Kansas AFL-CIO

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SENATE BILL 73
TESTIMONY OF KANSAS AFL-CIO
IN OPPOSITION
MARCH 14, 2013
HOUSE COMMERCE, LABOR AND ECONOMIC DEVELOPMENT COMMITTEE

Mr. Chairperson and Members of the Committee:

The Kansas AFL-CIO opposes the passage of Senate Bill 73 in its present form. There are three areas of concern to the Kansas AFL-CIO.

A. Recusal

The Kansas AFL-CIO is concerned about the appeal going to the Kansas Court of Appeals prior to full litigation of the claim. The way the statute is written, it could take three or four years before it is even determined who the judge should be in the case in chief. In short, after the five member Board of Appeals makes a determination relative to the judge, further appeals should not be permitted until the case is finalized.

Delay over determining who the judge should be is more detrimental to the injured worker than the respondent/insurance carrier.

B. Notice

In 2011, an ad hoc committee spent weeks compromising workers compensation legislation. Part of that compromise was a flat 30 day time limit for notice. This is consistent with virtually every state. The notice agreed to by the parties was shortened under certain circumstances to 20 days.

The purpose of notice is primarily to prevent fraudulent claims. Shortening the notice to ten days (an incredibly short period of time) does nothing to accomplish this goal. For example, if an individual injures himself over the weekend, that individual is not going to miss the notice requirement of the law. He will give notice at the end of the day on Monday, or on Tuesday morning.

A short notice traps the honest injured worker. Workers do not want to be in the system, and it is a black mark against them to file claims

when trying to obtain/retain employment. Honest workers hope their injuries will be temporary and simply go away, and they often cannot even see a doctor within the ten days from onset of a problem.

C. AMA Guidelines - 6th Edition

The bill proposes mandatory use of the 6th Edition of the AMA Guidelines as opposed to the 4th Edition (present law). Allegedly, this is to simply "update" Kansas. We believe that this change in the law will have substantial unintended consequences.

Researching the 6th Edition of the AMA Guidelines on the Internet brings up literally thousands of articles. In those articles, of which we are attaching a small sample, there are consistent themes from other states.

It is important to understand that a minority of states use the 6th Edition. The 6th Edition of the Guides was published in 2007. Currently, it is believed that 19 states (including Missouri) do not use the Guides at all. Twelve states apparently use the 6th Edition, and 19 states use either the 3rd Revised, 4th, or 5th Edition. The bottom line is that no one claims the 6th Edition is the "Holy Grail."

By definition, any rating system is arbitrary in nature. There is nothing scientific about a certain shoulder injury representing a 10% loss of function. Why not 8%, or 12%, or 15.2%? The Guides merely attempt to establish some consistency from doctor to doctor, and patient to patient. "Newer" does not necessarily mean "improved" or "more scientific."

In addition, there are these issues:

a) There is nothing more objective, evidence based, nor more "scientific" about the 6th Edition as compared to previous editions. (See attachments.)

b) The 6th Edition specifically objects to "treating physicians" rating their patients; and advises that any "rating physicians" receive significant training because of the complexity of the 6th Edition.

c) There is a shortage of doctors who are willing to rate injured workers in Kansas. In the words of the attached authors, doctors do not avoid rating under the 6th Edition, they "run from rating" under the 6th Edition.

d) Workers compensation laws are fixed by the date of accident. Thus, every time there is a legislative change, an entire new set of rules applies. Kansas underwent a major change in May 2011. The changes made previously have caused increased litigation and uncertainty. Additional changes will add to litigation and uncertainty. There have still been no decisions interpreting changes which took place two years ago.

e) The ad hoc committee which negotiated and presented to the legislature the changes in 2011 discussed and rejected a change from the 4th Edition. In part, the framework for the "new act" was premised around the 4th Edition.

It would appear that the singular purpose in promoting the 6th Edition is the belief by some that it will lower benefits to injured workers and their families. (There was never a discussion in Kansas about adopting the 5th Edition because businesses feared it would raise benefits to workers.) Kansas already has virtually the lowest benefits to workers in the nation, and the 2011 changes have excluded many injured workers from receiving any benefits.

In short, we believe that adoption of the 6th Edition should be rejected as multiple other states have done. We believe it is bad for employers, insurance carriers, and injured workers.

Respectfully submitted,

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Bruce Tunnell

Exhibit F

THE AMA GUIDES SIXTH EDITION TASK FORCE MEMBER REPORT

On June 26 2008; June 27, 2008; July 30, 2008 and July 31, 2008 a panel of nine met to discuss the problems associated with incorporating the sixth edition of the AMA guides into the Iowa Workers Compensation legal system. One additional meeting is scheduled August 26, 2008.

The Task Force has no final decision making authority. The Task Force is charged with making findings and recommendations. The Task Force is composed of a non voting deputy commissioner moderator, two former deputy commissioners now working as ALJ's in non work comp assignments, two attorneys who practice primarily for the defense, two attorneys who practice primarily for the claimant and two accomplished physicians with extensive Iowa workers compensation experience.

Upon completion of the fourth day of study, after numerous presentations by 6th edition contributors and Iowa doctors, the Task Force voted to recommend rejection of the sixth edition. The Task Force also recommended rejection of Chapter 14 of the sixth edition after a lukewarm endorsement by a well recognized Iowa clinical psychologist. Chapter 14 had shown promise. The Task Force also concluded that the sixth edition modifies some impairment ratings both up and down. Some ratings stay the same. Insufficient data is available to make any sound conclusions concerning global impact on impairment ratings.

Upon completion of significant study and four days of discussion the following opinions are expressed if the sixth edition is adopted as a guide by the Iowa Workers Compensation Commissioner under rule 876 IAC 2.4(85,86) . The following opinions are solely attributable to the undersigned and should not assume consensus of any other task force member. However the conclusions are largely the result of significant debate among the members.

The AMA Guides to the Evaluation of Permanent Impairment are used primarily by state workers' compensation systems. About 80% of the guides use is in work comp. A wealth of credible opinions brings forth the conclusion that doctors should not rate impairment under the sixth edition without first receiving formal training. Impairment analysis under the sixth edition is complex and burdensome. This conclusion was voiced not only by Task Force doctors but by contributors to the sixth edition. A doctor should expect 24 to 30 hours of self study to establish proficiency. In the alternative 8 hours of seminar training may suffice.

The fifth edition of the guides is deficient in that it fails to properly address epicondylitis, fibromyalgia and mental impairments. The Task Force is unwilling to recommend piece meal incorporation of the sixth edition, even temporarily, to address deficiencies of the fifth. The practicing Iowa lawyers understand that sixth edition ratings are admissible evidence even if not incorporated by rule 2.4. In litigated cases these conditions will most likely receive ratings and compensation where causation is established. However, since 80% of cases are not litigated a significant number of claimants will have compensable injuries that remain uncompensated because rule 2.4 makes the fifth edition prima facie evidence of compliance. The conclusion is that the majority of the three referenced ratable work injuries remain uncompensated.

