

DEVELOPMENTS IN STATE WORKERS' COMPENSATION SYSTEMS

HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE PROTECTIONS

COMMITTEE ON

EDUCATION AND LABOR

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DEVELOPMENTS IN STATE WORKERS' COMPENSATION SYSTEMS

**Wednesday, November 17, 2010
U.S. House of Representatives
Subcommittee on Workforce Protections
Committee on Education and Labor
Washington, DC**

The subcommittee met, pursuant to call, at 8:45 a.m., in room 2175, Rayburn House Office Building, Hon. Lynn C. Woolsey [chairwoman of the subcommittee] presiding.

Present: Representatives Woolsey, Payne, Sablan, Hare, and McMorris Rodgers.

Staff Present: Aaron Albright, Press Secretary; Tylease Alli, Hearing Clerk; Andrea Belknap, Press Assistant; Jody Calemine, General Counsel; Lynn Dondis, Labor Counsel, Subcommittee on Workforce Protections; David Hartzler, Systems Administrator; Sadie Marshall, Chief Clerk; Richard Miller, Senior Labor Policy Advisor; James Schroll, Junior Legislative Associate, Labor; Michele Varnhagen, Labor Policy Director; Kirk Boyle, Minority General Counsel; Ed Gilroy, Minority Director of Workforce Policy; Barrett Karr, Minority Staff Director; Ryan Kearney, Minority Legislative Assistant; Brian Newell, Minority Press Secretary; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; Ken Serafin, Minority Workforce Policy Counsel; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairwoman WOOLSEY. A quorum is present. The hearing of the subcommittee will come to order. I now will yield myself as much time as I may consume for my opening statement.

Thank you for attending. I appreciate this group of witnesses more than you will know, and my colleagues who are here this morning, we have changed the time because we as Members of both sides of the House have a lot of organizing to do today and we start at 10 o'clock. So thank you for being flexible.

The hearing is on developments in State workers' compensation systems. Here in Congress, we don't examine these State compensation programs very often because they are generally under the purview of the State legislatures. However, there have been some disturbing national trends that now compel a comprehensive re-examination of the State programs and their impact on injured workers.

As most of you are aware, workers' compensation statutes were passed beginning in the early 20th century to establish a no fault

system for providing efficient redress for injured workers. Workers' compensation was called the grand bargain. And of course, we all have to remember it was called workmens' compensation then. We have gotten modern and know that all workers are not men.

Workers waive their rights to bring individual suits against their employers and in return receive compensation for work related injuries regardless of fault. Every State and the District of Columbia have workers' compensation programs in place. Most employers purchase private workers' comp policies, but others self-insure or purchase insurance from State managed compensation funds.

Beginning in the 1990s, changes in State workers' compensation laws brought about by the lobbying efforts of employers and insurance companies have resulted in stricter eligibility requirements and the reduction in both the amount and duration of benefits, particularly for those workers with permanent partial disabilities. Unfortunately, this grand bargain of the 20th century is not so grand anymore, especially for injured workers.

In addition, there are two other recent developments that merit our attention today. The first has to do with the American Medical Association's AMA's guides to permanent impairment. And the second concerns cost shifting away from State workers' compensation programs where the employer is responsible for an employee's injury to the Federal Government's medical and disability programs. The AMA guides have been in effect since 1971, and are now in widespread use. Some States even require workers' compensation programs to use the latest edition of the guides. These guides were originally designed to be used by physicians in making a scientific assessment of a worker's level of impairment or loss of function due to work related injury.

The determination of whether a worker is permanently disabled and entitled to workers' compensation is based upon his or her impairment rating, which is then applied to the specific case of a given worker. For example, a worker who loses a hand may not suffer permanent disability if he or she is a teacher. But that same worker would be permanently disabled if he or she works in construction.

In 2007, the AMA published the sixth edition of the guides, and witnesses today will describe how this new edition has dramatically reduced impairment ratings for many types of conditions without apparent medical evidence and transparency. The sixth edition has become so controversial that many States, including Iowa, Kentucky, and Vermont have decided not to adopt them.

It also appears that the sixth edition was developed in near secrecy without the transparency and consensus which should necessarily accompany the development of standards that will have widespread use by State governments.

In addition, it appears that the physicians who developed the latest edition may have ties to insurance companies and are making a profit training doctors on the use of sixth edition, which is complicated and very difficult to apply. The National Technology Transfer Advancement Act of 1996 sets forth minimum criteria for the development of voluntary consensus standards, openness, balance of interests, due process protections and consensus. The process used for developing the sixth edition appears to significantly

deviate from these standards and is a focus of testimony before us today. Workers who are wholly dependent on the grand bargain when they were injured on the job are the ones paying the price. That is why the subcommittee invited the AMA to testify today, but unfortunately it declined.

Another troubling policy issue is that as eligibility for workers' compensation benefits has become more restrictive, there has been a cost shift to Medicare and Social Security disability, SSDI, placing an additional burden on the taxpayer.

In addition, costs are being shifted to private health insurance that should be borne by workers' compensation policies and the employer. This is particularly worrisome, especially during a time of record deficits. Chairman Miller and I believe that this cost shifting trend warrants further study. Therefore, we will be asking the Government Accountability Office, GAO, to do a study and issue recommendations.

The testimonies today will illuminate these problems, the problems facing injured workers and taxpayers and I look forward to hearing from our witnesses.

And now I yield to the ranking member for her opening statement for as much time as she may consume.

[The statement of Ms. Woolsey follows:]

**Prepared Statement of Hon. Lynn C. Woolsey, Chairwoman,
Subcommittee on Workforce Protections**

Thank you all for attending this hearing on "Developments in State Workers' Compensation Systems."

Here in Congress, we don't examine these state compensation programs very often because they are generally under the purview of state legislatures.

However, there have been some disturbing national trends that may compel a comprehensive reexamination of these state programs and their impact on injured workers.

As most of you are aware, workers' compensation statutes were passed beginning in the early 20th century to establish a no fault system for providing efficient redress for injured workers.

Workers' compensation was called the 'grand bargain.'

Workers waived their rights to bring individual suits against their employers and in return receive compensation for work-related injuries regardless of fault.

Every state and the District of Columbia have workers' compensation programs in place.

Most employers purchase private workers compensation policies, but others self-insure or purchase insurance from a state managed compensation fund.

Beginning in the 1990s, changes in state workers' compensation laws—brought about by the lobbying efforts of employers and insurance companies—have resulted in stricter eligibility requirements and the reduction in both the amount and duration of benefits—particularly for those workers with permanent partial disabilities.

Unfortunately this 'grand bargain' of the 20th century is not so 'grand' any more, especially for injured workers.

In addition, there are two other recent developments that merit our attention

The first has to do with the American Medical Association's (AMA) Guides to Permanent Impairment.

And the second concerns a cost-shifting trend away from state workers compensation programs, where the employer is responsible for an employee's injury, to the federal government's medical and disability programs.

The AMA Guides have been in effect since 1971 and are now in widespread use.

Some states even require workers' compensation programs to use the latest edition of the Guides.

These Guides were originally designed to be used by physicians in making a scientific assessment of a worker's level of impairment—or loss of function—due to a work-related injury.

The determination of whether a worker is permanently disabled and entitled to workers compensation is based upon his or her impairment rating, which is then applied to the specific case of a given worker.

For example, a worker who loses a hand may not suffer permanent disability if he or she is a teacher, but that same worker would be permanently disabled if he or she works in construction.

In 2007, the AMA published the 6th edition of the Guides, and witnesses today will describe how this new edition has dramatically reduced impairment ratings for many types of conditions, without apparent medical evidence, and transparency.

The 6th edition has become so controversial that many states, including Iowa, Kentucky and Vermont have decided not to adopt them.

It also appears that the 6th edition was developed in near secrecy, without the transparency and consensus which should necessarily accompany the development of standards that will have widespread use by state governments.

In addition, it appears that the physicians who developed this latest edition may have ties to insurance companies, and are making a profit training doctors on the use of the 6th edition, which is complicated and very difficult to apply.

The National Technology Transfer Advancement Act of 1996 sets forth minimum criteria for the development of voluntary consensus standards: openness; balance of interests; due process protections; and consensus.

The process used for developing the 6th edition appears to significantly deviate from these standards and is a focus of testimony before us today. Workers who are wholly dependent on this 'grand bargain' when they are injured on the job, are the ones paying the price.

The subcommittee invited the AMA to testify today, but unfortunately, it declined. Another troubling policy issue is that as eligibility for workers' compensation benefits have become more restrictive, there has been a cost shift to Medicare and Social Security Disability (SSDI), placing an additional burden on the taxpayer. In addition, costs are being shifted to private health insurance that should be borne by workers' compensation policies and employers. This is particularly worrisome, especially during a time of record deficits. Chairman Miller and I believe that this cost-shifting trend warrants further study. Therefore, we will be asking the Government Accountability Office (GAO) to do a study and issue recommendations. The testimony today will illuminate these problems facing injured workers and taxpayers, and I look forward to hearing from our witnesses.

Mrs. McMORRIS RODGERS. Good morning, Madam Chair, and welcome to our witnesses. We appreciate the time you have taken to be with us this morning and share your views and expertise with State workers' compensation systems.

Today, nearly every American employee is covered by a system of workers' compensation. Disability benefits are available in the event of an illness or injury that occurs on the job to help replace lost wages and cover the cost of medical care when an individual is unable to return to work. For many within the workforce and their families, workers' compensation is a critical lifeline during a very difficult time.

Anyone is considered disabled if they are unable to work, or only able to work at limited earnings levels as a result of an injury or illness. It may sound like a simple concept, but as anyone will tell you, the reality of workers' compensation is anything but simple. With an economy as diverse as ours, it is no surprise there are varying definitions and degrees of disabilities with their own set of rules and levels of compensation applied in different ways depending upon industry and workplace. For example, a software engineer and a construction worker with the same injury may face different challenges in performing their jobs. An engineer with a broken ankle may be fit to return to work while the construction worker may spend months away from the job site.

The complexity of workers' compensation is why most States and the Federal Government rely upon the expertise of the American

Medical Association. Since 1958, the AMA has provided medical professionals and policymakers with a guide to evaluate and quantify impairment. The AMA guide is an important part of the process to ensure injured workers get the assistance they need and taxpayer resources are spent appropriately. The AMA's guidance is periodically updated to ensure workers' compensation systems reflect the latest advances in medicine, science and technology.

Perhaps a particular injury or illness that rendered an individual disabled 20 years ago can be overcome today, thanks to a new medical device or therapy.

I look forward to hearing the testimony of Mr. Uehlein, who will address AMA's most recent guides.

Another issue we will look at today is the interaction between workers' compensation and the Social Security Disability Insurance Program, and whether a decrease in demand for one program leads to an increase in demand for the other. Again, while not squarely in this committee's jurisdiction, the information should help provide members with a clear picture of the disability assistance available to those in our workforce.

We are discussing a complex issue that has a potential to affect millions of people at some point in their careers. We all want to see that everyone gets the care and assistance that their families need in an unfortunate event that illness or injury occurs.

State and local authorities working closely with knowledgeable professionals in the medical community are responsible for operating these systems, and we appreciate this opportunity to learn more about their efforts on behalf of our Nation's workers. Thank you, Madam Chair. And I yield back.

[The statement of Mrs. McMorris Rodgers follows:]

**Prepared Statement of Hon. Cathy McMorris Rodgers,
Ranking Republican Member, Subcommittee on Workforce Protections**

Good morning Madam Chair and welcome to our witnesses. We appreciate the time you all have spared today to share your views and experience with state workers' compensation systems. While most of our discussion will fall outside the jurisdiction of this committee, members of Congress always welcome the opportunity to better understand issues that affect America's workforce.

Today nearly every American worker is covered by a system of workers' compensation. Disability benefits are available in the event of an illness or injury that occurs on the job to help replace lost wages and cover the cost of medical care when an individual is unable to return to work. For many workers and their families, workers' compensation is a critical lifeline during a very difficult time.

Workers are considered disabled if they are unable to work or are only able to work at a limited earnings level as the result of an injury or illness. It may sound like a simple concept, but as any worker can tell you, the reality of workers' compensation is anything but simple. With an economy as diverse as ours, it is no surprise that there are varying definitions and degrees of disabilities with their own sets of rules and levels of compensation applied in different ways depending upon the industry and workplace.

For example, a software engineer and a construction worker with the same injury face different challenges in performing their jobs. An engineer with a broken ankle may be fit to return to work, while the construction worker may spend months away from the job site.

The complexity of workers' compensation is why in most cases states and the federal government rely upon the expertise of the American Medical Association. Since 1958, the AMA has provided medical professionals and policymakers with a guide to evaluate and quantify impairment. The AMA guide is an important part of the process to ensure injured workers get the assistance they need and taxpayer resources are spent appropriately.

The AMA's guidance is periodically updated to ensure workers' compensation systems reflect the latest advances in medicine, science, and technology. Perhaps a particular injury or illness that rendered an individual disabled twenty years ago can be overcome today thanks to a new medical device or therapy. I look forward to hearing the testimony of Mr. Uehlein who will address the AMA's most recent guides.

Another issue we will look at today is the interaction between workers' compensation and the Social Security Disability Insurance program, and whether a decrease in demand for one program leads to an increase in demand for the other. Again, while not squarely in this committee's jurisdiction, the information should help provide members with a clearer picture of the disability assistance available to workers.

Today, we are discussing a complex issue that has the potential to affect millions of workers at some point in their careers. We all want to see workers get the care and assistance they and their families need in the unfortunate event that an illness or injury occurs. State and local authorities, working closely with knowledgeable professionals in the medical community, are responsible for operating these systems and we appreciate this opportunity to learn more about their efforts on behalf of our nation's workers.

Thank you again Madam Chair and I yield back.

Chairwoman WOOLSEY. Thank you. Without objection, all members will have 14 days to submit additional materials for the hearing record.

Just a little education on how to use these lights. You each will have 5 minutes. When you first start speaking, the green light goes on. When the yellow light comes on you have a minute left. And then a red light will come on. Now we aren't going to eject you from the floor of the committee room, but we would like you to wrap up at that time. And then when we have questions, each member will have 5 minutes to ask and get the answer. So if our question takes 5 minutes then don't worry, you don't have to answer it.

