuries

## Erroneous clinical findings result in erroneous ratings

- Findings must be reproducible
  - "Two measurements made by the same examiner using the *Guides* that involve an individual or an individual's function would be considered consistent if they fall within 10% of each other. Measurements should be consistent between two trained examiners or by one observer on two separate occasions, assuming the individual's condition is stable." (5<sup>th</sup> ed., 20)

## Many clinical findings are not totally objective

- Range of motion (active)
- Strength
- Sensation
- All dependent on the examinee.
- Examinee can demonstrate less capability than actual, however cannot demonstrate greater capability.

# Best Practices to AMA Guides Impairment Ratings

## 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

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## Example #1

- Commentary on Example #1
- This report is not AMA compliant and is not substantial evidence for the following reasons:

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## Example #1

- Expert Analysis – It is probable that the report is not “compliant”, however it is also probable there is no ratable impairment. Impairment is assessed when maximal medical impairment (MMI); hypothetically if there was ratable spine impairment it is not probable that she would be at MMI 2 months post injury. It is probable that it does not have the detail required as defined in Section 2.6 Preparing Reports (5th ed., 21-22), Section 15.1 (5th ed., 374-379) or Table 15-1 Physical Examination (5th ed., 375).

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## Example #1

- Impairment would be rated by the DRE method. “The DRE method is the principal methodology used to evaluate an individual who has had a distinct injury.” (5th ed., 379). It is probable there are (will be) no ratable clinical findings per Box 15-1 (5th ed., 382) and therefore would be DRE Category 1, 0%.

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## Example #1

- There is no correlation between disc bulging, injury, and low back pain (LBP). Disc bulges are seen in asymptomatic adolescents (Kjaer P, An Epidemiologic Study of MRI and Low Back Pain in 13-Year Old Children. *Spine* 2005; 30 (7): 798-806) and become more common with aging. (Kjaer P, Magnetic Resonance Imaging and Low Back Pain in Adults: A Diagnostic Imaging Study of 40-Year Old Men and Women. *Spine* 2005; 39 (10): 1173-1180) LBP is a common and usually a real complaint; but there is often no identifiable underlying pathology, and generally no permanent impairment.

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## Example #1

- A landmark prospective study performed by Eugene Carragee, MD and published in 2 articles in 2006 (Carragee E, Alamin T, Cheng I, Franklin T, van den Haak E, Hurwitz E. Are first-time episodes of serious LBP associated with new MRI findings. *The Spine Journal* 6: 624-635, 2006. Carragee E, Alamin T, Cheng I, Franklin T, Hurwitz E. Does Minor Trauma Cause Serious Low Back Illness? *Spine* 31(25):2942-2949, 2006.) reported that findings on MR imaging within 12 weeks of serious LBP inception are highly unlikely to represent new structural change.

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# Best Practices to AMA Guides Impairment Ratings

### Example #1

- Most abnormalities (loss of disc signal, facet arthrosis, and end plate signal changes) represent progressive aging, not acute trauma. In the study, Dr. Carragee found that among persons with known risk factors for lumbar degenerative disc disease, but with no history of serious low back pain, minor trauma does **not** appear to increase the risk of (cause) serious LBP episodes or disability. The outcome of the vast majority of episodes of low back pain or "injuries" may be predicted by a small set of demographic and behavioral variables, not by structural findings or minor trauma.

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### Example #1

- Expert Analysis – There is absolutely no indication that these films are required in this case. Clinical definition for instability is very rare, and when occurs is typically in the elderly with high force trauma. "When routine x-rays are normal and severe trauma is absent, motion segment alteration is rare; thus, flexion and extension x-rays are indicated *only* when the physician suspects motion segment alteration from history or findings on routine x-rays."

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### Example #1

- Expert Analysis – There is absolutely no rationale to support the need for EMG / NCV. There are no symptoms in the specific distribution of a nerve root, no objective findings (sensory deficits, motor deficits, atrophy, and/or reflex abnormalities), and no radiographic findings suggestive of a lesion that would result in a radiculopathy.

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### Example #1

- Expert Analysis – Although there is no documentation of inclinometric range of motion assessment (as described in Section 15.8 and 15.9, 398 – 410), the Range of Motion method is not applicable. Therefore, these are not required.

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### Example #1

- Expert Analysis – This is a mute point. Current science supports the conclusion that the radiographic findings are common and cannot be reasonably attributed to the injury.