It is recommended that the commissioner focus primarily on voluntary compliance when considering changes to the Iowa impairment rating system. The vast majority of Iowa work injuries resolve voluntarily. The Iowa work comp commissioner's 2007 statistics show about 22,000 work injury reports with a resulting 4,000 petitions filed and 600 hearings held. Thus, 80% of reported injuries are resolved without commissioner involvement. It is Iowa's voluntary compliance that allows Iowa's work comp system to function efficiently with only 29 employees. Voluntary compliance is driven by the predictability and consistency of permanent partial disability and industrial disability values. Sending even a small number of additional cases into litigation status will swiftly drain the commissioner's resources. Voluntary compliance is of paramount importance with litigation concerns a distant second. The Task Force is composed primarily of

litigation oriented individuals; consequently the focus often turns to litigation problems. The commissioner is discouraged from considering litigation as the primary consideration.

If adopted by Iowa the complicated nature of the sixth edition ppi paradigm will create a cascade effect within the industry. The following predictions are made should Iowa adopt the sixth edition as a guide to impairment under rule 2.4. Analysis is broken down by the end user in a cost, benefit and risk format. As previously stated the predictions below are solely the opinions of the undersigned. These are opinions and not factual findings.

1. **Employer, Insurance Company, Self Insured**

COST:

Incorporation of the AMA Guides sixth edition results in increased costs for the insurer, employer and self insured employer. First, there are costs associated with administration of the new guides. Insurance adjusters and claims personnel require training on the new guides due to the marked differences when compared to the prior editions. The sixth edition is so revolutionary that even doctors are advised to avoid its use without proper training. Due to normal and ongoing high turnover in claims personnel this administrative cost continues indefinitely.

The insurer and self insured need to adjust reserves in low back cases which receive higher ppi ratings under the sixth edition. This is especially true in non litigated cases where voluntary payments generally increase with the higher ppi ratings. This is offset somewhat by the lower ratings offered for less frequent cervical spine injuries in non litigated cases. Since low back injuries are more common an overall reserve increase is expected in non litigated industrial disability cases.

The overall industrial disability cost in litigated industrial disability cases does not change from past experience.

There is anecdotal evidence that the sixth edition lowers ppi values in scheduled member injuries. This information fails to take into account the frequency of particular injuries. The sixth edition is at significance variance with the fifth edition with respect to scheduled member ppi ratings. Some ratings go up and some go down. To conclude this as a windfall to the insurance company and self insured is foolishly premature. The prudent claims manager must closely monitor scheduled member injury reserves to avoid future financial difficulty. It is more than likely that scheduled member payouts based on ppi ratings under the sixth will be a wash to the insurer. Most doctors will not study the guides carefully and just carry on with ratings traditionally given in years past. Nevertheless, scheduled member reserves must be studied in great detail by the insurance company and self insured.

Benefits:

The purported advantage of the sixth edition is interrater consistency. The sixth edition provides a single number for a given diagnosis rather than a reference range. This should improve ppi rating consistency between physicians with proper training. This probably won't happen for years. First, the Iowa legal system is adversarial and divisive by nature. Since employer selects the treating doctor the conservative rating is generally granted by the treating physician. The section 85.39 IME is generally claimant oriented. The sixth edition is subject to the same conservative/liberal bias as the fifth edition. It is unlikely this benefit will accrue for many years, if ever.

Risk:

Under the sixth edition the insurance carrier and self insured experience markedly increase costs for medical testing and section 85.39 IME exams. The sixth proves a tedious and convoluted

method for determining impairment as compared to the fifth. Increased time preparing sixth edition ppi reports demands higher fees for section 85.39 IME exams. Some sections seem to demand testing before assessing impairment. If the treating doctors read the sixth edition carefully it may change habits of testing and treatment resulting in higher costs. Most doctors will not read the sixth that closely and continue on with what they believe is reasonable and necessary.

The sixth edition initially increases litigation costs. The new methodology invites a variety of legal issues. A fair number of cases of first impression will work their way through the system during the sixth edition's infant years. Doctor's lack of training and experience result in a significant increase in taking of medical depositions. The legal costs level off after about two to three years and gradually move closer to pre sixth edition levels.

In summary, the greatest risk presented is improper reserving of scheduled member cases and un-represented industrial disability cases. Absent a true statistical analysis of a large number of cases the insurance carrier and self insured are in the dark for years concerning true costs of scheduled member ppi and non litigated industrial disability cases.

2. Unrepresented Claimants:

Cost:

The unrepresented claimant comprises the vast majority of Iowa work comp claims. Incorporation of the sixth edition polarizes lawyers into those who specialize in work comp and those who don't. This phenomenon has been growing for years. The high learning curve in the sixth hastens the trend. This in turn hurts the unrepresented claimant in the more rural areas who only have access to lawyers engaging in general practice. The recent increase in travel costs chills access to proper representation for a small number of claimant's with serious injuries.

A second class of unrepresented workers suffers under the sixth edition: Those who fall into a category with injury that would have been rated higher by the fifth than the sixth. There is also a category that receives no rating under the sixth but is rated under the fifth. For the individual the cost is significant. The average injured worker will not understand that under the fifth they could receive a rating. As such it will not impugn the integrity of the system. Unions are quick to adapt to this inequity pushing such cases to litigation resulting in precedent setting case law. Those without union representation remain largely uncompensated.

Increased travel costs result because many rural doctors refuse to provide sixth edition ratings due to the steep learning curve.

Benefits:

The unrepresented claimant benefits most in low back claims where the impairment ratings increase. Such claimant's realize higher net proceeds from voluntary payment of the ppi rating. Since low back injuries are the more frequent claim this is a significant benefit to the represented and unrepresented claimant.

Ppi ratings increase under the sixth in certain types of scheduled member injuries resulting in higher voluntary payments. The sixth provides a means to rate impairment of mental, epicondylitis and fibromyalgia work injuries.

In theory, the sixth edition should bring the ppi ratings closer together even when different doctors rate the same condition. This is an untested and unlikely outcome because the sixth edition's complexity encourages its improper interpretation.

Risk:

The unrepresented claimants' greatest risk is falling into one of the injury categories that result in lower or zero ratings under the sixth as compared to the fifth.

The second risk involves the class of immigrant workers with English as a second language. The sixth edition DASH and QUICK DASH system modifier is not appropriate for those with poor English skills. Many immigrants cannot complete this aspect of a sixth edition rating. As such, they lose out on one aspect of the sixth edition which increases ppi.

3. Claimant Attorneys and Represented Claimant's:

Cost:

Claimant attorneys experience a modest to moderate decline in revenues after incorporation of the sixth edition primarily due to voluntary ppi payments in low back cases and increased administrative lost time attributable to training.