But we really have until, we have a good solid hour; we are going to get going and we will have as many questions as we can get in during that time period after your opening statements.

We will start with Ms. Spieler and go down the witness panel. Now I will introduce each of you and then you will go in order. Congressman Payne is going to introduce Mr. Burton, because he has a great need to do that.

All right, so we will start with Dean Emily Spieler. Dean Spieler is the dean and Edwin W. Hadley professor of law at Northwestern University School of Law. She is an expert on workers' compensation and has written widely on this issue. She also served as the commissioner of West Virginia's workers' compensation program and was chair of the Federal Advisory Committee to the Department of Energy on the Energy Employees Occupational Injury Compensation Program. Dean Spieler received her BA from Harvard College and her JD from Yale Law School. And now Congressman Payne.

Mr. PAYNE. Thank you, Madam Chair. And it is my honor to introduce the gentleman from the great State of New Jersey, and that is where I have the privilege to call my home State. Dr. John F. Burton, Jr., is professor emeritus at Rutgers University and at Cornell University, and is a former dean of the School of Management and Labor Relations at Rutgers. Dr. Burton is the most widely recognized expert on workers' compensation in the country, and he served as chairman of the National Commission on State Work-

ers' Compensation Laws in the early 1970s. He has written extensively about workers' compensation over the course of more than 40 years in academia. He received his BS from Cornell University, and his LLB and Ph.D from the University of Michigan.

Chairwoman WOOLSEY. Thank you, Congressman. I have to correct. Dean Emily Spieler is professor of law at Northeastern University. I apologize.

Dr. John Nimlos is a certified independent medical examiner and physician of occupational health. He served as the chief of the East Side Occupational Medicine Clinic from 1987 to 2007, where he evaluated the treatment of work-related injuries, illnesses and exposures. Dr. Nimlos received his BA and MD from the University of Minnesota.

W. Frederick Uehlein is the founder and chairman of the Insurance Recovery Group and an attorney with over 30 years of experience in workers' compensation. He is also a member of the Workers' Compensation Trial Lawyers Association and serves on the advisory committee of John Burton's workers' compensation resources. Mr. Uehlein is a graduate of Boston College Law School and Trinity College. Welcome.

Mr. Christopher Godfrey is the commissioner of the Iowa Division of Workers' Compensation. Before becoming commissioner, Mr. Godfrey was an associate attorney at Max Schott & Associates, where he practiced workers' compensation and employment discrimination law. Mr. Godfrey has a BA from Drake University and a JD from Drake Law School.

We have a panel of experts. We are so honored. We will begin with you, Dean Spieler.

**STATEMENT OF EMILY SPIELER, DEAN,
NORTHEASTERN UNIVERSITY SCHOOL OF LAW**

Ms. SPIELER. Chairwoman Woolsey, Ranking Member McMorris Rodgers and members of the subcommittee, thank you for the opportunity to appear before you today. I appear to express my deep concern about the trajectory of State workers' compensation programs in general, and my particular concern regarding the sixth edition of the AMA guides to the evaluation of permanent impairment.

Workers' compensation is the social benefit system designed to provide income replacement benefits and medical care to people who have been injured or made ill by their work. The backdrop for today's hearing is important. Analyses of trends in workers' compensation suggest that the adequacy and the availability of compensation for injured workers are declining and declining significantly. The AMA guides have become a commonly used vehicle for rating the permanent defects of workplace injuries, and are now used in 44 States as well as in the Federal Employees Compensation Act.

The adoption of the guides has not been without controversy, and that controversy has increased with the sixth edition. The key element that the guides add to the existing medical literature is not new diagnostic or treatment techniques. Rather, it is the numeric quantification of impairment. There are core problems with this quantification system. First, the impairment numbers are not

based on my evidence and are therefore simply numbers that have been created out of thin air.

In the 40 years since the publication of the first edition of the guides, the AMA has made no attempt to conduct validation studies of these numeric ratings in terms of the relationship of the impairment rating numbers to the actual functional loss or disability of injured workers.

Second, the process for development of the impairment numbers is quite opaque. The numbers are developed based upon consensus of a small number of physicians. The result is that public programs, including FECA, are tied to a publication from a nongovernmental organization that has been developed without public comment or full peer review.

Third, workers' compensation is supposed to provide benefits for disability, and the guides pretend to quantify impairment. Impairment is often not a good predictor of the economic consequences of injury or disease, and there has never been any attempt by the AMA to correlate their percentage values to any ability to function at work.

Much of the concern about adoption of the guides relates to the fact that the impairment ratings of the guides have become a proxy for the rating of disability in many State workers' compensation programs. The sixth edition adds to these problems.

The sixth edition adopts a new definitional structure based on the International Classification of Functioning, Disability and Health, ICF, of the World Health Organization and diagnosis-based grids for assessing impairment. It purports to increase its attention to functional assessment and to reduce variations in ratings performed by different examiners. But a careful reading reveals many changes that are troubling.

In all organ systems, actual functional limitations, the most lauded change in the sixth edition, have very small impact on the ultimate impairment rating. The concern about inter-rater variability has resulted in an increased focus on objective evidence in medical pathology despite the rhetoric associated with the inclusion of functional assessment. This addition rejects subjective symptoms such as pain, range of motion, downgrades the role of treating physicians who would be most familiar with the individual's functional capacity and actually restricts the effect of any assessment of functional loss.

While admitting the fact that there is no empirical basis for the impairment quantifications, the sixth edition decreases many of the numeric ratings, sometimes a lot. This results, in fact, in reduced availability of workers' compensation benefits for injured workers and the externalization of economic costs of injuries from workers' compensation systems.

It is not true that disability is impossible to measure. Studies have been done on the relationship of impairment ratings to actual loss of earnings and loss of quality of life experienced by workers with work-related injuries. The AMA has never incorporated those studies into its guides.

I urge that you request the National Academies of Science's Institute of Medicine to conduct a review of the guides and an assessment of permanent disability. Their review should include rec-

ommendations 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, work disability and noneconomic losses.

I would be happy to answer any questions you have.

Chairwoman WOOLSEY. Thank you.

[The statement of Ms. Spieler follows:]

**Prepared Statement of Emily A. Spieler, J.D., Dean and
Edwin W. Hadley Professor of Law, Northeastern University School of Law**

Chairwoman Woolsey, Ranking Member McMorris-Rodgers and Members of the Subcommittee on Workforce Protections of the Committee on Education and Labor: Thank you for the opportunity to appear before you today.

My name is Emily Spieler. I am currently the Dean of the School of Law at Northeastern University in Boston. In the past, I served as the head of the workers' compensation program in the State of West Virginia, I have written and spoken frequently on issues relating to state workers' compensation program, and I have served on committees relevant to this issue for the National Academy of Social Insurance, the National Academies of Science, and the American Bar Association. I served as Chair of the Federal Advisory Committee to the Department of Energy on the implementation of the Energy Employees Occupational Injury Compensation Program Act. I was a member of the seven-member Steering Committee appointed by the American Medical Association to provide advice on the development of the Fifth Edition of the AMA Guides to the Evaluation. That committee was disbanded before the edition was completed, and five of us from the committee then published "Recommendations to Guide Revision of the Guides to the Evaluation of Permanent Impairment" in the Journal of the American Medical Association.¹ I declined the opportunity to be a formal reviewer for the Sixth Edition of the Guides.

I would like to acknowledge the assistance of John F. Burton Jr., Emeritus Professor at Rutgers University, and the nation's leading expert on workers' compensation, in the preparation of this testimony.

I appear before you today to express my deep concern about the trajectory of state workers' compensation programs in general and my more particular concern regarding the Sixth Edition of the AMA's Guides to the Evaluation of Permanent Impairment.

Workers' compensation is the social benefit system designed to provide income replacement benefits and medical care to people who have been injured or made ill by their work. After an injury, a worker generally requires a temporary period of healing, during which s/he may not be able to work and will collect temporary total disability (TTD) benefits. The length of this period may vary, but at the end of it the health condition will stabilize and the individual will be viewed as having reached maximum medical improvement (MMI). At this point, all workers' compensation programs have a mechanism for providing compensation for the permanent effects of the compensated injury or illness. In almost all cases, the individual is partially (not completely) disabled and will receive permanent partial disability (PPD) benefits. In severe cases, the worker may receive permanent total disability (PTD) benefits, generally paid for life. PTD benefits are extremely rare in workers' compensation systems, even if an individual is unable to reenter the workforce successfully. PPD benefits are therefore the critical benefit providing compensation for permanent losses.

PPD is the most costly area of cash benefits paid by workers' compensation programs, although the medical costs associated with the programs now surpass the cost of all cash benefits paid directly to workers.² The systems used by workers' compensation programs to award these benefits vary. Almost all states (43 jurisdictions) use a statutory schedule for a small number of injuries, such as loss of a limb. Most of these statutes also provide that multiple losses of body parts will result in a PTD award.

Beyond this, there is large variability among jurisdictions in both methodology and outcome in PPD cases. In general, PPD is assessed based on one of three methodologies: loss of earning capacity, a predictive model, used by about 13 states; actual wage loss (about 10 states); and, most commonly, permanent impairment without direct consideration of actual loss of earnings. Some states use a combined approach, modifying the impairment rating (as in California) or assessing the disability differently if the worker has returned to work. In 14 of the "impairment" states, the worker receives a benefit based on the degree of impairment, and loss

of earnings is not considered at all. In these states, a percentage of impairment is simply converted to a monetary award using a formula set by statute or regulation, so that each percentage point can be equated to a specified number of weeks of weekly benefits, generally based on the individual worker's pre-injury wage, with a statutory wage cap.³

I believe all but one state now allows cases to be settled for a lump sum settlement through a process called compromise and release agreements. This means that the worker and the payer (private insurance carrier, state fund or self insured employer) attempt to quantify the worth of the injury and eliminate any on-going obligation to pay benefits to the worker. In many states, this includes a settlement of the potential future medical costs as well.

Analyses of trends in workers' compensation suggest that the adequacy and availability of compensation are declining, perhaps significantly. States are erecting greater barriers to compensability. Increasing weight is being given to impairment ratings, and fewer and fewer jurisdictions offer wage replacement benefits without time limits.

Given this background, it is no surprise that there is a quest for a magic formula that quantifies the effects of injuries. At its best, this is a quest for an efficient, reliable and valid methodology that would be fair to individual workers by reflecting the true extent of their disabilities; would be equitable to injured workers as a group by providing consistent awards for similar injuries and disabilities; would limit transaction costs so that benefits are provided efficiently and without undue delay; and would provide predictive value to payers so that premium rates would not be unduly inflated by excessive caution in the face of uncertainty.

It is for these reasons that the American Medical Association's Guides to the Evaluation of Permanent Impairment (Guides) has become so important.

Guides for impairment rating of organ systems were initially developed before 1970 and were first published together as the Guides for the Evaluation of Permanent Impairment in 1971. Since then, the book has been revised repeatedly; the Sixth Edition, published in 2008, is the latest in the series. Each edition has been critical of prior editions, and each edition has made changes in the assessment techniques.

Some elements have been constant. The book is organized by organ system, providing a methodology for examination and then rating (numeric quantification) of the extent of impairment, currently expressed as a percentage of whole person impairment (WPI). The Guides has specifically stated that these are impairment ratings, not intended for use to rate disability—economic and noneconomic loss—because disability reflects a combination of medical and non-medical factors. In fact, many of the specific WPI ratings have not changed over time, despite significant advances in the understanding of impairment, functional loss and disability.

It is critical to understand that the key element that the Guides adds to the existing medical literature is the numeric quantification of impairment. It is this aspect of the Guides that encourages its expanding use. As noted below, this quantification is not, and has never been, evidence-based.

The use of the Guides has increased rapidly, precisely because it has successfully been characterized as the best vehicle to meet the complex goals of fairness, reliability and efficiency in rating permanent impairment. The Guides is reportedly now used in more than 44 states as well as federal compensation programs. Guides 6th p. 20. Increasingly, state workers' compensation programs have moved to using the impairment ratings as a proxy for the extent of disability. It is used in cases under the Federal Employees' Compensation Act, the Energy Employees Occupational Illness Compensation Program Act and, to a more limited extent, under the Longshore and Harborworkers Compensation Act. It is showing up for the ratings of injuries in automobile accident cases. It is used in Canada, New Zealand, Australia, and South Africa. This represents, of course, remarkable reach for a publication of a non-governmental organization that is developed without public comment or full peer review.

It is therefore no surprise that each new edition of the Guides is highly scrutinized: The impairment ratings in the Guides have become the proxy for the rating of disability in many state workers' compensation programs—despite the admonition in the book that its purpose is to rate impairment, not disability. This poses a particular challenge because the extent of impairment may not be a good predictor for the economic consequences (work disability) or for the noneconomic consequences (nonwork disability or noneconomic loss) of injury or disease.

When I served on the Steering Committee for the development of the Fifth Edition, serious issues were raised about the legitimacy of the Guides in terms of its use in workers' compensation systems. Since then, the AMA has published two additional editions, each with changes.

The Sixth Edition explicitly acknowledges the criticisms of the prior editions of the Guides⁴ and attempts, for the first time, to draw links between impairment and functional loss by standardizing assessment of the ability of the patient to perform specified Activities of Daily Living (ADLs). It applies functional assessment tools and includes, to a limited extent, measures of functional loss in the impairment ratings. It organizes the medical examination to incorporate history, physical clinical studies and functional status. It also strives to increase inter-rater and intra-rater variability.⁵ These are all important and laudable steps.

But a more careful reading of the Sixth Edition reveals many changes that are troubling in their scope or in their application. The edition also retains some of the most problematic features of the earlier editions.

I will now summarize the changes in the Sixth Edition, as well as the areas of continuing concern that have not been addressed by this latest edition of the Guides.

Changes in the Sixth Edition of the Guides

There are five key areas of changes in the Sixth Edition:

1. Definitional structural changes in the Sixth Edition

Adoption of the ICF definitional structure.