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### Example #1

- Expert Analysis – There is no Category ID; assume the reference is to Category III. This Category is not applicable since there is not even a single **objective** finding of radiculopathy, furthermore would not be Category II since "nonverifiable pain is pain that is in the distribution of a nerve root but has no identifiable origin." The "bulge" is not a determinate for impairment. "It is important to note that a positive imaging study in and of itself does not make the diagnosis." (378)

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## Example #1

- Expert Analysis – The DRE method is the correct method since “distinct injury” and does not meet any of the criteria that mandates the use of the ROM method.

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## Example #1

- It is probable that the report was “non compliant”, however it is also probable that there is no ratable permanent impairment.
- All of the commentaries and the final rating were incorrect.

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## 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.” (5<sup>th</sup> ed., 508)

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## Lower Extremity Impairment Errors

- Combining duplicative impairments inappropriately
- Rating for gait derangement or muscle strength
- Rating for arthritis without adequate assessment of causation and apportionment

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## Pain Impairment Errors

- Duplicating rating provided by Conventional Impairment Rating System
- Rating “ambiguous or controversial syndromes”, such as myofascial pain syndrome, fibromyalgia, and thoracic outlet syndrome
- Assigning a numeric rating more than 3% whole person

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## 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 - cytokines

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# Best Practices to AMA Guides Impairment Ratings

## Novel, wrong approaches

- Chapter 13 (Central and Peripheral Nervous System): Rating subjective complaints (including sleep and sexual dysfunction) when no neurological injury or illness, and rating subjective chronic pain complaints

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## Software Rating Errors

- Over reliance on software systems without understanding the principles of impairment assessment results in erroneous ratings, or perhaps purposeful attempt to mislead
- “Garbage in – Garbage out”
  - This saying points out the fact that a computer can do only what it is programmed to do and is only as good as the data it receives and the instructions it is given. If there is a logical error in software, or if incorrect data are entered, the result will probably be either a wrong answer or a system crash. The saying is sometimes shortened to “GIGO” (GUY-go). (The New Dictionary of Cultural Literacy, Third Edition. 2002.)

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## Software Rating Errors

Range of Motion	Flexion	Extension	Total Imp
Flexion	90 (R)		
Extension		30 (L)	
Adaptation	None		0
Other Disorders	None		0
Total Impairment			30

Figure 16-32 Flexion and Extension of Elbow

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## Software Rating Errors

Range of Motion	Flexion	Extension	Total Imp
Flexion	90 (R)		
Extension		30 (L)	
Adaptation	None		0
Other Disorders	None		0
Total Impairment			30

Figure 16-38 Shoulder Flexion and Extension

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## Strategies to assure accurate ratings

- Understand the challenges and opportunities for improvement – with excellent return on investment
- Obtain accurate, unbiased ratings
- Expert evaluation of all impairment ratings
- Manage erroneous ratings
- Discredit erroneous ratings

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## Selection of Impairment Review Services: Recommended Criteria

- Does the reviewer have substantial experience with the *Guides*? (i.e. performed or reviewed > 500 AMA Guides ratings)
- Does the review involve an experienced physician who is appropriately credentialed? (ABMS board certified, Certified Independent Medical Examiner, Certified Impairment Rater)
- Do the participants understand the specific challenges of workers' compensation in California and does the organization have an office in California?
- Is there nationally recognized leadership in regards to the *Guides*? (Therefore resulting in higher quality review, better access to resources, and greater credibility.)

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## Selection of Impairment Review Services: Recommended Criteria

- Can referrals and records be provided via the Internet?
- Are reviews performed in a timely manner, typically within 5 days, with a low-cost screening review option?
- Are detailed narrative critique reports available that will clearly explain any errors and the rationale for the correct ratings?
- Does the organization collect and analyze data on every review and also provide you that data electronically?
- Can the organization provide you with both case specific summary and narrative reports, and group data?
- Does the organization have an effective quality assurance process?

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## Specific Recommendations

- Implement an approach that reflects best practices for evaluating and managing impairment ratings, starting with low cost screen and more detailed assessment when required.

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## Specific Recommendations

- Educate your clients of the significant impact of erroneous ratings and as a firm distinguish yourselves by your ability to manage these ratings.
- Educate yourselves and other participants in the use of the AMA Guides ([www.guidesiq.com](http://www.guidesiq.com))

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## Specific Recommendations

- Utilize our expert services in a consultative role. (Use technologies such as gotomeeting.com and skype to facilitate the meeting.)
- If develop significant relationship, access is provided to data.

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## Discussion

- What is your understanding of the scope of the problem and the potential achieved by obtaining correct ratings?
- What are the next steps in implementing the best practices approach of expert review of all ratings?
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## Thank you

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