The prudent claimant representative immediately takes intense training on use of the sixth edition. Self study is not sufficient to properly understand the convoluted paradigm. Furthermore, each time a supplement is presented the prudent claimant attorney takes a refresher course. Waiting to take a training course until after the supplements are published leaves the client at a significant disadvantage where sixth edition ppi ratings are at issue. The training is less important in cases of industrial disability and far more important to cases classified as scheduled member. Claimant lawyers devote more time to less valuable scheduled member cases resulting in revenue diminution. Familiarity with the sixth edition provides a strategic advantage in medical depositions. Initial deposition preparation time of 3 to 4 hours per chapter is generally required.

Benefits:

Claimant attorneys appreciate some scheduled member cases with higher ppi ratings as compared to the fifth edition. Claimant attorneys trained on the use of the sixth edition gain a strategic advantage in medical depositions as it is likely that treating doctors will be slow in understanding the new paradigm. Advanced training allows claimant's attorneys to educate their IME doctors to the pitfalls and advantages of the sixth edition.

Lawyers who specialize in work comp see increased client base as general practitioners shy away from cases with complicated medical issues involving the sixth edition. Knowledge of the new ppi scheduled member ratings allows the claimant attorney to screen out the injuries which are now lower under the sixth edition.

Risk:

Failure to take immediate and continuing training on the sixth edition use creates significant risk of poor awards and the rare legal malpractice claim. Since the sixth edition lowers and eliminates certain ppi ratings for specific injuries, the unwary lawyer may accept cases that receive inconsequential awards under the sixth. Awards and overall generation of revenues in work comp scheduled member injury cases is strongly related to a lawyer's knowledge of the sixth edition. This phenomenon will continue for several years until the Iowa doctors become familiar with the complicated new impairment system.

4. Defense Lawyers and Clients:

Cost:

As noted for claimant lawyers, the savvy defense lawyer immediately takes training in the sixth edition with refresher courses each time a supplement is published. Intimate knowledge provides

a strategic advantage in medical depositions. The savvy defense lawyer warns the client of higher legal costs continuing for several years due to the number of cases of first impression generated by changes in the sixth edition. Defense lawyers initially dedicate 3 to 4 hours of extra time preparing for medical depositions per chapter of the sixth edition.

Risk:

Defense lawyers who fail to warn and counsel clients of increased legal costs and the need to train insurance claims personnel, experience erosion of client confidence. Failing to get on top of the issue immediately and stay ahead results in loss of client base.

Benefit:

The administrative cost of training is offset by increased billings due to increased litigation in scheduled member cases and cases with issues of first impression. Defense lawyers experience an overall increase in revenues for several years while the cases of first impression work their way through the system. This flurry of litigation, after a few years, levels off but never does move back to pre sixth edition levels as the sixth will always require additional preparation time.

5. Medical Professionals:

Cost:

Doctors using the sixth edition face even greater challenges to their time. Incorporation of the sixth edition forces a costly learning curve with a choice of 8 hours seminar time or 24 to 30 hours of self study. Ppi evaluations under the sixth edition take significantly more time as compared to the fifth edition.

Complexities of the edition are detailed to treating and evaluating doctors by the various special interest groups within days of the sixth edition incorporation to rule 2.4. Doctors are promptly informed by this grapevine that training is mandatory prior to issuance of ratings under the sixth edition. Claimant lawyers inform and help educate the IME doctors while defense lawyers train and inform the treating employer selected doctors. As a result, a consensus emerges within weeks. The informed work comp doctor refuses to evaluate under the sixth edition until after attending a formal training course. The prudent and time starved doctors delay any training course until the sixth is supplemented at lease once and maybe until after several supplements are issued. Many doctors refuse to rate under the sixth edition resulting in reduced access to doctors willing to rate impairment and increased claimant travel costs borne by employers.

Benefit:

The sixth edition provides a solid number for ppi instead of a reference range. The sixth should eventually lessen the need for follow up letters, depositions and calls questioning the ppi rating. The ratings should be more consistent. However the opinion of one medical professional on the task force accurately predicts:

"The issue in the 6th edition is not interrater reliability; it is the data, the quality of the data, and the biases of the doctors who provided the numbers in the grids. If the underlying numbers are incorrect, or biased inappropriately in one direction or the other, then the outcome is still wrong, regardless of interrater reliability. "

This benefit is years in the future, if ever. Resolution of the ppi number differences in scheduled member cases is important. If the sixth is adjusted to match the ppi ratings in the fifth, faster and more widespread acceptance is expected.

This issue of changing impairment numbers was noted by the fifth edition authors at page five. The fifth edition authors indicated that numbers should not change arbitrarily.

Doctors are justified in charging higher fees when evaluating ppi under the sixth edition.

The sixth edition provides a guide to evaluate mental conditions which is absent in the fifth edition. Other conditions evaluated by the sixth are not addressed in the fifth. This impact is small due to the low volume of Mental Mental and Physical Mental claims.

Risk:

Early implementation of the sixth edition results in a marked increase in doctor depositions. This trend lasts for several years at a minimum. The time starved work comp doctor must manage this aspect of the practice to avoid being overwhelmed with depositions. Some doctors refuse to use the sixth edition to rate impairment because of this consequence.

The sixth edition also provides some treatment and ethical dilemmas for the treating doctor. The sixth edition seems to require certain tests prior to granting ppi; whereas, clinical examinations are sufficient for evaluation in the fifth edition. The conflicting views on testing and treatment present ethical questions for the work comp doctor. Since most doctors fail to read the sixth closely these ethical issues are overlooked. Should the sixth cause a liability or ethical issue for just one doctor, such would undoubtedly result in wholesale rejection by the medical community.

6. Workers Compensation Commissioner Administrative Costs

Cost:

Little in the way of training is required if the sixth edition is adopted as a guide. The significant increase in doctor depositions will train the deputy staff on the nuances of the sixth edition. The significant increase in deposition submission places a strain on deputy time.

The greater cost stems from appellate review. Adoption of the sixth edition generates a considerable flurry of litigation. Issues of first impression abound including but not limited to:

a) Does the sixth edition ppi rating in industrial disability cases incorporate traditional industrial disability factors? Does the ppi rating invade the province of the Commissioner?

b) Does the sixth edition ppi rating amount to a true rating of loss of use as defined by Miller making it the better rating for scheduled members as compared to other guides?

c) Does the sixth edition discriminate against immigrants and those with lower education and intelligence in the DASH and QUICK DASH modifier?

d) Does the sixth edition invade the province of the legislature by changing ppi values arbitrarily based on a consensus of doctors and not based on any scientific data?

e) Does the sixth edition violate Iowa law by rating simultaneous nerve injuries at 100% for the first, 50% for the second and zero % for the third?

Increases in deputy work load due to medical depositions will be easy to manage. Increased deposition submission does not significantly impact day to day operations for the deputy. Adjustments to work load shifting deputy hours to appellate hours causes increased time from hearing to decision at the deputy level. This impact will last at a minimum of three years. It takes at least 6 to 9 months before the flurry of litigation begins.