The Sixth Edition purports to adopt the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization, designed to describe health and disability at the individual and population levels. According to the Guides' authors, this system looks at what an individual can—can cannot—do, and it claims to provide “greater weight to functional assessment than do prior Editions.” Guides 6th p. 26. The “relationships between impairment, activity limitations, and participation are not assumed to be linear or unidirectional.” Guides 6th p. 3. The Senior Contributing Editor to the Sixth Edition, Dr. Christopher Brigham, has noted that “use of the ICF model does not indicate that the Guides will now be assessing disability rather than impairment. Rather, the incorporation of certain aspects of the ICF model into the impairment rating process reflects efforts to place the impairment rating into a structure that promotes integration with the ICF constructs for activity limitations and limitations in participation, ultimately enhancing its applicability to situations in which the impairment rating is one component of the ‘disability evaluation process.’”⁶ This is described by the authors of the Sixth Edition as a ‘paradigm shift,’ and the Guides now uses validated questionnaires for assessing function.

But there are serious problems raised by this shift.

First, this definitional structure is different from the prior definitions under the Guides, is not consistent with terminology in workers' compensation programs, and is quite different from definitions under the Americans with Disabilities Act—thus creating new confusion in an already confused and complex field.

Second, although importing the ICF model and including evaluation of ADLs gives the Guides the appearance of improving its approach to functional assessment, the actual effects of the change are in fact extremely limited: “Patients' responses on functional assessment instruments will act as modifiers of the percentage impairment they are awarded, but the awards will, in general, primarily reflect objective factors.” Guides 6th p.39. As is discussed below, whole person impairment ratings are based on placement into a class, and functional assessment can only change the actual WPI rating by a limited amount. In essence, these are small adjustments within limited bands. At the same time, the consideration of significant indicators of function—including range of motion assessment and pain, which were used in preparing the WPI ratings in the Fifth Edition—are eliminated or reduced in the Sixth Edition. There is real tension between the rhetoric rooted in the ICF model and human functioning and the reality of continuing a diagnosis-based approach with exclusion of critical subjective factors.

Third, the use of ADLs for this purpose is troubling. The Guides uses both a definition of 100% (approaching death) and a functional assessment approach (ADLs) that is inappropriate for assessing the level of impairment for workers—although these may be appropriate for elderly patients facing self-care issues. ADLs include basic personal hygiene, dressing, eating, functional mobility, sleep and sexual activity. Guides 6th p.7, 482-484. Data from the National Health Interview Survey conducted by National Center for Health Statistics, Centers for Disease Control and Prevention indicates that the number of people who report inability to perform work due to disability far exceeds the number who report inability to perform ADLs. This is not surprising: ADLs represent very basic self care issues and are not a good match for the issues of disability that confront injured workers.⁷

Fourth, the Guides now gives the appearance, but not the reality, of assessing function in setting the WPI ratings. This could result in further growth of the inappropriate use of the Guides as a proxy for disability.

Changes in key definitions

Important changes and additions were made to the definitions of key terms in the Sixth Edition of the Guides. Some of these reflect the adoption of the ICF model, but others are not explained by this shift. Appendix 1 provides a comparison between the Fifth and Sixth Editions of some of these terms. A quick glance through these changes shows the adoption of a new definition of disability, which may be consistent with ICF terminology but is quite confusing in the context of U.S. workers' compensation, and an introduction of the word "significant" into the definition of impairment. The definition of impairment rating introduces the inclusion of ADLs, despite the fact that ADL assessment plays a very small role in the calculation of WPI in the new system. The Sixth Edition also introduces definitions for a series of terms relate directly to legal terminology. I discuss this issue below.

2. Conceptual congruity among organ systems through creation of diagnosis-based grids

The Sixth Edition developed a generic template for diagnosis-based grids across organ systems and attempts to graft this onto the ICF conceptual framework. The ICF classification system uses five impairment classes, and this has been imported into the Sixth Edition for most organ systems and diagnoses. A "key factor" for each organ system determines the placement into the class; the key factor for use on any grid is specified in the text. The key factor is diagnosis-based; it can be derived from clinical presentation, objective testing or, less commonly, physical findings. Class is determined by "diagnosis and/or other specific criteria." Guides 6th p. 14.

Each class is then generally divided into five grades, with assigned WPI ratings. The middle grade is considered the default, and can be modified—but only within the class—by application of "non-key factors." These include physical findings, clinical test results and patients' self reports on Activity of Daily Living functional scales. Thus, choice of diagnosis and of impairment class are the two most important elements in determining the final impairment rating. The generic template is attached as Appendix 2.

In all organ systems, actual functional limitations—the lauded change in the Sixth Edition—can have very small impact on the ultimate WPI rating.

3. Reducing inter-rater variability and reliability by eliminating subjective factors

Despite the rhetoric and the large amount of effort that went into the conversion to the ICF model and diagnosis-based grids, in fact the primary focus in the development of the Sixth Edition seems to have been on reducing inter-rater variability, irrespective of the accuracy of the rating in terms of the actual functional capacity of the individual.

In the effort to address this concern, the Sixth Edition focuses on objective evidence and pathology, rejects subjective symptoms, downgrades the role of treating physicians who would be most familiar with the individual's functional capacity, and, as noted above, restricts the effect of any assessment of functional loss. Rater discretion is reduced by the diagnosis-based grid methodology, which narrows the bands of available WPI ratings as well as by the insistence on objective findings. Although this has been characterized as increasing 'fairness,' it in fact may have the result of lowering the WPI rating, without any consideration for the effects of these changes on injured individuals.⁸

Pain is unquestionably the most important subjective symptom. Because it is subjective, however, it is viewed with suspicion by the authors of the Guides. Under the Sixth Edition methodology, pain is assumed to be included in the rating for any condition covered in the organ system chapters. In contrast, the Fifth Edition allowed for an additional 3% WPI for pain. For painful conditions not subject to rating in the organ system chapters, the Sixth Edition allows up to 3% WPI. This is true despite the fact that the Guides indicate that there is a "linear trend for decreasing positive outcomes (e.g. return-to-work and work retention) as the [pain disability questionnaire] score categories increased." Guides 6th p.40. The Guides chooses objective factors—to ensure reliability—over accuracy in assessing the actual outcomes for disabled persons.

Musculoskeletal Impairments and Range of Motion: The Sixth Edition eliminates range of motion as a basis for rating spine and pelvic impairments. Classification of these disorders is based solely on diagnosis, and then placed within the appropriate class. Again, the justification is standardization that "promotes greater inter-rater reliability and agreement."⁹ In contrast, the Fifth Edition used both ROM and

diagnosis-related estimate (similar to the diagnosis-based impairment) to determine the WPI rating. Range of motion is an indicator of functionality.

Treating physician reports: According to the Sixth Edition, treating physicians' reports carry inherent bias, and therefore require great scrutiny. One of the Section Editors of the Sixth Edition, Dr. Kathryn Mueller, observed, "One study noted higher impairment ratings by treating physicians as compared to an expert who reviewed the same information." Noting that studies show that PPD payments do not adequately reflect actual wage loss of individuals after MMI, she went on to note, "Thus, if the treating physicians' ratings were slightly higher than 'expert' ratings, in a social sense, this may be appropriate. Perhaps the treating physicians are considering the overall functional effects of the injury or illness on the individual."¹⁰ This suggestion is, of course, in sharp contrast to Dr. Brigham's assertions that ratings were consistently too high under the Fifth Edition.¹¹

4. *New direct links to legal issues relating to compensation*

The Sixth Edition is the first edition to openly acknowledge the use of the Guides for determination of economic benefits: "The primary purpose of the Guides is to rate impairment to assist adjudicators and others in determining the financial compensation to be awarded to individuals who, as a result of injury or illness, have suffered measurable physical and/or psychological loss." Guides 6th p. 6. In fact, although this edition continues to state that it should not be used to create direct estimates of disability, the Sixth Edition no longer sets out this caution in bold in the text. It also significantly expands into areas of legal definitions. It adds definitions for causality, aggravation, exacerbation, and recurrence—all legal concepts in workers compensation programs—thereby usurping these programs' prerogative to define these terms. See Appendix 1.

The approach to apportionment is particularly troubling. The traditional rule in workers' compensation programs is that an employer takes a worker as "he finds him." Under this traditional view, the compensable impairment from an injury would include any underlying disease or degenerative process. Although some workers' compensation systems have moved away from this traditional approach, the majority have not. While noting the need to follow the rules of the local jurisdiction, the Guides now instructs raters on how to separate out the portion of the impairment that is not directly caused by the immediate injury. Guides 6th p.26. This may have a troubling normative effect on programs in which apportionment is not currently appropriate, and further reduce the adequacy of benefits for injured workers.

5. *Specific changes in whole person impairment ratings*

The Sixth Edition specifically states that, where there was no compelling reason to change impairment ratings from prior editions, there would be consistency from the prior edition. Thus, despite the adoption of the ICF model and the diagnosis-based grids, the editors assert that very little change was to be made in impairment rating values.

Despite this assertion, there are many unexplained changes in the WPI ratings, and the majority of these appear to lower the ultimate WPI rating for the injured worker.

Examples include:

- Ratings for the most severe impairments for non-musculoskeletal organ systems have been reduced significantly, including for some common occupational diseases such as pulmonary disease. See Appendix 2 for a comparison of the values in the Fifth and Sixth Editions for pulmonary impairment and hypertension: the top rating for the most severe category was lowered from 100% WPI to 65% from the Fifth to the Sixth Editions. Equivalent changes were made in most other organ systems. The top of the scale was lowered, and therefore the scale for severe and moderate disabilities was reduced because of the decrease in the top available rating.¹²

There are, admittedly, some unchanged WPI values, including the conversion of noise-induced hearing loss to WPI and the WPI ratings for voice/speech impairments. And, after perusing all non-musculoskeletal organ chapters, I did find the following increase in values: in the central and peripheral nervous system, the highest impairment rating was increased from 90% to 100% WPI in the Sixth Edition for someone exhibiting a "state of semi-coma with total dependence and subsistence on nursing care and artificial medical means of support or irreversible coma requiring total medical support." Guides 6th p. 327. On the other hand, the ranges for this category were changed: from 70-90% in the Fifth Edition to 51-100% in the Sixth. As a result, the next class down in "consciousness and awareness" was reduced from a range of 40-69% to 31-50% WPI in the Sixth Edition. It is, of course, possible that there are other examples of increases in the top rating or in the scale. In addition, some charts are new (e.g. HIV).

One explanation for these reductions was offered by Dr. Kathryn Mueller, who wrote: “[T]he editors found that the majority of the chapters included a 100% whole person rating even when the 100% whole person rating for that particular body system would not be appropriate [because 100% is equivalent to near death]. Therefore, the editors lowered the 100% whole person ratings in many of the chapters.” She goes on to make the following assumptions: that these individuals will have other organ system impairments that will raise their total WPI, and that “most individuals with severe deficits will be permanently totally disabled, and therefore, in most systems, a permanent partial disability rating relying on the AMA Guides will not be applicable.”¹³ This last statement assumes an availability of PTD benefits that is unlikely to be correct.

- As previously noted, the pain ‘add-on’ of up to 3% has been eliminated from all ratings in organ system chapters. Given that the overall available WPI ratings were not increased to reflect pain, but the Sixth Edition simply states that pain is included, this will result in reductions in WPI ratings for individuals with significant pain.

- Musculoskeletal cases: It is more difficult to assess the changes in the new Sixth Edition chapters for musculoskeletal disorders (upper and lower extremities and spine) because the methodologies of the chapters are quite different from the prior edition. Probably the most significant changes are the elimination of the Range of Motion assessment and the pain add-on. In addition, cases involving surgical intervention are all substantially reduced in terms of WPI. These include spinal fusion (reduced from 24% to 15% WPI), ankle replacement with poor result (30% to 24% WPI), total knee replacement (from 20% to 15% WPI) and hip fracture (from 25% to 12% WPI). I believe that the change in ratings for these cases may be due to the fact that the Sixth Edition does not consider treatment of the injury in the rating.¹⁴ Attached as Appendix 3 is an overview of the WPI rating ranges in the Fifth and Sixth Editions for spine injuries.

There are a few increases in ratings in these chapters, including for vertebral fractures, but the magnitude of these is small. Similarly, some previously non-ratable conditions, such as soft tissue and muscle/tendon injuries and non-specific spinal pain are now rated, all with low WPI ratings of 1-2%.

- In assessing non-orthopedic consequences of spinal injuries, reductions were made in WPI ratings similar to those made for non-musculoskeletal organ systems. For example, comparing the chapter on central and peripheral nervous system disorders in the Sixth with the spine chapter in the Fifth Edition, top WPI ratings for neurogenic dysfunction were reduced as follows: bladder dysfunction from 60% to 30%; sexual dysfunction from 20% to 15%; respiratory problems from 90+ to 65%; station and gait disorders from 60% to 50%. Bowel and upper extremity dysfunction were unchanged.

There are undoubtedly many other changes in these values that a careful review of each chapter would reveal.

Notably, many of the changes in values are inadequately explained. Certainly, it is clear that the move to functional assessment has not led to any review of the adequacy of the impairment ratings for injured workers.

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 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(tm) (our unique, online resource to assess the accuracy of ratings) to ImpairmentExpert(tm) (expert physician reviews). These services are complemented 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. 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 non-economic losses).

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.

ENDNOTES

¹E. Spieler, P. Barth, J.F. Burton, Jr, J. Himmelstein, L. Rudolph (2000) Recommendations to Guide Revision of the Guides to the Evaluation of Permanent Impairment. *JAMA* 283 (4) 519-523.

²I. Sengupta, V. Reno and J.F. Burton, Jr. (2010) *Workers' Compensation: Benefits, Coverage, and Costs*, 2008. Washington, DC: National Academy of Social Insurance.

³This information is drawn from P.S. Barth (2003-2004). *Compensating Workers for Permanent Partial Disabilities*. *Social Security Bulletin* 65(4) 16-23.

⁴These acknowledged criticisms included: "There was a failure to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system; Impairment ratings did not adequately or accurately reflect loss of function; Numerical ratings were more the representation of 'legal fiction than medical reality.'" *Guides* 6th (2)

⁵The Sixth Edition adopts five new "axioms": (1) The Guides adopts the terminology and conceptual framework of disablement as put forward by the International Classification of Functioning, Disability, and Health (ICF). (2) The Guides becomes more diagnosis based with these diagnoses being evidence-based when possible. (3) Simplicity, ease-of-application, and following precedent, where applicable, are given high priority, with the goal of optimizing interrater and intrarater reliability. (4) Rating percentages derived according to the Guides are functionally based, to the fullest practical extent possible. (5) The Guides stresses conceptual and methodological congruity with and between organ system ratings. *Guides* 6th (2-3).

⁶C.Brigham. (2008) *AMA Guides Sixth Edition: New Concepts, Challenges and Opportunities*" *IAIABC Journal* 45(1) 13- 57.

⁷E. Spieler & J.F. Burton. (2010) *The Distressing Lack of Correspondence Between Work-Related Disability and the Receipt of Workers' Compensation Benefits*. Unpublished paper.

⁸According to Dr. Brigham, ratings done under prior editions had high rates of error. He assembled a group of experts to review ratings by other physicians and they disagreed with 78% of the ratings: the average WPI of the raters was 20.4% and the re-rating was 7.3%. He concludes that the ratings being given to injured people were too high, and the Sixth Edition is specifically designed to correct for this. C.R. Brigham, W. F. Uehlein, C.Uejo, L.Dilbeck. (2008) *AMA Guides Sixth Edition: Perceptions, Myths, and Insights*. *IAIABC Journal* 45(2) 65-81. Compare this with the statement by Dr. Mueller regarding treating physicians.

⁹Brigham, supra n. 6.

¹⁰K. L. Mueller. (2008) *The 6th Edition of the AMA Guide to Permanent Impairment: Its Foundation, Implications for Jurisdictional Use, and Possible Future Directors*. *IAIABC Journal* 45(2) 35-47, 42.

¹¹See note 8, supra.

¹²Top WPI ratings for severe impairments were lowered from the Fifth to the Sixth Editions of the Guides as follows: for pulmonary impairment and hypertension from 100% to 65% WPI; for upper and lower digestive tract impairments from 75% to 60% WPI; for liver or biliary tract disease from 95% to 65% WPI; for upper urinary tract disease from 95% to 75% WPI; for bladder disease from 70% to 29% WPI; for urethral disease from 40% to 28%WPI; for penile disease from 20% to 15% WPI; for vulval and vaginal disease and for cervical & uterine disease from 35% to 20% WPI; skin disorders from 95% to 58% WPI; anemia from 100% to 75% WPI; hypothyroid-pituitary axis from 50% to 14% WPI; thyroid abnormalities from 25% to 20% WPI; for diabetes mellitus from 40% to 28% WPI; for hypoglycemia from 50% to 6% WPI; for vestibular (balance) disorders from 95% to 58% WPI; facial disorders 50% to 45% WPI; air passage disorders 90+ to 58% WPI; episodic loss of consciousness or awareness 70% to 50% WPI.

¹³K.L. Mueller (2008) *The 6th Edition of the AMA Guide to Permanent Impairment: Its Foundation, Implications for Jurisdictional Use, and Possible Future Directors*. *IAIABC Journal* 45(2) 35-47, 37

¹⁴For a listing of additional specific changes in musculoskeletal ratings, using the case examples given in the Guides, see T. McFarren (2008), *AMA Guides, Sixth Edition Arrive on the Scene*, <http://www.lexisnexis.com/Community/workerscompensationlaw/blogs/workerscompensationlawblog/archive/2010/02/17/AMA-Guides-2C00-Sixth-Edition-Arrive-on-the-Scene.aspx>

¹⁵Spiele et al, supra, n. 1.

¹⁶Spiele et al, supra n. 1, at 523.

¹⁷Peter 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.

¹⁸Sinclair, 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.

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Chairwoman WOOLSEY. Mr. Burton.

**STATEMENT OF JOHN BURTON, PROFESSOR EMERITUS,
SCHOOL OF MANAGEMENT AND LABOR RELATIONS, RUT-
GERS UNIVERSITY AND SCHOOL OF INDUSTRIAL AND
LABOR RELATIONS, CORNELL UNIVERSITY**

Mr. BURTON. Chairwoman Woolsey, ranking member Rodgers, Congressman Payne and other members of the Subcommittee on Workforce Protections. Thank you for the opportunity to testify about workers' compensation.

As you know, each State has a workers' compensation program that provides cash benefits, medical care, and rehabilitation services. There are no Federal standards for these State workers' compensation programs, and as a result, there are substantial differences among jurisdictions in terms of level of benefits, coverage of employers and employees, and the rules used to determine which disabled workers are eligible for benefits.

Over the past 100 years, there have been periods of reform and regression in workers' compensation. As an example, the level of workers' compensation cash benefits declined substantially in the decades immediately after World War II, and one consequence of this deterioration was the creation as part of the Occupational Safety and Health Act of 1970 of the National Commission on State Workmens' Compensation Laws. The National Commission issued its report in 1972 critical of the State workers' compensation programs, described them as, in general, neither adequate nor equitable, and the National Commission made a number of recommendations for State programs and described 19 of them as essential.

And in the aftermath of the National Commission's report, there were substantial changes in a number of State laws improving these laws. But that improvement has come to a halt, and if anything, a decline. At the risk of oversimplifying the last 40 years, I would say the 1970s were a reformation period, the 1990s was a relative tranquility period, and the years since 1990 are the counter-reformation period.

A number of States changed their laws during the 1990s to reduce eligibility for benefits in contrast to the historical standards for compensability and workers' compensation, and Dean Spieler and I have written extensively on those developments.

There has also been research to quantify the impact of these changes in State laws, and I will mention some work that I have done with Professor Guo. Steve Guo and I have looked at changes in State laws during the 1990 and found that these changes in levels of benefits and in compensability standards were the major source of the decline in cash benefits during the 1990s more so than the decline in the injury rate.

There have been changes in the current decade that continue this process of cutting back on State workers' compensation laws,

and I mentioned several of these in my written testimony, which I will skip over here.

Now, the Social Security Disability Insurance Program is the largest income replacement program for nonelderly Americans. And as you know, this is a Federal program with Federal rules that are standardized throughout the country.

Workers' compensation and the SSDI program serve overlapping, although identical, populations. And Congress has been concerned for a long time about the relationship between workers' compensation benefits and SSDI benefits. Since 1965, there has been a provision requiring that the combined total of the two benefits not exceed 80 percent of pre-injury earnings. And Congress has continued to be concerned about this issue and has made some subsequent changes in these offset provisions.

I think there are several reasons why Congress needs to be concerned about the possible shifting of costs from State workers' comp programs to the Federal SSDI program. For one thing, you have the 15 States which essentially reduce workers' compensation benefits as a way of making sure the combined total of SSDI and workers' compensation do not exceed 80 percent. There are also reasons to be concerned because of the fact that safety incentives and workers' compensation depend upon the costs being charged back against employers. To the extent these costs are shifted, we have a reduction in the safety incentives from workers' compensation.

There is some evidence about the cost shifting that is in the paper, again, some work that Professor Guo and I are doing indicating that the changes in the 1990s were, in fact, responsible for some portion of the increase in SSDI applications during the 1990s. There is mixed evidence on this question. We are doing additional research, but I think there is at least, if not a red flag, an orange flag here that is waving saying we need to be concerned about what is happening in workers' compensation because of its impact for SSDI.

I suggest some policy changes for workers' compensation. My own view, Federal standards for workers' compensation are desirable. I note in here that the National Commission's recommendations were unanimous, and the members of that National Commission were basically Republicans appointed by the Nixon White House. And if it could be done in the Nixon White House Republicans, there is no reason why we can't do it in the present time.

And I also offer some suggestions for the SSDI program. The Federal Government has already taken efforts to stop the transferring of medical costs from State workers' compensation programs to the Medicare program, and I propose here a modest piece of legislation that would also limit the ability of the States to shift the cash benefit portion of workers' compensation into the SSDI program.

Thank you. I appreciate your toleration of my going over a little bit here.

Chairwoman WOOLSEY. Thank you, Mr. Burton.

[The statement of Mr. Burton follows:]

**Prepared Statement of John F. Burton, Jr., Professor Emeritus,
Rutgers University and Cornell University**

Chairwoman Woolsey, Ranking Member Rodgers, and Members of the Subcommittee on Workforce Protections: Thank you for the opportunity to testify about “Workers’ Compensation: Recent Developments and the Relationship with Social Security Disability Insurance.”

I am an Emeritus Professor at Rutgers University and at Cornell University. I was the Dean of the School of Management and Labor Relations at Rutgers from 1994 to 2000. I have conducted research and served as consultant on workers’ compensation throughout my career. I was the Chairman of the National Commission on State Workmens’ Compensation Laws, which submitted its Report to the Congress and to President Richard Nixon in 1972. I am Chair of the Workers’ Compensation Data Study Panel of the National Academy of Social Insurance.

Workers’ Compensation: Overview and Developments

Each state has a workers’ compensation program that provides cash benefits, medical care, and rehabilitation benefits to workers who are disabled by work-related injuries and diseases as well as survivors’ benefits to families of workers who experience workplace fatalities. There are also several federal workers’ compensation programs. However, there are no federal standards for state workers’ compensation programs, and there are considerable differences among the states in the level of benefits, the coverage of employers and employees, and the rules used to determine which disabled workers are eligible for benefits.

The initial state workers’ compensation programs were enacted in 1911, which makes workmens’ compensation (as the program was known until the 1970s) the oldest social insurance program in the U.S. Over the last 100 years, workers’ compensation programs have experienced periods of reform and regression.

As an example, the level of workers’ compensation cash benefits relative to wages deteriorated in most states in the decades after World War II. One consequence of the deterioration in state workers’ compensation programs was the creation of the National Commission on State Workmens’ Compensation Laws by the Occupational Safety and Health Act of 1970.

The National Commission’s 1972 Report was critical of state workers’ compensation programs, describing them as “in general neither adequate nor equitable.” The National Commission made 84 recommendations, and described 19 of the recommendations as essential. The reforms in state workers’ compensation programs in the next few years were impressive: the average state compliance score with the 19 essential recommendations increased from 6.9 in 1972 to 11.1 in 1976 to 12.0 in 1980 (Robinson et al. 1987: Table 1). But reform of most state workers’ compensation laws then slowed, so that by 2004 (when the U.S. Department of Labor stopped monitoring the states), on average states complied with only 12.8 of the 19 essential recommendations of the National Commission (Whittington 2004).

At the risk of oversimplifying the almost 40 years since the National Commission submitted its Report, I would characterize the 1970s as the Reformation Period, the 1980s as the Relative Tranquility Period, and the years since 1990 as the Counter Reformation Period. The extent of the deterioration in adequacy and equity of state workers’ compensation programs in the last 20 years is not reflected in compliance scores with the essential recommendations of the National Commission. Rather, the slippage has occurred in other aspects of the program. A number of states changed their workers’ compensation laws during the 1990s to reduce eligibility for benefits (Spieler and Burton 1998). These provisions included limits on the compensability of particular medical diagnoses, such as stress claims and carpal tunnel syndrome; limits on coverage when the injury involved the aggravation of a preexisting condition; restrictions on the compensability of permanent total disability cases; and changes in procedural rules and evidentiary standards, such as the requirement that medical conditions be documented by “objective medical” evidence.

Research indicates that these legislative changes affected the workers’ compensation benefits received by injured workers. For example, in 1990 Oregon adopted legislation that required that the work injury be the “major contributing cause” of the claimant’s disability for the worker to qualify for workers’ compensation benefits. Thomason and Burton (2005) estimated that this and similar changes reduced the amount of benefits received by Oregon workers by about 25 percent by the mid-1990s. Guo and Burton (2010) found that changes in state compensability statutes and rules and more stringent administrative practices were major contributors to the decline in workers’ compensation cash benefits during the 1990s. More of the decline in workers’ compensation cash benefits in the states during the 1990s is ex-

plained by these changes in workers' compensation provisions and practices than is explained by the drop in workplace injuries and diseases during the decade.

The changes in workers' compensation programs in the current decade have not yet been analyzed using the methodology relied on by Guo and Burton (2010). However, my impression is that the statutory and regulatory changes in recent years may have carried the Counter Reformation Period to new levels. One traditional "principle" of workers' compensation is that "the employer takes the worker as she [the employer] finds him [the employee]". As a practical matter, this principle meant that if an employee had a previous medical condition that had not resulted in lost earnings, and if the employee had a workplace injury that produced a degree of disability that was due to the combination of the new workplace injury and the previous medical condition, the employer was responsible for all of the consequences of the workplace injury, including those that resulted from the interaction of the previous medical condition and the new workplace injury. While there were serious inroads into this principle in the 1990s, the current decade has added a new challenge. California now apportions permanent partial disability awards so the employer is only responsible for the portion of the permanent disability that can be attributed to the new workplace injury.

The current decade also appears to have unusually significant reductions in the amount of benefits that workers are entitled to receive if they qualify for permanent partial disability (PPD) benefits. Since 2000, workers' compensation reforms reduced PPD benefits in several large states. California, Florida, and New York accounted for almost one-third of all workers' compensation benefit payments as of mid-decade (2005) (Sengupta, Reno, and Burton 2010, Table 7). Between 2000 and 2009, California reduced permanent partial disability benefits by over 60 percent, Florida reduced PPD benefits by almost 20 percent, and New York reduced PPD benefits by about 20 percent (NCCI 2010, Exhibit III).

Social Security Disability Insurance

Social Security Disability Insurance (SSDI) is the largest income replacement program for non-elderly Americans. The coverage rules for employers and workers, the eligibility standards for SSDI benefits, and the benefit levels are determined at the federal level. The federal SSDI and Medicare programs provide cash benefits and health care coverage to disabled beneficiaries until they return to work, die, or qualify for Social Security Old Age benefits. The SSDI cash benefits are provided to former workers (and their dependents) who are totally disabled from any cause. In addition, Medicare benefits and rehabilitation benefits are provided regardless of the cause of the disability.