In Summary, the Commissioner's office experiences a considerable increase in appellate caseload resulting in a marked time increase from submission to final decision. Shifting of deputy work to appellate work is inevitable to balance the work load.

Benefit:

Adoption of the sixth under rule 2.4 has no practical benefit other than preparation for the seventh edition publication. Implementation and acceptance may take a full five years. If the seventh is based on the same paradigm and evolutionary the transition to the seventh edition is simple.

Risk:

There is significant risk to the Workers Compensation Commissioner's office. The paradigm shift in the sixth edition causes protracted litigation burdening the Commissioner's resources to the point that significant case backlogs exist at both the deputy and appellate level. The degradation of the litigation system spills over causing poor voluntary compliance by insurance carriers and self insured's. Case loads increase quickly and significantly.

Summary:

The sixth edition paradigm is not the future for Iowa. It is not a better system for Iowa work comp than the fifth edition. Iowa should continue with the fifth edition with modifications to correct some minor problems. Iowa should entertain the creation of its own diagnosis based scheduled member impairment guide that is simple and easy to use.

Respectfully submitted by,
Marlon D. Mormann, Administrative Law Judge
August 7, 2008.

7. 8/12/2008 Response to Mormann Analysis by Peter J. Thill, Defense Attorney

Alternate Summary

After a thoughtful review of the 5th Edition, 6th Edition with Errata, information and writings from other states workers' compensation systems, and various commentary by medical professionals actively involved in the creation and editing of the 6th Edition, I would not support adoption of the 6th Edition at this time or a separate Iowa Guide to the Evaluation of Permanent Impairment. I would be in favor of revisiting the possibility of adopting the 6th Edition after at least two years of data is available from other states or research groups comparing a large number of injuries rated under both the 5th and 6th Editions to determine the overall impact on ratings and whether interrater reliability is actually increased under the 6th Edition as suggested in the Guide in way that is fair to both Claimant and Employer/Insurance Carrier. Increased interrater reliability would in theory drive down litigation costs and increase predictability in scheduled member cases. Everyone in the system would benefit by increased interrater reliability in a way that is fair to all parties. The first most important step in ensuring increased interrater reliability is training in the use of any new Guides adopted by Iowa in the future. Without proper and consistent training of all medical professionals that will use a new addition of the Guides, interrater reliability would be only a possibility, not a probability. The complexities of 6th Edition warrant, in my view, a serious consideration of requiring state mandated training of all medical professionals that will use the Guides. The goals of state mandated training in the use of the Guides would be to increase interrater reliability, increase predictability in scheduled member cases, and thus decrease litigation costs (including decreased IMEs and depositions).

Peter J. Thill, Attorney at Law-

8. AUGUST 26, 2008 FINAL TASK FORCE MEETING

The task force met for a final meeting on August 26, 2008. The task force voted against recommending that Iowa create its own impairment guide notwithstanding a vote to create some type of guide to cover conditions not rated by the fifth edition. The task force voted to recommend several non-substantive changes to rule 2.4. A final presentation was given by Dr. Rondinelli, who generously volunteered his time on two occasions. The 52 page sixth edition errata published to the internet was discussed. One task force member printed the errata and taped its amendments into her copy of the sixth edition. The cut and tape task consumed 3.5 hours notwithstanding the member's intimate familiarity with the sixth edition guides. It would take much longer for a person not familiar with the guides. Concerns were expressed about the errata and the ongoing updates. The errata, considering its ongoing growth, increase the steep learning curve for the sixth edition. It appears the sixth edition was rushed to publication without proper review. It is obvious that the AMA used an inappropriate model for authoring the sixth edition when employing a committee of highly qualified doctors to form a consensus.

9. IOWA IMPAIRMENT GUIDE

A suggested long term solution for Iowa is to publish a guide to impairment addressing those few issues corrected by the sixth edition. The Iowa guide should also provide impairment ratings for more prevalent scheduled member injuries.

Immediately publishing by rule impairment rating guides for carpal tunnel syndrome, epicondylitis and fibromyalgia encourages voluntary compliance.

Insufficient information is available to make suggestions on impairment ratings in work related mental cases. The undersigned is gravely aware that mental injury impairment has been ignored by Iowa work comp for decades. The sixth edition chapter 14, while holding some promise, remains deficient. The errata resolve some issues. Many task force members simply refuse to accept the sixth edition in any form due to the steep learning curve. The trepidation of task force members is not well founded. Its incorporation would only affect a small number of Iowa mental health practitioners in an equally small number of cases. Iowa should not become the sixth edition chapter 14 guinea pig. Chapter 14 deserves a second review after two years.

The commissioner is encouraged to explore the Utah impairment guide as a model for creating an easy to understand and user friendly Iowa impairment guide. The Utah guide author indicates that no restrictions exist on its use. The Utah guide is not endorsed for its content but suggested only as a guide model written by a single author. Creation of an Iowa guide which complies with Iowa law is not expensive nor is time consuming. An easy to use guide promotes voluntary compliance. The easier it is to understand the greater the interrater reliability that results.

The Iowa commissioner is discouraged from creating a new guide for body as a whole injuries.

10. SUGGESTED FORMAT FOR AN IOWA IMPAIRMENT GUIDE

Iowa has much to learn from the AMA sixth edition mistakes. The AMA wrote a book by committee consensus. The AMA chose some of the best doctor's in the world as co-authors. This utopian management philosophy is highly impractical. Choosing the best doctors in the field and asking them to concede their expertise on any issue is not realistic. The result is a guide bloated with inconsistencies and burdensome procedure. The AMA violated some basic management tenets:

The best way to kill a good idea is to send it to committee.

No business achieves financial success when managed by consensus.

Autocracy is the most efficient form of governance.

The commissioner is encouraged to create a diagnosis based system of impairment rating for one to three conditions. Carpal tunnel syndrome is a good diagnosis to start with because of its prevalence. Historical ppi numbers from the fifth edition and case law are incorporated into the Iowa guide to maintain the status quo for impairment value. Fibromyalgia and epicondylitis impairment numbers are compiled from the AMA and other state's guides. Doctors now rate injury impairment based on experience as opposed to training and education. The percentage numbers used below are illustrative only.

A suggested Iowa impairment guide format follows:

CARPAL TUNNEL SYNDROME IMPAIRMENT GUIDE

0% No impairment

1% Good outcome

3% Average outcome

5% Poor outcome

Treating and examining doctors need no more instruction than the above to evaluate CTS impairment. Doctors simply answer a ppi question with no impairment, good outcome, average outcome or poor outcome. Doctors *no longer* use percentage numbers. The claims rep correlates the description of causally connected impairment outcome with the rule's CTS ppi number and pay accordingly. Doctors go back to practicing medicine rather than math. Minimal, Moderate and Maximal may also substitute for Good, Average and Poor language depending on the author's preference. The concept is to use one word that will categorize the treatment outcome which in turn corresponds to the final impairment value.