There are important limits on SSDI and Medicare benefits for disabled persons. SSDI benefits are only provided to workers with an extended period of covered employment prior to disability. Benefits are paid regardless of the cause of the disability, but only when the disability precludes substantial gainful employment. SSDI benefits only begin after a five-month waiting period and Medicare benefits are only available twenty-nine months after the onset of total disability.

Differences Between Workers' Compensation and SSDI

Workers' compensation differs from Social Security Disability Insurance and Medicare in important ways. Workers are eligible for workers' compensation benefits from the first day of employment. Workers' compensation medical benefits are paid immediately after the injury occurs. Temporary disability benefits are paid after a waiting period of three to seven days; permanent partial and permanent total disability benefits are paid to workers who have lasting consequences from injuries and diseases caused by the job; and every state pays benefits to survivors of workers who die of work-related injuries and diseases. The most expensive type of workers' compensation benefits involves workers with permanent, but partial, disabilities.

Relationship Between Workers' Compensation and SSDI

SSDI (in conjunction with Medicare) is the largest source of cash and medical benefits for disabled workers in the U.S. and workers' compensation is the second largest source. Workers' compensation and SSDI serve overlapping, although not identical, populations. Both programs pay medical and cash benefits to workers' with chronic, severely disabling conditions. SSDI benefits are limited to workers whose injury or disease precludes substantial gainful employment. To use workers' compensation terminology, SSDI benefits are limited to persons who are permanently and totally disabled.

Workers' compensation is the only significant civilian disability income program, either private or public, that pays benefits to workers who are either partially or

totally disabled.¹ However, the criteria used by state workers' compensation programs to determine whether a worker is totally disabled differ from those used by the Social Security Administration (SSA) for the SSDI program. Consequently, it is possible for an injured worker to be judged totally disabled by the SSA, and thus eligible for SSDI benefits, but only partially disabled by a state workers' compensation program. Furthermore, the criteria used to determine the extent of disability vary among state workers' compensation programs.

Coordination of Benefits

Congress has long been concerned about the relationship between workers' compensation benefits and the SSDI benefits since some individuals qualify for benefits from both programs. The payment of SSDI and workers' compensation benefits has been coordinated since 1965. Specifically, if a person is receiving both SSDI and workers' compensation benefits, the combined benefits are limited to 80 percent of the claimant's preinjury wages. Federal law provides as a "default" that SSDI benefits are reduced or "offset" in order to achieve the 80 percent limit. Initially, states could enact laws that reduced workers' compensation benefits rather than SSDI benefits (which are known as "reverse offset" laws). However, in 1981 Congress eliminated this option for all but the 15 states that already had "reverse offset" legislation.

Congress appears to have had several overlapping purposes with the offset provision. First, by limiting the combined SSDI and workers' compensation benefits to 80 percent of preinjury wages, the total costs of the programs are reduced for workers who continue to qualify for both programs. Second, by limiting the portion of preinjury wages that is replaced, workers are encouraged to engage in rehabilitation and to return to work rather than continue to receive disability benefits from the two programs. Third, the 1981 decision to prohibit additional states from adopting reverse offset laws was motivated by an effort to protect the financial status of the federal SSDI Trust Fund rather than allow the savings from the 80 percent limit on benefits to be returned to employers and carriers in state workers' compensation programs.

As of December 2009, 7.9 percent of SSDI beneficiaries had a current connection to workers' compensation or public sector disability programs, including beneficiaries in reverse offset states, and an additional 7.0 percent of SSDI beneficiaries had a previous connection to workers' compensation (Sengupta, Reno, and Burton 2010, Table 17).

Possible Shifting of Costs from Workers' Compensation to SSDI

There are several reasons why Congress should be concerned about the possible shifting of the costs of workplace injuries and diseases from the state workers' compensation programs to the federal SSDI program.

First, the 15 states with "reverse offset" provisions allow carriers and employers to reduce workers' compensation benefits when the SSDI program is paying benefits to disabled workers, thereby requiring the federal program to pay for some of the consequences of workplace injuries and diseases.

Second, there is evidence indicating that the SSDI program is paying benefits to workers who were disabled at work but who did not qualify for workers' compensation benefits. Reville and Schoeni (2003/2004) examined a nationally representative sample of persons aged 51 to 61 in 1992. Among those who reported a health condition caused by their work, only 12.3 percent ever received workers' compensation benefits, while 29 percent were currently receiving SSDI benefits.

Third, the Reville and Schoeni results pertain to a 1991 sample, but there have been changes in workers' compensation programs since then that are likely to have further increased the number of workers whose disabilities were caused by the workplace who do not qualify for workers' compensation benefits. Burton and Spieler (2001) suggested that these changes are likely to have a disproportional effect on older workers, who in turn are the most likely applicants for SSDI benefits.

Fourth, as Sengupta, Reno, and Burton (2010:43-44) recently observed: "The opposite trends in workers' compensation and Social Security disability benefits during much of the last twenty-five years raise the question of whether retrenchments in one program increase demands placed on the other, and vice versa. The substitutability of Social Security disability benefits and workers' compensation for workers with severe, long-term disabilities that are, at least arguably, work related or might be exacerbated by the demands of work, has received little attention by researchers and is not well understood."

¹ Accidental death and dismemberment (AD&D) insurance provides benefits if an accident results in an employee's death or certain dismemberments enumerated in the insurance contract.

Fifth, workers' compensation programs rely on experience rating of premiums, which are based in part on benefits paid by all firms in the industry and in part on the firm's own benefits compared to other firms in the industry. In theory, firms have incentives to improve safety in order to reduce premiums and to remain competitive. While the evidence supporting the theory is mixed, Thomason (2005: 26) concluded "Taken as a whole, the evidence is quite compelling: experience rating works." To the extent that the costs of workplace injuries are shifted from workers' compensation to SSDI, the safety incentives provided by the workers' compensation program are diluted.

Evidence on the Shifting of Costs from Workers' Compensation to SSDI

There are several studies examining whether the changes in the workers' compensation programs during the 1990s resulted in more applications for SSDI benefits. Xuguang (Steve) Guo and I published an article (Guo and Burton 2008) examining the application rates for SSDI benefits in approximately 45 jurisdictions between 1985 and 1999.² We found that higher levels of expected cash benefits provided by workers' compensation programs relative to state average weekly wages are associated with lower application rates for SSDI benefits. Since expected workers' compensation cash benefits actually declined during the 1990s, the variable helped explain higher SSDI application rates during the decade. We also found that tightening compensability rules in state workers' compensation programs are associated with higher application rates for SSDI benefits. Since the compensability rules were tightening during the 1990s, this variable also helped explain an increase in SSDI applications during the decade.

Professor Guo and I have been refining our model and methodology in the last two years, including the improvement of the variables measuring factors other than those pertaining to the workers' compensation programs that help explain applications for SSDI benefits. Our recent (and as yet unpublished) results indicate that the aging population was the largest contributor of the growth in SSDI applications during the period we examined (1981-1999), and can explain more than half the growth SSDI rolls in 1990s. The share of female employment is another important factor, which was associated with almost 18 percent of the change of SSDI applications between the 1980s and 1990s.³ Our results suggest that reduction in the amounts of workers' compensation permanent disability benefits and the tightening of eligibility rules for workers' compensation permanent disability benefits during the 1990s accounted for about 3 to 4 percent of the growth of SSDI applications during the decade.

The finding that applications for SSDI benefits during the 1990s were affected by changes in workers' compensation programs must be used with caution. Professor Guo and I received this month the data for SSDI applications by state for years after 2001. We do not currently have the values after 1999 for the workers' compensation variables we used to analyze the SSDI application rates during the 1981 to 1999 period. However, in very preliminary work, we did not find that the changes in other measures of the workers' compensation programs through 2006 helped explain the changes in SSDI applications during the current decade. In addition, an unpublished article by McInerney and Simon (2010) of the determinants of SSDI applications concluded that it was unlikely that state workers' compensation changes were a meaningful factor in explaining the rise in SSDI applications and SSDI new cases during the period from 1986 to 2001.

There is thus some modest, although not compelling, empirical evidence that changes in workers' compensation programs since the early 1990s resulted in additional applications for SSDI benefits. The need for additional research on this issue is obvious.

Policy for Workers' Compensation

The developments in state workers' compensation programs in the last two decades are reminiscent of the deterioration of state workers' compensation programs in the decades prior to 1972, when the National Commission on State Workmens'

²Professor Xuguang (Steve) Guo and I receive support for our study of the relationship between the workers' compensation program and the SSDI program from the Program for Disability Research (PDR) in the School of Management and Labor Relations at Rutgers: The State University New Jersey. The PDR has a subcontract from the Employment and Disability Institute at the School of Industrial and Labor Relations at Cornell University, which receives support from the National Institute on Disability and Rehabilitation Research (NIDRR).

³The SSDI replacement rate and the Unemployment rate generally declined across those two decades, which inter alia would have resulted in fewer SSDI applications, and the change in the disability prevalence rate was minimal during the same period. Thus those three factors were not the sources of SSDI growth in the 1990s.

Compensation Laws concluded that “State workmens’ laws are in general neither adequate nor equitable.”

If the plight of workers’ compensation in 2010 sounds like that of 1972, then the fundamental causes of the problems of the workers’ compensation program also have a familiar tone. As the National Commission observed (1972: 124-125):

The economic system of the United States encourages efficiency and mobility. These forces tend to drive employers to locate where the environment offers the best prospect for profit. At the same time, many of the programs which governments use to regulate industrialization are designed and applied by States rather than the Federal government. Any State which seeks to regulate the byproducts of industrialization, such as work accidents, invariably must tax or charge employers to cover the expenses of such regulations. This combination of mobility and regulation poses a dilemma for policymakers in State governments. Each state is forced to consider how it will regulate its domestic enterprises because relatively restrictive or costly regulations may precipitate the departure of employers to be regulated or deter the entry of new enterprises.

Can a State have a modern workers’ compensation program without driving employers away? * * * While the facts dictate that no State should hesitate to improve its workmens’ compensation program for fear of losing employers, unfortunately this appears to be an area where emotion too often triumphs over fact. * * * it seems likely that many States have been dissuaded from reform of their workmens’ compensation statute because of the specter of the vanishing employer, even if that apparition is a product of fancy not fact. A few states have achieved genuine reform, but most suffer with inadequate laws because of the drag of laws of competing States.

If the current plight of state workers’ compensation programs and the cause of the deficiencies strike a familiar chord with those from 1972, so do the basic solutions resonate across the years. One approach considered and rejected by the National Commission was federalization of the state workers’ compensation programs—that is the enactment of a federal workers’ compensation law that would displace state laws and turn over the administration of a national workers’ compensation program to federal employees. In contrast, the policy recommended by the National Commission to enhance the virtues of a decentralized, state-administered workers’ compensation programs was the enactment of federal standards for the state programs if necessary to guarantee state compliance with the 19 essential recommendations of the National Commission

The notion of federal standards for workers’ compensation is probably unrealistic in the current political environment. And determination of appropriate federal standards for a 21st century workers’ compensation program would probably be more difficult now than it was in 1972. The fact that most of the recent deterioration in state workers’ compensation laws has involved tightening of eligibility standards in ways unforeseen prior to the 1990s suggests how difficult it would be to frame new federal standards to deal with current manifestations of lack of adequacy and equity. But if the National Commission on State Workmens’ Compensation Laws, whose members largely consisted of Republicans appointed by the Nixon White House, could unanimously endorse federal standards in 1972, I do not totally despair that Congress or some other responsible organization could in the current era reaffirm the National Commission’s final sentence: “the time has now come to reform workmens’ compensation substantially in order to bring the reality of the program closer to its promise.” And the advantage of federal standards as a way to conserve the essential characteristics of the state-run workers’ compensation system—however paradoxical at first glance—also warrants reaffirmation.

Policy for SSDI

My research with Professor Guo provides the first evidence we have seen that changes in workers’ compensation programs since 1990 increased the number of applications to the SSDI program. As I indicated, the evidence is not conclusive and the relationship between workers’ compensation and SSDI needs further research. But if additional research confirms our preliminary findings about the shifting of costs of workplace injuries and diseases from workers’ compensation to SSDI, one consequence will be the aggravation of the financial problems of the federal program.⁴

⁴According to the latest report of the Social Security Trust Funds (Social Security Board of Trustees 2010, 28) “Total DI disbursements, which started to exceed non-interest income in 2005, continue to exceed such income in 2009. In 2009, DI disbursements exceeded total DI income (including interest), the first time DI assets have declined on an annual basis since 1993.”

Congress has previously enacted legislation to protect the SSDI program from costs being shifted from state workers' compensation programs. There are two types of new legislation that could serve the Congress's legitimate role in protecting the SSDI program from increased applications resulting from lower permanent disability benefits and more restrictive compensability standards in workers' compensation.

First, Congress could enact Federal standards for state workers' compensation programs that require states to provide adequate permanent disability benefits to workers who can establish that their disabilities were caused by the workplace using causation standards that do not contain the restrictive provisions adopted by many states since the early 1990s.

Second, Congress could enact legislation treating applications for cash benefits from the SSDI program in a manner roughly similar to the current Federal policy for Medicare benefits when the patient's need for medical care is due at least in part to a workplace injury or disease. Under the Medicare Secondary Payer Act, certain types of workers' compensation claims must set aside funds to cover medical expenses that might otherwise be shifted to the Medicare Program.

The principle for medical benefits could be adapted to cash benefits by the enactment of the Social Security Disability Insurance Secondary Payer Act (SSDISPA). The SSDISPA would apply to all claims filed for SSDI benefits that:

- Involve injuries or diseases with consequences that last at least six months after the date of disablement, and
- Are compensable under the applicable state's workers' compensation law or would have been compensable using the work-related test included in the Workmen's Compensation and Rehabilitation Law (Revised), [Model Workers' Compensation Law], which was published by the Council of State Governments in 1974.

For all claims to which the SSDISPA applies, the employer (or carrier) must reimburse the Social Security Administration for all SSDI benefits paid because the employer did not pay all of the permanent disability benefits required by the Model Workers' Compensation Law.

I recognize that this proposal for the SSDISPA lacks some important components, such as the specification of an agency for determining whether the SSDI applications involve injuries or diseases to which the SSDISPA is applicable. And there would be additional administrative expenses required to implement the SSDISPA. However, there may be no alternative to such legislation if Congress is unwilling to enact federal standards for state workers' compensation programs and if Congress wants to protect the financial integrity of the SSDI program.

Thank you again for the opportunity to present this testimony.

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Chairwoman WOOLSEY. Dr. Nimlos.

**STATEMENT OF JOHN NIMLOS, M.D.,
OCCUPATIONAL MEDICINE CONSULTANT**

Dr. NIMLOS. Good morning, Chairwoman Woolsey, Ranking Member Ms. McMorris Rodgers, and subcommittee members. 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 have examined workers under two different State workers' compensation systems as well as Federal employees under the Federal Employees Compensation Act and the Longshore and Harborworkers Act.

I make decisions every day about impairment and disability. These are two different terms. Impairment refers to loss of function. It simply means, for example, that the grip is weak or that the arm has less mobility, for example. Disability is the effect of that impairment on the ability to perform a specific job.

For example, I injured my right shoulder years ago. My arm was so weak I could hardly lift a gallon of milk. I couldn't reach higher than my shoulders. I was impaired let's say 5 percent. I could do all my work as a doctor, so I was not disabled. I was zero percent disabled.

On the other hand, if I were a carpenter with the same 5 percent impairment, I would likely be 100 percent disabled. Doctors' im-

pairment ratings are an estimate of how much loss of function is present. Disability is how that function loss affects a person's job. I have significant experience with the editions of the guides. I have taught doctors about impairment ratings and explained ratings to patients. I can state that the sixth edition is dramatically different from prior editions, and as the authors say a paradigm shift.

It is controversial for good reason. It does not appear to be evidence-based. In fact, comments in the sixth edition reiterate that it is a consensus document and also mentioned when they do talk about evidence based research that it is not adequate at this point for doing impairment ratings. It produces impairment ratings far different from those in prior editions, most of them lower and without adequate support for doing so.

In addition, it is difficult to use, requires extensive training of doctors and is inefficient. There are many unexplained rating changes in this new edition compared to the earlier editions. Of 35 cases that I reviewed, 21 were lower in the sixth edition. Several were a lot lower. In another series, I saw that there were 52 cases, 46 were rated lower in the sixth edition. In that same report, the series of 200 cases also showed a large number of reduced ratings by the sixth edition.

One of the guide's authors presented a small series, also with lower editions than the sixth edition, and actually, had he done the math correctly, it would have been lower than he showed in this example.

The impairment rating for total knee replacement with good result is 37 percent of the lower extremity in the fifth edition and 25 percent in the sixth. I didn't find any objective reason for making that change.

The sixth edition is needlessly complex. For sixth edition ratings, I charge more because I find its methodology clumsy and difficult to work with. Every rating under the sixth edition takes several steps regardless of how straightforward the rating could be. After the examination, plus a required patient questionnaire, the doctor first goes to the chart for the diagnosis, then he goes to three other charts for examination results, test results, and claimant's function. The doctor gets numbers from these three and subtracts each number from the number assigned to the diagnosis, then adds these three sums together. That sum is subtracted or added to the number at the diagnosis chart to find out where, in a very narrow range, the final rating really is. That is hard.

Fifth edition rating requires a physical examination and sometimes tests. The doctor goes to a table for each pertinent measurement and matches the claimant's measurement with an impairment percent from the table. For some ratings, there is more than one table, but even then, in most cases it is not that difficult. With some guidance, cases could be rated by an attending doctor. I have even given phone instructions to doctors enabling them to do accurate ratings. It is difficult to get those treating doctors to embrace the impairment rating in the guides. Most step back slowly if I bring out the book. But I believe they will run from the complicated multi step arithmetic and rules of the sixth edition.

Doctors have become familiar with the fifth edition over these 10 years, and the system has some stability now. Adding the sixth edi-

tion, an untested and unproven departure from the format of 40 years doesn't seem worth the disorientation it will cause.

Sixth edition ratings take more time. Experts doing identical sample cases average 5 minutes to rate a case by the fifth edition. To do sixth edition ratings, these same experts in same cases averaged 25 minutes per case.

In addition, early reviews in the sixth edition ratings show an error rate that is similar to those of the fifth edition, so this new edition doesn't seem to fix the problem of training. The sixth edition authors suggest that there is a better inter-rater reliability, but that is likely due to the narrow range of ratings allowed.

The sixth edition fails to grasp the essential factor of impairment assessment, functional losses and activities of daily living. Instead of being the focus for the rating, they are relegated to the last position of three modifying factors, and in some cases, actually can be thrown out.

The validity of impairment ratings will not improve until direct measurement of functional loss and activities of daily living becomes the standard. Reduced rating values are not evidence-based nor is there any explanation given. The fifth edition, for all its shortcomings, more accurately allows assessments of functional losses than the sixth edition in my opinion. Thank you.

Chairwoman WOOLSEY. Thank you.

[The statement of Dr. Nimlos follows:]

AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT

The 5th and 6th Editions Comparison: A Failed Paradigm Shift

JOHN E. NIMLOS, M.D., *November 17, 2010*

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 of the claimant. 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 the methodology clumsy and extremely difficult to work with. Every rating under the 6th Edition takes several steps, regardless of how straightforward a rating could be. After the examination, plus a required questionnaire (or two) 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 function estimate. Applying scores from "no problem" to "severe" in each chart, the doctor gets numbers from these three tables, 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 through 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 sometimes, tests. The doctor then 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 appear based on his own studies. The material from those studies are taken from his practice, 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 cases thought to be too high, and high enough to save that at least that amount by getting it corrected. In that setting, ratings thought by the insurance companies to be correct, or too low, would not likely show up in Dr. Brigham's 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 requested my advice whether or not to agree with the IME. In this series, I found that 45% of the IME's were valid. The remaining 55% had serious flaws, for a variety of reasons, one of them being incorrect impairment ratings. The majority of errors had to do with impairment rating. In my series every rating but one was too low. Quite a few declared no impairment to be present when the examiners own findings supported an impairment rating. 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 these issues, I question the validity of Dr. Brigham's generalizations 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 rating errors to be too low. My data are in agreement with a series of 17 ratings in an international journal. 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, the authors of the Guides do refer to evidenced based research in the 6th Edition, but the only studies they reported 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, 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 occurrence 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 one third (36%)—almost twice the magnitude of decrease amount of the impairment ratings.

My analysis is not the only one that show this drop in ratings. 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 done 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.

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 $\frac{1}{8}$ s of the rating, it means that the average rating went from 24.8% to 12.2%—cutting that rating in half. 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 200 cases were also reviewed, showing many lower ratings in the 6th edition, proportions in similar to the preceding group. 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 “remained to be seen”. However, his own recent report in The Guides Newsletter,* was cited by, and provided the above statistics in the 200 cases in the Sedgwick report.

The Sedgwick report conclusion was that North Dakota annually 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 by the Department of Labor and Industries. 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, a contributor to the 6th Edition, 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 pervasive and dramatic changes to ratings compared to previous edition changes. I believe that the previous new editions generally provided improvements. The changes in the 6th edition are many, but are not improvements in my opinion. If adopted, the 6th edition of the AMA Guides will disrupt disability 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.

Chairwoman WOOLSEY. Mr. Uehlein.

**STATEMENT OF W. FREDERICK UEHLEIN, FOUNDER AND
CHAIRMAN, INSURANCE RECOVERY GROUP**

Mr. UEHLEIN. Thank you very much, Chairwoman Woolsey and Ranking Member McMorris Rodgers and other members. I am pleased to be here with you to discuss this topic of disability benefits, a subject I have been passionate about for the last 40 years.

The one thing I think we can agree on as members here, as testifying here, is that this is a, indeed, very complex subject. And I may be the contrarian in saying to you that the evidence that our company has compiled is contrary to what my brother has said here a second ago.

I remained active in this field for so long because I believe that we can significantly help disabled Americans improve their health and achieve the kind of contribution that they are capable of by structuring our compensation systems to be clear, simple, and to the greatest extent possible based on science and fact. Employers in turn will gain when that happens from the reduction of friction costs associated with poorly designed systems.

Let's face it. Over the next 10 years we are going to be faced with very difficult economic decisions. We want to make sure that the compensation systems that we design fairly allocate the funds that are available.

The guides are used in most systems to determine an injured person's medical functionality. We all agree on that. That is what impairment refers to, medical functionality. So when you see the words "guides to impairment," it is referring to a book designed to help a physician give a determination of medical functionality.

What is confused, even by experts, is that the impairment of medical functionality determined by physicians is not now, nor should it ever be, synonymous with the word "disabilities." That is stated in the guide, "disabilities" meaning loss of wages. In the workers' compensation and Social Security fields, "disability" means loss of wages.

Impairment is something that doctors seek to minimize. Their mission is to maximize functionality. It is obvious to all of us in the field that other factors are relevant such as age, occupation and experience.

The problem is that these other factors, and this is a significant problem, are difficult to objectively and consistently measure. Therefore, that is the task of legislatures, not the AMA guides, around the country to determine how, once you have decided what the medical functionality is, what the disability payment should be.

As I said, that is not the job of the guides. Rather, impairment is only the starting point, the determination of it, for the benefit structure.

The guides create a consistent approach for physicians and for injured workers to have the same determination of impairment and loss of functionality. A physician who looks at three different injured employees with the same condition should arrive at the same rating for each employee. Likewise, three physicians who look at the same injured employee should come up with the same rating.

The goal of the guides is to foster equity, fairness and objectivity to the greatest extent possible rather than subjectivity.

My company, of which I am a director, has performed numerous comparative analyses of the guides. And our conclusion from these studies has been that there is not a great significance in the change of percentage of functionality, the change in ratings between the fourth, fifth and sixth editions. And in fact, the sixth edition extends the benefits to a greater number of impairments.

What we notice in the fifth edition is that certain ratings, such as surgical spine cases increased without explanation over the fourth edition. High ratings occurred even with excellent outcomes. Now, these issues have been addressed in the sixth edition.

So in the fifth edition, just to give you a specific quick example, you could find a situation in the fifth edition where somebody had a single level cervical fusion and get a rating of 28 percent, but in the—have two level fusion and get a rating of 18 percent. I submit to you that isn't fair and that is the type of thing that the sixth edition addressed.

I will just give you this one thought and leave you with my written submission.

The guides are the best objective study that we have today, the sixth edition. It isn't perfect, but it is the best that they have—that we have. It is evidence-based to some extent, and largely consensus-based, but it is consensus-based by experts.

Would you go down with a broken arm to the hospital and ask your orthopedic doctor to use an outdated version of the medical literature to operate on your arm? I don't think so. I recommend that you consider the facts, and not fiction, and that the sixth edition is the best objective test that we have today. Thank you.

Chairwoman WOOLSEY. Thank you.

[The statement of Mr. Uehlein follows:]

Prepared Statement of W. Frederick Uehlein, Esq., Framingham, MA

I am pleased to discuss with you today, injured worker disability, a topic that I am still passionate about after 40 years of work in the field of workers compensation and social security, including work as a plaintiff's attorney, a defense attorney, starting a social security advocacy company and in service companies that support disability claims activities. I am Chairman of Insurance Recovery Group of Framingham, Massachusetts, and a Director of Impairment Resources of San Diego, California. I am an associate editor of the American Medical Association Guides Newsletter. However, I am before you today as an individual who wishes to share what knowledge I have accumulated over these decades from the vantage of the many participants in this complex system, particularly the two primary stakeholders: injured workers themselves and the employers who pay for their care and benefits throughout their recovery.

I have remained active in this field for so long because I believe that we can significantly help disabled Americans improve their health and achieve the kind of contributions they are capable of by structuring our compensation systems to be clear, simple, and to the greatest extent possible, based on science and fact. Employers in turn gain from the reduction of friction costs associated with poorly designed systems. The allocation of funds, then, can more equitably be distributed.

My colleague, Christopher Brigham, MD, Chairman of Impairment Resources, is submitting written testimony for your consideration today, the focus of which is two-fold: first, preventing needless disability and, second, advocating for the use of the most current edition of the AMA Guides to the Evaluation of Permanent Impairment, the Sixth Edition. Going forward, I will refer to these as "the Guides" in my testimony.

Dr. Brigham regrets not being able to attend in person, but is on a long-standing commitment in Australia. His biography and extensive experience are included in

his Testimony. Suffice it to say that he has voluntarily, without pay, devoted thousands of hours to the effective development and utilization of the Guides, serving as the Senior Contributing Editor and working with physicians and other experts from all over the country in developing the most recent edition of the Guides. These Guides are based on expert consensus and the best science- and evidence-based medicine available today. I can attest that Dr. Brigham is the country's most widely recognized expert in the utilization of the Guides and the development of data involving their use. Dr. Brigham speaks from fact, and from the heart, when he says that the most recent version of the Guides is best for both employees and for the employers. It is evidence based, affords consistency and ease of use, and it results in fewer errors.

Let me take a minute to give a brief, but important, primer on the role of the Guides in our disability systems and its relationship to benefit payments. An employee who has had a serious work injury and has improved to the maximum extent that he can is usually entitled to a benefit for his permanent disability. Disability means loss of the employee's earning capacity. He was able to earn a certain wage and now he cannot as a result of this injury. Thus, he is entitled to a benefit to replace that wage. The first step in determining this entitlement is to turn to the medical profession for a report on the employee's medical functionality (impairment). The Guides are used in most systems to determine an injured person's functionality. That is what impairment refers to, medical functionality. So when you see the title "Guides to Impairment," it is referring to a book designed to help a physician give a determination of medical functionality.