This guide model is so simple that an experienced claims examiner can make payment based on reviewing medical notes rather than waiting for an impairment rating. A simplified system dramatically increases voluntary compliance and reduces litigation for scheduled member injuries. The guide costs nothing to publish as it is posted to the commissioner's web page for easy access.

The commissioner is discouraged from creating an impairment guide for every diagnosis. The focus is best placed on injuries of high frequency. Consideration for inclusion are the top five or ten scheduled member injuries. Creating a simple guide for CTS alone will have a dramatic positive impact on voluntary compliance. A CTS guide provides necessary feedback for future diagnosis based, experience rated guides.

The greatest danger faced by the commissioner when creating an Iowa guide stems from litigation and political influence. Considerable pressure to over define each diagnosis and rating category is expected. Special interests may lobby to create ranges in each category such as 1% to 2% for good and 5% to 7% for poor. This would again force doctors into the mathematics realm, a concept that has not worked well under the AMA guides. The longer the definition, the less user friendly. The more discretion in impairment ranges the less predictable the outcome. Any Iowa work comp guide must be so user friendly that the majority of doctors pick up the concept after five minutes of self study. The Iowa guide is best authored by one person much like what occurred in Utah where implementation has experienced success. Editorial review is through the rule making process.

11. In conclusion, it is best to remain with the fifth edition unless the Iowa guide is significantly more user friendly. One person should author the Iowa guide to avoid inconsistencies and burdensome definitions caused by consensus decision making.

Marlon D. Mormann, Administrative Law Judge
September 2, 2008

12. 9/2/2008 Response and Concurrence by Peter J. Thill, Defense Attorney

I generally concur with the report and resubmit the alternate summary noted in paragraph 7 above.

Core problems of the *Guides* retained in the Sixth Edition

Before the Fifth Edition was finalized, a number of former members of the Steering Committee for that edition published an article in the *Journal of the American Medical Association*, raising concerns about the validity of the *Guides*.[15] Many of the most critical problems raised in that article have not yet been addressed.

1. ***Impairment ratings are not now, nor have they ever been, evidence based.*** The Sixth Edition acknowledges again that the WPI percentages are based on "normative judgments that are not data driven" that still "await future validation studies." *Guides* 6th p. 6, 26. In the 40 years since publication of the First Edition, the AMA has made no attempt to conduct validation studies. Each new edition claims that it is objective – and to have corrected the errors of the past edition(s). Each instructs that the *Guides* not be used for direct computation of benefits. Each has substantial effect on the benefits paid to workers. The original ratings in the First Edition did not even correlate with the scheduled awards that were already included in the workers' compensation statutes. The differences between AMA impairments ratings and states' statutory ratings is striking, in particular with regard to relative weight (e.g. loss of arm versus loss of leg). But despite the passage of time and the accumulation of relevant information from studies by economists and others, the relative importance of body parts in the *Guides* is same in Sixth as it was in the First Edition in 1971. Although the Sixth Edition sets up a new approach so that the evaluation of different organ systems is placed within similar diagnosis-based grids, there is also still ***no validation of percentages across organ systems.***

2. Although the *Guides* are predominantly used for assessment of work disability, there has never been any attempt to correlate the percentage values to work. In fact, ***ability to work is excluded from consideration in setting the percentage.*** To the extent the Sixth Edition now appears to be creating correlation by including functional assessment, the *Guides* use ADLs, which do not correlate with work disability, and severely limits the effects on WPI of the functional assessments.

3. ***The process for development of these WPI numbers is opaque.*** The numbers are developed based upon ***consensus of a small number of physicians.*** This persists in the Sixth Edition, which gives "consensus-derived percentage estimate of loss." *Guides* 6th p.5. Only 53 specialty-specific experts contributed to the Sixth Edition; the extent of involvement of each is unclear; the process for derivation of new numbers is not described. This is consistent with past editions. There is not, and there has never been, a possibility for public discussion and input into the process, despite the use of the *Guides* in federal and state governmental programs.

4. ***The Guides presumes that 100% represents a state close to death – a scale inappropriate for assessing the impairment of workers.*** The scale used to generate WPI ratings is a critical component of the validity of the numerical ratings. The appropriate top of the impairment

[15] Spieler et al. *supra*, n. 1.

scale for assessing workers should reflect a level of functional loss related to inability to perform tasks necessary for independent life and capacity to work. By defining 100% as comatose or approaching death, and 90+% as totally dependent on others, the values for all impairments are inappropriately depressed. The reduction in the top of the scale for many organ systems in the Sixth Edition expands the problem, rather than solving it.

5. ***The Guides combines impairments by reducing the value of each subsequent injury after the first injury, failing to reflect the true effect of multiple injuries.*** The scale that presumes that 100% is equivalent to death forces the devaluation of all injuries after the first. The *Guides*, including the Sixth Edition, therefore requires that each subsequent impairment be reduced in value. Thus, if the first impairment is valued at 25% for one limb, and the same injury occurs in a second limb, the value for the second limb will be less than 25%, and the total impairment will be less than 50% . From the standpoint of real life, this makes no sense whatsoever. If I were to lose the use of one arm, and then lose the second arm, surely I am more not less impaired by this second loss! We suggested in 2000 that later impairments may be more or less impairing than the original impairment: the *Guides*' system of combining impairments means that all additional impairments are viewed as less impairing.

6. ***The Guides is not broadly acceptable to the many constituencies involved in workers' compensation.*** As we noted in 2000, "Acceptability depends in part on the origins of the relative values and in particular on whether there is some scientific basis for the ratings."[16] Plainly, this has not been achieved.

A number of these points were raised in the JAMA article in 2000, prior to the publication of the Fifth Edition. They have still not been addressed.

Additional concern regarding the Sixth Edition of the *Guides*:

The Senior Editor of the Sixth Edition, Dr. Christopher Brigham, has a separate business called Impairment Resources, described at http://impairment.com/ as follows:

> Impairment Resources provides services designed to drive accurate impairment ratings. One of the greatest opportunities in workers' compensation is effective management of impairment ratings.
>
> We are best able to serve you by providing unique professional abilities, innovative technology solutions and offering a suite of services ranging from ImpairmentCheck™ (our unique, online resource to assess the accuracy of ratings) to ImpairmentExpert™ (expert physician reviews). These services are complimented by Internet-based educational resources and tools for all Editions of the AMA Guides to the Evaluation of Permanent Impairment, and expert consultation. Our core values are integrity, service and excellence.

Dr. Brigham has performed surveys that have concluded that the ratings have been too high under the Fifth Edition; it is these conclusions that seem to underpin key changes in the Sixth Edition. The text of the Sixth Edition specifically discourages use of the *Guides* by treating physicians and tells rating physicians that they need "significant training." *Guides* 6th p. 35; Dr.

[16] Spieler et al, *supra* n. 1, at 523.

Brigham's business is a primary conveyor of that training. All of this certainly raises a concern regarding an appearance of a conflict of interest that is troubling in view of the controversy surrounding the *Guides*.