What is confused, even by experts, is that the impairment or medical functionality determined by physicians is not now, nor should it ever be, synonymous with disabilities—i.e., loss of wages. In the workers compensation and social security fields, disability means loss of wage earning capacity. Impairment is something that doctors seek to minimize. Their mission is to maximize medical functionality. It is obvious to all of us that there are many other factors than medical functionality—such as age, occupation and education—that determine loss of wage-earning capacity. The problem is that these other factors are difficult to objectively and consistently measure. Therefore, legislators all over the country and the world make different decisions as to how to reconcile a person's injury and functionality/impairment, with the amount of benefit that should be paid or that society can afford to pay.

That reconciliation is not the job of the Guides, nor should the Guides be used as a proxy for the amount of benefits to be paid. Rather, impairment is only the starting point to the determination of a benefit structure for wage loss.

The Guides create a consistent approach for physicians and for injured workers to have the same determination of impairment and loss of functionality. A physician who looks at three different injured employees with the same condition should arrive at the same rating for each. Likewise, three physicians who look at the same injured employee should come up with the same rating. The goal of the Guides is to foster equity, fairness and objectivity to the greatest extent possible, rather than subjectivity and personal opinion.

The Guides have been updated every five or so years by the medical profession under the direction of the AMA in an effort to improve their objectivity, consistency, ease of use, and relationship to the then state of medical science.

Our company, Impairment Resources, is involved in consultation on the use of the Guides and has reviewed many thousands of ratings. This experience has led to our unequivocal statement that the latest version of the Guides is easier to use and more consistent with the realities of modern medicine.

Additionally, Impairment Resources has performed a number of comparative analyses of ratings. We recently looked at the same injuries rated by the Fourth, Fifth and Sixth Editions of the Guides. What these studies indicate is that the rating percentages on the whole are not—and I repeat not—significantly different between editions. The methodology and approach to reach the ratings are different, and in our experience the latest edition, the Sixth, extends ratings to more injuries than the Fifth Edition. In the Fifth Edition certain ratings, such as surgical spine cases, increased without explanation over the Fourth Edition. High ratings occurred even with excellent outcomes. This has been addressed in the Sixth Edition.

In our training role and in our consultations and speaking engagements, we have experienced natural push back from some physicians around the country who, after spending years utilizing the Fifth Edition, are now reluctant to take the time to re-train in the Sixth.

We have experienced, while testifying before various state legislators around the country, push back from the plaintiffs bar. I believe, in all candor, that the reason for that is that the Fifth Edition rates impairment in the spine higher than the Sixth Edition. The expert doctors who wrote the spine chapter of the Sixth based

their ratings more on the end result and impact on the patient. All treatment is designed to increase functioning, ability to participate in activities of daily living, and, therefore, to decrease impairment. Therefore, impairment should reflect the outcome, not just that surgery was performed to improve function.

I fear that a battle over benefit rates is being fought as a proxy battle using the Guides rather than directly addressing benefit rates before legislators. This is probably because legislators have simply not been educated on the purpose of the Guides and the distinction between impairment and disability. To the extent this may be true, this does a disservice to the effective functioning of compensation systems that are improved by the use of the Guides.

The underlying premise of the Sixth Edition is something that you and I, as lay people, have been observing and reading about for a long time: modern medicine is improving health and functionality. That means that we can and should acknowledge that impairment is trending down, not up, and health is improving. I simply do not believe that it is better to use the Fifth Edition and tell an injured worker who has had a successful spine surgery that he has a permanent impairment of 25%; i.e., he has loss of one quarter of who he or she was, when in fact the surgery was successful. I know for myself that, if you tell me I have that kind of impairment, I am going to adjust my behavior to meet it.

To be frank, as I watch testimony before state legislators across the country take up the issue of using the Fourth, Fifth or Sixth Editions, I am struck by the absence of a discussion about the purpose of the Guides. First the purpose should be articulated. Then the debate should turn to whether the latest edition, an older edition or some other system is best.

Because the Fifth Edition, in relation to the other chapters and to medicine today, overrates the spine and because it is not as clear, concise and simple to use as the Sixth, it lends itself to abuse and error, costing employers and eventually taxpayers millions, if not billions of dollars annually. Furthermore, I believe the psycho/social burden of such errors and overrating on injured workers is harder to measure, but likely much costlier.

My hope is that this committee and labor leaders, as well as employers, agree that the goal of utilizing the Guides is to create a level playing field that is based on evidence and fact or, at a minimum, consensus of a broad group of physicians and experts. Legislators should look at the facts and not the fiction.

I would like to emphasize that the mission of our company, Impairment Resources, is to drive accurate impairment ratings. To dispel any notion that our recommendation is based on self-interest or profit, let me make it clear that our company stands to earn more when the Fifth Edition is in widespread use because the error rate for that edition exceeds 70%, while the error rate is significantly lower in reports from trained doctors using the Sixth Edition.

I conclude with this thought as you address the issue the Guides further: Would you go down to the hospital with a fractured arm and ask your orthopedic doctor to use an outdated textbook to repair it or would you ask them to use the latest textbook version?

Our conviction is based on our belief that the Sixth Edition is fairer to all stakeholders because physicians will not only utilize a new methodology more in keeping with modern medicine but with more consistency and less friction.

The Sixth Edition is a reflection of the latest medicine created by hundreds of the leading experts in medicine in the country and put through a rigorous peer review process. It is clear and easier to use. It offers the best opportunity today to achieve the role it is designed for, to create a fair and equitable playing field to reflect impairment consistent with the advances in medicine.

Thank you.

Chairwoman WOOLSEY. Mr. Godfrey.

**STATEMENT OF CHRISTOPHER JAMES GODFREY,
IOWA WORKERS COMPENSATION COMMISSIONER**

Mr. GODFREY. Thank you to members of the subcommittee, Chairwoman Woolsey. Thank you for the opportunity to come here today to speak on behalf of the people of the State of Iowa, and also the more broad workers' compensation community.

My written testimony, I think, does a fair job of describing the way in which the—we have an interplay between impairment and

disability. And that also explains why the sixth edition of the AMA guides has such an important impact upon the people of the State of Iowa.

As we talked about the facts of the sixth edition, we felt it would be good in Iowa to have a task force. The task force report from the State of Iowa has been included within the written record, and is available online as well. The link to that is within my materials. I would urge you all to read through that material. It is fact, it is objective-based, and it comes from the testimony of most of the doctors whose names are on the book or have very important roles in creating the book.

Now, why is this important to you? I think as the ranking member suggested, how does the decrease in the State workers' compensation program affect the Federal Government? I would urge you to look at the Medicare system. The interplay between workers' compensation settlements and the resulting impact on Medicare is very well known, and it is a significant controversy. We see that employers' insurance companies will settle a workers' compensation claim for a premium amount, and then liability for future medical care can be passed on to the Federal Government. That is an important thing for all of you in these times.

When we have an impact on the level of disability benefits paid to injured workers through a workers' compensation system, which I will explain here shortly, there is a corresponding risk to the Federal Government that we will have increased applications and need for Social Security Disability benefits. If people are not going to get the benefits they are entitled to and have previously been entitled to under State workers' compensation laws, they will turn to an alternate system.

Now, when we went through our task force, we came up with four very important ideas that we felt were at issue. First, we felt there was an encroachment on our legal community in the State of Iowa with our own laws. We are concerned about the consensus of the people that make up this guide. We are also concerned about the numerous errors, the need for an errata, and also a subsequent publication of the guides, and we are also very concerned about cultural biases.

Now, first the encroachment of legal boundaries. Iowa has its own workers' compensation program. It started in 1913 and it is the same type of system throughout the United States where each State has its own system. One issue that I would encourage to you look at is the apportionment. In section 2.5 of the new AMA guide, they deal with apportionment. It allows doctors to apportion out some rating of impairment. That is in direct violation to Iowa Code section 85.34(7). That was an apportionment statute that came about through political compromise. It does not allow the apportionment that is allowed under the AMA guide. So that is of deep concern to us.

The consensus. Why won't the AMA tell the State of Iowa who is involved in writing this book and being the editors of this book? Within our written materials, we have posted the questions that we pose to the AMA. And you can see their responses. And I would say that they are not responses. We are passed off to the marketing department and given very brief questions. I would urge the sub-

committee to ask the AMA, tell us who is involved in writing each of these chapters? And who was the editors of each of those chapters?

In all the previous editions of the book when you open it up, it will tell you who wrote each individual chapter and edited that chapter. That is not within the sixth edition, and our concerns about that are summed up in our task force report.

Now the numerous errors, as I mentioned, there is a reprinting of this book, which I don't have before me, but it is almost the same size. When you have, as a work comp judge, an impairment rating under the sixth edition come before you, how will you know, or how would I know whether this book was used that contains numerous errors, or the reprinted edition which does not have those same errors, how would I know where that impairment rating came from? There is no indication on the second printing of the book that that is the corrected version.

So we have State workers' compensation bodies paying disability benefits based upon impairment ratings, and we don't know where they came from. That is not the way that these systems should be set up. This is a book for serious business purpose. We feel it fails to live up to that guideline.

Lastly, the cultural biases in Iowa we have a significant immigrant workforce. We have Bosnians, Hispanics, Asians, Sudanese. Those people react to injuries differently. They react to pain differently. There is levels of trust which are different between people of various cultures. The guides which come out of this book are determined based upon the use of various tests which are included in the book. Those are not tested for cultural sensitivity and therefore people of different races and different educational backgrounds could have different impairment ratings.

I would say that that is a bias which should not be allowed within the legal system. That is part of the reason that we could not endorse this book, and I think it needs further study. When we asked the editors of the book how you would address the fact that there are these cultural differences not cared for, they were told, we were told, well, just don't use the test. Well if you don't use the test you don't get your impairment rating either up or down, and that is treating people differently based upon their culture, and that is not allowed.

So there are various questions. They are summed up very well, our answers and responses to that within our task force, and I would be happy to answer any additional questions. Thank you.

[The statement of Mr. Godfrey follows:]

Prepared Statement of Christopher James Godfrey, Workers' Compensation Commissioner, Iowa Division of Workers' Compensation

MEMBERS OF THE COMMITTEE: Thank you for the opportunity to come before you to address the impact resulting from the publication of the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition on the Iowa Division of Workers' Compensation and other workers' compensation jurisdictions more generally. I also plan to testify about the impacts restricted workers compensation programs have on federally funded programs such as Medicare and Social Security Disability.

It is a great honor personally for me to speak to the members of the Subcommittee today about the workers' compensation system in the state of Iowa and share with you the detailed findings of the Task Force I convened in May 2008 to study the Sixth Edition of the Guides.

In my capacity as the Iowa Workers' Compensation Commissioner I plan to explain the impact the publication of the Sixth Edition has had on my jurisdiction, which has historically relied upon the most recent edition of the Guides for assignment of permanent impairment ratings. I can also address issues faced by other jurisdictions which are mandated by law to use the most recent edition of the Guides. More importantly I plan to share my thoughts about how the problems identified by our Task Force regarding the Guides can ultimately affect federal programs over which you have oversight responsibility.

Each state has its own unique workers' compensation system. Iowa passed its Workers' Compensation Act in 1913 and it has evolved into a model system which is annually recognized as one of, if not the best in the United States.¹ Iowa prides itself on being a national leader while keeping premiums low for Iowa employers and benefit rates high for injured workers. The workers of Iowa annually sustain 21,000 or more reportable workplace injuries. From those injuries the Division receives petitions for contested cases in approximately 4,200 cases and holds 600 administrative hearings. It is evident from the statistics that the vast majority of injury claims in Iowa resolve without intervention of our administrative agency. The high voluntary resolution statistics are driven by the self-effectuation of workers' compensation claims between employers and injured workers. It is envisioned within the Iowa Act that disability claims will be fairly and reasonably investigated and reasonable benefits owed pursuant to the Act will be paid.² This compliance with voluntary payment obligations is necessary as the Division of Workers' Compensation is limited to 26 full time employees following quite extensive cuts across the board in state funding.

Iowa's self-effectuating workers' compensation system relies upon disability payments that are reliable and consistent. For injuries that are considered "scheduled" injuries—limbs and portions of limbs—Iowa has a specific numerical value assigned as a number of weeks for loss/loss of use of the particular body part. For instance, in Iowa an arm is worth 250 weeks of disability benefits. If a worker loses 10 percent use of the arm the worker is entitled to payment of 25 weeks of permanent partial disability benefits. (250 weeks x 10 percent = 25 weeks) For injuries that are considered "whole body" injuries—spine, head, nervous system, etc.—the minimum permanent partial disability rating is most often the level of permanent impairment plus, perhaps, additional compensation for loss of earning capacity of the worker. Whole body injuries are compensated on a 500 week schedule. Therefore if a worker has a 10 percent whole person impairment the worker is entitled to payment of 50 weeks of permanent partial disability benefits. (500 weeks x 10 percent = 50 weeks)

Likely resulting from extensive study and political compromise, Iowa Code section 85.34 assigns a weekly value to the various body parts, the whole body, and for permanent total disability. As the weekly value of a disability is a constant, the assignment of impairment for the body part can drastically impact the extent of weekly benefits owed as a voluntary payment. For instance, for an arm the 250 week schedule is a constant. If an impairment guide modifies impairment from 8 percent to 4 percent for a certain condition the workers' disability entitlement can be reduced from 20 weeks of compensation to 10 weeks. An impairment level that increases following modification of an impairment guide would likewise greatly affect the obligation of the employer to compensate a worker.

As a result, the decision of the AMA to alter the impairment paradigm and assign new impairment values based upon a diagnosis significantly impacts both Iowa employers and injured workers. This system-altering change occurred without open discussion or transparency. More troubling is that the change was made without consultation with the various state jurisdictions including the Iowa Division of Workers' Compensation or elected leaders of the many states. Consequently, numerous state jurisdictions were left to react to the Sixth Edition following publication. What Iowa uncovered following a comprehensive study by an appointed, independent Task Force was both troubling and frustrating. It is a great concern that as fewer benefits may be awarded to injured workers due to drastic impairment reductions, those workers will likely turn to state or federal programs for assistance.