Status of the *Guides*' usage in workers' compensation programs:

Adoption of the *Guides*, and particularly the Sixth Edition, has not been without controversy. Nevertheless, 44 state jurisdictions use one of the editions of the *Guides*. Many states as well as Ontario, FECA, FELA, and the Washington D.C. compensation system are mandated to use the most recent edition of the *Guides* in evaluation of workers for PPD. Appendix 4, drawn from Dr. Brigham's 2008 article, shows the projected adoption of the various editions of the *Guides* as of the time that the Sixth Edition was published.

Disputes regarding adoption of the Sixth Edition have arisen in several states, including Iowa and Kentucky. In Kentucky the legislature voted to delay adoption of this edition. The Sixth Edition was not imported into the EEOICPA, perhaps because of the importance of pulmonary impairment ratings in that system.

Some states continue to use the Fourth or the Fifth Edition. A few states have chosen to develop their own rating systems (including Florida, Illinois, Minnesota, New Jersey, New York, North Carolina, Utah and Wisconsin). Some states do not use a specified rating guide, although it is unclear whether physicians refer to the *Guides* in doing evaluations for workers' compensation. California now chooses to use the *Guides*, but uses a process by which the WPI rating from the *Guides* is adjusted for diminished earning capacity and modified based on occupation and age.

In 2007, an Institute of Medicine Committee charged with studying Veterans Disability Benefits recommended that the Veterans Administration update its own rating schedule rather than adopting an alternative impairment schedule, explicitly rejecting the AMA *Guides*, because the *Guides* measures and rates impairment and, to some extent, daily functioning, but not disability or quality of life.

What is to be done?

The critical issue in all of this technical discussion is this: The *Guides* has a direct effect on the permanent partial disability benefits provided by workers' compensation programs to injured workers. The *Guides* is currently the presumptive gold standard and is therefore used in large numbers of jurisdictions, and the authors of the Sixth Edition are advocating for its expanded use in the United States and elsewhere. While admitting the fact that there is no empirical basis for the WPI quantifications, the Sixth Edition decreases the availability of benefits and thereby increases the externalization of economic costs of injuries from workers' compensation systems.

There is no question that "achieving cost-efficient outcomes and both horizontal and vertical equity (equal treatment of equals and unequal treatment of those with varying levels of

disability) remains elusive."[17] It is not, however, true that disability is impossible to measure. Researchers have studied nonwork disability and compared the ratings in the *Guides* (3rd) to loss of enjoyment of life using an accepted methodology in the field of psychology. [18] Studies have also been done on the relationship of impairment ratings to actual loss of earnings experienced by workers with work-related injuries.[19]

It is true that a reliable and valid tool is challenging to develop, and this may require further research. The existing studies do, however, show an important level of consistency that can form the basis of a new empirically-driven rating system.

The status quo, in which the AMA *Guides to the Evaluation of Permanent Impairment* forms the basis for these discussions, is simply unacceptable. With the widespread adoption of the *Guides*, a small number of physicians is designing the system based on consensus without validation or any real attention to justice. The Sixth Edition has only made this worse. We are pessimistic about the ability of the AMA to produce a *Guides* that serves the real needs of workers' compensation programs for impairment ratings that are accurate predictors of work disability.[20]

We can improve the approach and increase by validity and reliability, but I doubt that we can turn to the AMA in this effort. As the *Guides* itself indicates in each edition, physicians lack the necessary expertise to assess non-medical issues. Moreover, they are driven by normative judgments of 'what is right' – thus making social policy in the guise of medical science. Despite the availability of both recent studies and the historical information in workers' compensation statutes, the AMA has continued to publish *Guides* with ratings that do not incorporate the available data.

I urge that you ask the National Academies of Science / Institute of Medicine to conduct a review. This review should include recommendations regarding the best way to develop a new system for rating workers' injuries as measured by the impact of those injuries and diseases on the extent of permanent impairments, limitations in the activities of daily living, work disability and nonwork disability (or noneconomic losses).

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[17] Peter Barth (2010) Workers' compensation before and after 1983. In R.Victor & L.Carrubba (Eds.), *Workers' Compensation: Where Have We come From? Where Are We Going?*. Workers Compensation Research Institute.

[18] Sinclair, S. & Burton, J.F., Jr. (1994). Measuring noneconomic loss: quality-of-life values vs. clinical impairment ratings. *Workers' Compensation Monitor*, 7,4, 1-14: Sinclair, S. & Burton, J.F., Jr. (1995). Development of a schedule for compensation of noneconomic loss: quality-of-life values vs. clinical impairment ratings. In T. Thomason & R.P. Chaykowski (Eds.), *Research in Canadian Workers' Compensation*, pp. 123-140. Kingston, ON: IRC Press; Sinclair, S. & Burton, J.F., Jr. (1997). A response to the comments by Doege and Hixson. *Workers' Compensation Monitor*, 10(1) 13-17.

[19] Berkowitz, M. &. Burton, J., Jr. (1987). *Permanent disability benefits in workers' compensation*. Kalamazoo, MI: W.E. Upjohn Institute for Employment Research; Boden, L.I., Reville, R.T. & Biddle, J. (2005). The adequacy of workers' compensation cash benefits. In. K. Roberts, J.F. Burton, Jr., & M. M. Bodah (Eds.), *Workplace Injuries and Diseases: Prevention and Compensation: Essays in Honor of Terry Thomason*. (pp. 37-68). Kalamazoo, MI: W.E. Upjohn Institute for Employment Research; Reville, R.T., Seabury, S.A., Neuhauser, F.W., Burton, J.F., Jr., & Greenberg, M.D. (2005). *An evaluation of California's permanent disability rating system*. Santa Monica, CA: RAND Institute for Civil Justice.

[20] John F. Burton, Jr. (2010) The AMA *Guides* and Permanent Partial Disability Benefits. *IAIABC Journal* 45 (2), 13-35.

The alternative would be for the various workers' compensation systems – both federal and state – to develop their own mechanisms that do not rely so heavily on the *Guides*. The current furor over the Sixth Edition suggests that there is considerable concern in some jurisdictions regarding this issue. Nevertheless, I think that there is strong interest in a 'gold standard' for PPD evaluation, and it is doubtful this will be produced in any single jurisdiction.

Thank you for the opportunity to appear before you today. I would be happy to answer any questions that you may have.

AMA Guides to the Evaluation of Permanent Impairment,

The 5th and 6th Editions Comparison: a failed paradigm shift

John E. Nimlos MD November 17, 2010

Written testimony to the House Committee on Labor and Education,

Sub-Committee on Worker Protection

Executive Summary

This presentation will show that the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* remains the preferred reference for impairment rating, as the 6th Edition is a disruptive document with many more disadvantages than improvements. Over the 10 years of its publication, the 5th Edition has effectively guided a national cadre of experienced physician raters. In contrast, the 6th Edition requires a complicated, multistep process for each rating. If the new, time-consuming process leads to better, more scientific, and more accurate ratings, it might be worth it. It does not.

The 6th edition, despite making major changes to ratings, mostly downward, has no more science behind it than the 5th. In fact, there appears to be less science. Therefore, relying on the 6th Edition will lead to greater expense: training doctors, system adjustment to the new impairments, increased litigation, and increased wage replacement cost due to delays in claim resolution. In contrast, if the 5th Edition shows consistent problems in one or another area, and some rational science becomes available to address those, addenda can be added cheaply and efficiently.

If there are multiple areas scientifically shown to need improvement, a "5th Edition-Revised" can be provided. Until such time, continued use of the *AMA Guides* 5th Edition generates no new expenses, can be adjusted to reflect new science if needed, and allows systems using the *Guides* to continue the adjudication decisions, standards, and adjustments already in place. The simple decision to retain the 5th Edition eliminates the considerable time and expense of dealing with a new system that has no proven value or reliability.

Introduction

I am a medical doctor specializing and board certified in Occupational Medicine. I treat employees for injuries and illness incurred in the workplace. For 24 years, I've examined workers under two different state workers' compensation systems, as well as federal employees under the FECA and Longshore and Harborworkers programs. I make decisions every day about impairment, and disability.

I am familiar with all editions of the Guides, and used the 3rd, 3rd (Revised), 4th, 5th and 6th to determine impairment ratings, as well as using Washington State's impairment system. I have taught doctors about impairment ratings and explained ratings to patients for many years. I can

state that the 6th Edition is dramatically different from the prior editions, and as the authors say, a paradigm shift.

Impairment and Disability are not the same

These two words are frequently used interchangeably, but they actually have importantly different meaning. *Impairment* refers to a *loss of function*. It simply means, for example, that the grip is weak, or that the arm has less mobility. *Disability* refers to the *effect of the impairment* on the ability to perform a job or specific task.

For example, I injured my shoulder years ago. My arm was so weak, I could hardly lift a gallon of milk, I couldn't reach higher than the level of my chest. I was *impaired*. I could do all my work as a doctor, so I was *not disabled*. However, if I were a carpenter with the *same impairment*, I'd be both *impaired* and *disabled*. The *AMA Guides to the Evaluation of Permanent Impairment* have been in existence for 40 years and are used to rate the extent of *impairment*. Doctors' impairment ratings a measurement of how much loss of function is present. It refers to limits to everyday living tasks, common to all people. Disability is how that impairment affects a person's job. Impairment rating percentages are just the beginning of disability determination. Disability rating or compensation, depends on how each system applies its own rules and process to come to a monetary amount or qualification for benefits.

The 6th Edition greatly increases the complexity of impairment ratings

The 6th edition uses the same structure and method for all of the different body parts and systems. Though this is intended to make it more consistent, it also makes it difficult to fit the rating process to the rated part, and reduces the role of the examining doctor to best reflect the actual limitations for the claimant he or she is evaluating. In addition, because of this rigid adherence to structure, impairment ratings which are easy and straightforward under the 5th Edition are made needlessly complex.

For 6th Edition ratings I charge extra; I find this methodology clumsy and extremely difficult to work with. Every rating under the 6th Edition takes several steps, regardless of how straightforward rating a patient could be. After the examination, plus a required patient questionnaire to score, the doctor first goes to a chart for the diagnosis. The diagnosis has a number associated with it. It also has a range from A through E, with C being the middle, and the default impairment rating that is meant to represent the average impairment for that diagnosis. Then he must find three other charts for 1) examination results, 2) test results, and the 3) claimant's function. Applying estimates from "no problem" to "severe" in each chart, the doctor gets numbers from these three, and subtracts each number from the number assigned to the diagnosis, then adds those three results together. The result is added or subtracted from the number on the diagnosis chart. This sum is the number that determines how far up or down the narrow A though E range that determines the final rating, as adjusted from the average for that diagnosis.

By contrast, the 5th Edition rating requires physical examination and tests. With the medical information, he or she goes to a table for each measurement or claimant characteristic, and matches the claimant's measurement or description with an impairment percent from the table. Sometimes there is more than one table, but even then, for most cases it's not that difficult. With some guidance, many cases can be rated by an attending doctor. I've even given phone instructions to doctors, enabling them to do ratings successfully with the patient or medical record in front of them.

The 6th Edition still uses consensus-based estimates for impairment rating that are no more scientific, and with non-medical factors now present in these estimates, there is even less medical science in this edition than previously.

The 6th Edition is controversial for another reason. Though it claims to be, it is not really evidence-based. It produces impairment ratings far different from those in prior editions, most of them lower than before, it without adequate support for doing so. In the course of evaluation of the 6th Edition for the state of Iowa, Mr. Matthew Daker, and Dr. John Kuhnlein, the authors of both evaluations that I found for review also concluded with the advantage of author interviews, that there remained too many obstacles to effective and reliable ratings. The authors admitted that there was no more scientific evidence brought to bear in the 6th edition, and noted the influence of insurance and adjudicators in the adding of very low, once-in-a-lifetime ratings so that people could qualify as having impairments, perhaps a minimal response to requests from plaintiff groups for at least some recognition of conditions previously given zero impairment.

I suspect that Dr. Brigham's assertions that ratings are too high (his estimate at 8% too high) also had to do with the consensus estimates of the 6th Edition authors. Dr. Brigham's assertions about the distortion of ratings are based on his own studies. The material from those studies are taken from his practice in reviewing ratings sent to him for analysis. Dr. Brigham's advertisements appear clearly to focus on the defense (employer, workers comp insurer, defense attorney) population, so it is likely that the only clients who would be spending the $150 fee would be those for whom they thought would save that at least that amount by finding out about a rating suspected to be too high. In that setting, ratings too low, or that were appropriate would not likely show up in his numbers.

In contrast to this, I have a series 401 consecutive independent medical examination (IME) reports received by me as attending physician, or reviewed by request from other physicians who my review of the IME's to advise the doctors whether to agree or not with the report. In this series, I found that 45% of the IME's were valid. The remainder had serious flaws, for a variety of reasons, one of them being incorrect impairment ratings. The majority of errors had to do with rating, and every rating but one was *too low*. Unlike Dr.Brigham's study, mine was only selected by my presence in the case as attending physician, or were sent by physicians with only the interest in knowing the accuracy of the report, not by whether the rating was too high or low. In light of this, I question the validity of Dr. Brigham's assertions about ratings too high. Dr. Brigham's population suggested 89% of ratings to be too high. Another said that 78% of ratings

were incorrect, and again, too high. My study showed essentially 99% of ratings to be *too low*. My data are in agreement with another study of 17 patient ratings. Though the patient number was disappointingly low, this was the only one I could find in a literature search for peer-reviewed reports on IME quality. It is a sad comment on the role of science in the *AMA Guides*, that I found more information about these issues in a Google search than I did by searching the medical literature by PubMed (The National Library of Medicine).

Lastly, though the authors of the *Guides* do refer to evidenced based research in the 6th Edition, the only studies they could find were deemed unreliable for use as impairment rating information, and that further research was required. The only approach in the 6th Edition that has to do with evidence is the assertion that the diagnosis used for rating be made based on evidence. Perhaps this edition's authors somehow believe that doctors making diagnoses for prior editions' were not based on evidence.

Many of the 6th Edition ratings are different, with no explanation of why the rating is changed. Most changes are to a lower rating, some are far lower.

With regard to medical reliability, there seem to be many unexplained rating changes in this new Edition compared with the earlier editions of the *Guides*. Questions arise about the ratings recommended by the Sixth Edition. For example, why is the impairment rating for a total knee replacement with "good" result 37% in the 5th Edition and 25% in the 6th Edition? Is that evidence based, as the 6th Edition purports to be? No, the rationale for this particular rating is, as expressed by Dr. Chris Brigham, Senior Contributing Editor for the 6th Edition, who has stated that the "improvement in medical technology" is the reason for the lower rating.

Though this suggests that some science backs up the lower rating. However, the actual process of rating determination is different between the two editions. The 5th Edition appears to actually draw *more* upon science than the Sixth. In the 5th edition, the "good" rating is defined by a numerical score derived from several measurements, and used by orthopedic surgeons as a recognized standard for describing and categorizing knee replacement outcomes. In the 6th Edition, the "good" definition uses undefined degrees of outcome measures, *e.g.* "mild", "good", "severe" *usw*. These are imprecise at best, and subject to the judgment and/or bias of the examiner.

The total knee replacement decrease in impairment is not alone. In my own analysis of ratings coming from the AMA's publication by Dr. Chris Brigham, *The Guides Casebook*, 3rd Edition, selecting all the extremity ratings, as in Washington the *Guides* are prescribed for rating these, and a couple others due to their common occurance as rating questions. Of the total of 35 ratings examined, only 6 ratings went down in the 5th compared to the 4th Ed. Those ratings averaged less than one fifth (19%) lower than the 4th Edition. In contrast, 21 of 35 ratings go down in the 6th compared to the 5th; 3-and-a-half times *more ratings* are made lower by the 6th Edition than were reduced in the 5th. And, in the 6th Edition, not only are more ratings reduced, but they are

made lower by an average of more than a two fifths (36%) – almost twice the magnitude of decrease amount of the impairment ratings.

My analysis is not the only one that does this. Dr. Melhorn did an analysis of selected diagnoses comparing 5th and 6th edition ratings, demonstrating the rating averages to be lower for the Sixth edition, though at a less dramatic amount. However, if he'd gotten the arithmetic accurately, he'd had shown a more significant difference between the average rating in the 6th from the 5th than appears in his tables found in his article in the IAIABC Journal.

Lastly, a large number of ratings, 52, were examined by Sedgwick Claims Management Services for the state of North Dakota involving extremities and spine as well as multi-injury cases. Six ratings were the same or slightly higher by the 6th edition. The other 46 ratings were lower, many much lower. On average by body region, ratings were 0.8% higher for ratings of the Hand to 12.6% lower for the Cervical Spine. This does not mean that the rating was 12.6% lower as in lowered by about 1/8 of the rating, it means that the average rating went from 24.8% to 12.2%. These are very large differences. When compared in order of magnitude of initial 5th edition rating, the lowering of the impairment rating was much more dramatic as the 5th edition ratings that were higher. For ratings in the highest range, the average for 5th Edition was 67% impairment, in the 6th edition, the same cases averaged 44.7%. This is a decrease of nearly one third.

Another study of 200 cases from Dr. Brigham was also reviewed showing many lower ratings in the 6th edition, in similar magnitudes. This is particularly interesting in light of my recall from Dr. Brigham stating that he did not think the 6th edition would result in many reduced ratings, and that whether or not it would remains to be seen. By virtue of his own recent report in *The Guides Newsletter**, as cited by, and providing the above statistics from, in the Sedgwick report

The Sedgwick report goes on to estimate that using the 6th edition. The conclusion was that North Dakota would save $1.1 million dollars in permanent partial impairment awards by adopting the 6th Edition. This was immediately followed by a statement that asserted, "The *6th Edition of the AMA Guides to the Evaluation of Permanent Impairment* is the latest version of the Guides and is the result of the evolution of medical science as well as research based medicine." As thorough as the report is in many respects, it appears the report authors did not investigate the assertion of science and research as the basis for the 6th edition, and were likely to convey to the decision makers for North Dakota an opinion that is not supported by the facts.

It will be expensive and difficult to maintain an adequate population of qualified doctors for impairment ratings under the 6th Edition.

In my home state of Washington, more ratings by attending doctors are desired. I know from my experience in encouraging primary and specialty doctors to do ratings for their own patients, that it is already difficult to get treating doctors to embrace impairment rating and the *Guides*. Most step back slowly if I bring out the book, but I believe they will *run* from the complicated, multistep arithmetic and rules of the 6th Edition. Doctors are quite familiar with the 5th Edition,

and the system has begun to find stability with the 5th Edition. The 6th Edition's methods are dramatically different from the prior systems, and already throw controversy and error into systems relying on their use. Adding the 6th Edition's untested, and unproven departure from the format used for the past 40 years, doesn't seem worth the disorientation it will cause.

6th Edition ratings take much more time, and likely will add to rating examination expense.

Dr. J. Mark Melhorn, an orthopedic doctor from Kansas, a contributor to the 6th Edition *Guides* conducted an informal study on the time consumed in ratings. He found that 7 expert raters who teach other doctors how to use the *Guides*, doing identical sample cases, averaged 5 minutes to rate by 5th Edition, but to do 6th Edition ratings they averaged 25 minutes. Because of this additional time and hassle, I charge an extra fee for 6th Editions ratings that adds between 15 and 20% to the cost of the examination. Other doctors who do ratings will need to pay for the additional training and certifications costs, and are likely to pass this cost along to their clients.

Especially at the beginning, disagreement about ratings is likely to occur resulting in additional costs for IME's and/or legal expense.

Physician clinical judgment remains the hallmark of impairment ratings, it is greatly restricted in the 6th Edition, but with no science to back up that decision, or the altered ratings.

Thus, it appears that the transition from the 5th to the 6th Edition shows much more pervasive and dramatic changes to ratings than previous edition changes. I believe that the previous edition changes generally provided improvements. The changes in the 6th edition are many and large. If adopted generally, the 6th edition of the *AMA Guides* will disrupt disablility systems, increase examination costs, increase litigation expenses and seriously threaten fair compensation for injured workers.

In light of all these issues, I agree with the states of Iowa, Kentucky, Washington, Colorado, Utah and others, that the 5th Edition should remain in use, until something truly better comes along.

* Brigham CR, Uejo C, McEntire A, Dilbeck L. Comparative Analysis of *AMA Guides* Ratings by the Fourth,Fifth, and Sixth Editions. *Guides Newsletter*. January - February 2010.

Complete annotated bibliography will follow.