¹ Iowa ranked as best performing state for Workers' Compensation by Work Loss Data Institute, July 22, 2009. Iowa remains a Tier 1 state for performance of its Workers' Compensation system per the Work Loss Data Institute, March 15, 2010.

² A claim for penalty benefits can be commenced against an employer who fails to timely pay indemnity benefits without reasonable or probable cause or excuse known to the employer at the time benefits were not paid. Iowa Code section 86.13(4).

The Iowa Task Force

Upon publication of the AMA Guides, Sixth Edition, Iowa's workers' compensation community was confronted with many concerns and questions. Were physicians to use the Fifth or Sixth Edition; were employers to pay benefits using ratings from the Fifth or Sixth Edition to show compliance with voluntary payment obligations; was the Sixth Edition peer-reviewed; was the Sixth Edition compliant with Iowa laws; and what training was necessary to either complete or review an impairment rating under the Sixth Edition? These significant issues and others led to the convening of a Task Force comprised of two medical professionals who frequently practice in the Iowa Workers' Compensation system, two "claimant" and two "defendant" attorneys who frequently practice in the Iowa system, two former Deputy Workers' Compensation Commissioners from Iowa, and one moderator to perform various administrative tasks and issue the final report.

The Task Force was assigned five primary agenda items:

1. Provide an analysis of the new paradigm for rating impairment contained in the sixth edition as compared to the prior editions of the guides as well as other rating guides. Identify advantages and disadvantages of the new paradigm.
2. Document errors or areas of concern contained in the sixth edition of the AMA Guides.
3. Outline an analysis that can be used to determine whether there is a significant impact on impairment ratings when using the sixth edition of the Guides as compared to prior editions of the Guides—most specifically the fifth edition. If possible, provide an analysis of the impact on ratings and corresponding benefit payments.
4. Provide a recommendation on whether the sixth edition of the Guides should be used, whether parts of the sixth editions should be used, or what other impairment guides should be used in evaluating permanent impairment. Provide a further recommendation as to whether Iowa should create its own "Iowa Guide" for assigning impairment in Workers' Compensation claims—and if so recommended, outline what process and timeline would be necessary to create the new "Iowa Guide".
5. Report back on other considerations that the task force finds compelling.

The Task Force met 5 times from June 26, 2008 to August 26, 2008. The Task Force accepted testimony from several medical practitioners involved in developing the Sixth Edition including Alan Colledge, M.D., Mark Melhorn, M.D., Mohammed Ranavaya, M.D., Douglas Martin, M.D., Christopher Brigham, M.D., John Brooke, Ph.D., and James Gallagher, M.D. The Task Force also studied comparative data, held extensive discussions, and proposed administrative rule amendments for the Iowa system. The findings of the Task Force concluded with a vote of 7-1 against Iowa allowing the use of the Sixth Edition. I ask that a complete copy of the Task Force Report be included into the Record of the hearing. It can also be found online at the following location: <http://www.iowaworkforce.org/wc/amatastaskforce/2008amaguidesprocessreport.pdf>

A paradigm shift in the Sixth Edition—blurring boundaries between medical and legal determinations

The Task Force learned that at the heart of the Sixth Edition is a change in the paradigm of rating impairment. The Sixth Edition replaces the "1980 International Classification of Impairments, Disabilities and Handicaps" with the World Health Organization's model of disablement "International Classification of Functioning, Disability and Health" (ICF). The ICF model in the Sixth Edition defines impairment as "a consensus derived percentage estimate of the loss of activity that reflects the severity of a given health condition and the degree of associated limitations in activities of daily living." The Task Force expressed significant concern that the Sixth Edition blurs the line between the level of impairment (a medical determination) and the level of disability (a legal determination). Dr. Mark Melhorn admitted that some of the Sixth Edition analysis clearly crosses into the area of disability as opposed to merely assigning impairment. It is the province of the workers' compensation jurisdictions to assign the extent of disability resulting from a medical finding of impairment.

Chapter 2 of the Sixth Edition provides Iowa with a significant number of troublesome principles contained within the Guides which conflict with Iowa statutory and case law. Other jurisdictions will face similar conflicts.

Section 2.5 blurs the line between medical and legal standards for disability by defining "causality". Whether an injury arises out of and in the course of employment is a legal determination to be made by an administrative law judge or a member of the judiciary, as opposed to a medical practitioner. The Sixth Edition states that to opine that a cause relates to an effect within a reasonable degree of medical probability, it is necessary that the event occurred, that the individual who experi-

enced the event must have the possible condition, that is, the effect which may be related to the event, and that medical probability exists for the event to have caused or materially contributed to the condition. The Task Force noted that “if medical probability means a greater than 95% relationship, this definition of causality differs from the more likely than not legal probability standard in Iowa workers’ compensation law.” If the causation standard is to be amended in Iowa, that change should occur through the political process and not through an unelected, undisclosed panel within the AMA.

Section 2.5 further blurs the line between medical and legal standards by defining “aggravation”, “exacerbation”, “recurrence” and “flare up”. An aggravation is described as a permanent worsening of a pre-existing or underlying condition, which results from a circumstance or event. It is distinguished from an exacerbation, recurrence, or flare up. Those three terms are said to imply a temporary worsening of a pre-existing condition that then returns to a baseline. The Task Force notes that “Iowa workers’ compensation law makes no such distinction between exacerbation and aggravation; each may be considered to result in a permanent, potentially compensable, substantial change in a pre-existing condition.”

Finally, section 2.5 provides a methodology for allocating or “apportioning” impairment between or among multiple factors. The Sixth Edition allows for a final rating which is derived by subtracting from current impairment any pre-existing impairment. This “apportionment” of disability conflicts with the recently amended Iowa Code section 85.34(7) and places employers at risk of a penalty if they pay an impairment rating value which improperly reduces the impairment in violation of section 85.34(7). Likewise, for injured workers who are paid a reduced disability award based upon improper apportionment, the worker may never obtain the extent of disability owed pursuant to Iowa law or may be required to file a contested claim with the agency and incur legal expenses—both of which are to be avoided in the self-effectuating Iowa workers’ compensation system.

Dr. Christopher Brigham presented the Task Force with an article he relates to be published. Dr. Brigham concludes his article as follows:

In interpreting reactions by different stakeholders it is important to distinguish between the criticism of the process and the perceived impact on the stakeholders. The more significant problems do not lie with The Guides, but rather, with how impairment ratings are used by Workers’ Compensation Systems or other systems. The AMA Guides will continue to evolve and improve. The systems that make use of the Guides must also evolve.

With all due respect to Dr. Brigham, the Iowa Workers’ Compensation system will evolve and improve when it is decided by the citizens of Iowa that it will evolve and improve. The system will not evolve at the whim or business opportunity of either one physician, one medical association, or a small consensus of the two.

Iowa has long held that the question of how disabled an injured worker has become following an injury is a legal question, not a medical question, to be decided by the workers’ compensation commissioner as trier of fact with the causation standards set forth in the Iowa Code. In violation of Iowa law, the authors and editors published a Sixth Edition which unquestionably and explicitly “crosses the bridge into,” “attempts to determine,” and “is a surrogate for” legal disability. Sixth Edition, p. 5 (defining “impairment rating” to include the disability concept of the “degree of associated limitations in terms of ADL’s”). Such encroachment of state law by an unelected body is a serious breach. Furthermore, states which are bound by their statutes to rely upon the most recent edition of the Guides will turn away injured workers who previously were entitled to benefits or may leave workers with benefit awards that fail to adequately compensate the worker to the extent as before adoption of the Sixth Edition. Injured workers denied coverage under a workers’ compensation act will turn to other available venues for support—most likely applying for Social Security Disability benefits or federally sponsored medical care.

Other Sixth Edition Concerns

Consensus

In order to determine the basis for the paradigm shift and to determine who was included in the “consensus” for such changes, the Task Force submitted 5 questions to the AMA. The AMA and the medical practitioners questioned by the Iowa Task Force (each of whom specifically stated he did not speak for the AMA) either failed or refused to explain a legitimate rationale for the paradigm shift to the ICF. Such lack of transparency raises concerns about the motives and justifications behind the shift. Furthermore, there was a wholesale refusal to provide the names and qualifications of those involved in the decision to shift the paradigm and adopt the ICF model. Dr. Melhorn stated that the decision to change the assessment methodology was made prior to his involvement with the upper extremity committee and he did

not believe that all chapter editors agreed with the paradigm change. Also, the AMA further refused to identify who ultimately assigned the values to the numerous impairment ratings found in the Sixth Edition, or why the values were changed from those found in the Fifth Edition. Information shared with Task Force members suggests that much of the construction of the book and assignment of impairment values was not the result of a consensus at all as much as it was the work of one person, Dr. Christopher Brigham. It must be noted that Dr. Brigham has a successful enterprise based upon reviewing, correcting, or commenting on other physician's ratings. Dr. Brigham further offers several courses to teach physicians and others how to use the Guides.³

The questions and responses from the Task Force to the AMA are set forth herein:

When the AMA asserts that it relies upon a group/consensus process to assign values of impairment, it becomes important to know who comprised the group as it is obvious that outcomes may vary significantly depending upon those who are included or excluded from the consensus process. Without knowing the composition of the groups who determined the ratings in the book it is impossible to determine the biases which may exist or which may suggest an unfair group composition. Moreover, the lack of transparency furthers the belief that "consensus" may have succumbed to the decisions or opinions of one particular person. The Iowa Task Force continued to ask, "Why the Editors and the AMA are being so vague as to who was involved in developing the particular chapters?" In the Fifth Edition, the AMA freely shared the members involved in the development and editing of each chapter. It also appears that "consensus" may have been reached in the Sixth Edition because those who were initially consulted and had differing opinions were no longer part of the "consensus" by the time "consensus" was reached. Such a belief is bolstered by the suggestions that Dr. Brigham ultimately was a consensus of one for many chapters of the Sixth Edition.

Members of the Iowa Task Force were also concerned about the biases of the consensus itself. This concern emanates from comments and correspondence received from Dr. Douglas Martin, a physician from Sioux City, Iowa, who was one of the reviewers for the Fifth Edition of the Guides and is also on the Editorial Board of the Sixth Edition. In correspondence and in a meeting with the Task Force, Dr. Martin expressed concerns about "hidden agendas and biased allegiances which many physicians (involved in the development of the Sixth Edition) cannot say." As noted by the Task Force members, this is an extremely troubling statement from a member of the Editorial Advisory Board and calls into question the consensus that derived the impairments to be assigned in this book.

Errors and Editorial Concerns

The limited, initial involvement of workers' compensation systems in the production of the Sixth Edition was quickly reduced by attrition. Two Medical Directors for state workers' compensation systems, Dr. Alan Colledge and Dr. Hal Stockbridge, withdrew from the editorial process of the Sixth Edition. Dr. Stockbridge apparently withdrew for reasons unrelated to the editorial process. However, Dr. Colledge testified before the Iowa Task Force that he withdrew because of disagreements over the content and the methodology being developed for the Sixth Edition. Dr. Colledge has practical experience in workers' compensation systems from clinical practice and impairment ratings to medico-legal settings, to government experience as Utah's workers' compensation medical director. While state Medical Directors were initially involved, the Iowa Task Force was not informed of any state commissioner or agency head being invited onto the editorial staff.

Of perhaps greater concern than the editorial makeup of the Sixth Edition is the significant number of errors included in the initial publication as well as in the subsequent errata. The AMA and the editors have produced a product that people rely upon for serious business purposes that has so many identified errors that it required a 52 page errata to publish them all, as well as an entirely new printing for additional changes. It is noted that the second printing is not identified as a corrected version. Therefore, it is perhaps impossible for a state workers' compensation agency, which must review an impairment rating, to know if it was done with the

³ Dr. Brigham's company can be found on the internet at www.impairment.com and there one can find his education courses, rating review charges, and many of his primarily employer-insurance carrier oriented topics. It was noted by the Iowa Task Force that Dr. Brigham's company provides a service to evaluate impairment ratings, and charges \$95 for correct ratings and \$195 for incorrect ratings—likely making it in his own best interest to find incorrect impairment ratings. With the significant difficulty in training physicians following the paradigm shift it was noted that there will be a significant increase in impairment rating errors which would also be to Dr. Brigham's own financial best interest. Since the findings of the Iowa Task Force were published, Dr. Brigham has amended his fee schedule.

corrected version of the Sixth Edition, or the original flawed publication. Dr. Rondinelli has stated that corrections and clarifications to the Sixth Edition are likely to be ongoing in nature. Therefore, a workers' compensation agency cannot accurately rely upon the Sixth Edition as the publication is under continual amendment. Furthermore, a recent business solicitation from Dr. Brigham reports that 80 percent of impairment ratings are incorrect and his team of "certified" raters will review ratings and provide corrections.

Although the Iowa Task Force detailed the numerous errors, those errors are too detailed and require significant explanation and will not be further detailed herein but can be found within the Task Force Report at the link previously provided.

Cultural Bias

The Iowa Task Force was the first body to question the scientific basis of and the potential for cultural bias in the questionnaires and tests included within the Sixth Edition. It was confirmed that the Dash and Quick Dash questionnaires, which were created for the Sixth Edition, are not culturally sensitive and they have not been tested to determine the reading proficiency level which a native English speaker must possess in order to be able to read, understand, and answer questions appropriately. By failing to properly test the Dash and Quick Dash forms it is highly possible that the questionnaires may result in invalid (artificially high or low) scores for any of the numerous and diverse non-Anglo cultures which exist in the Iowa workforce. Lack of reading level proficiency testing means these questionnaires may result in invalid scores for those of lower educational levels.

This lack of sensitivity and proficiency testing results in a significant possibility of a disparate impact in the ultimate impairment rating assigned to persons of different cultures or educational levels. The Dash and Quick Dash scores are not only used as part of the "net adjustment formula" which can modify the normal impairment ratings, Sixth Edition, p. 11; if the scores are inconsistent with other modifiers by 2 or more grades then the grade modification process is thrown out entirely, Sixth Edition, pp. 406-407; and if they are simply too high (above 60) then the worker may be classified as a symptom magnifier or in need of a psychiatric diagnosis, Sixth Edition, pp. 447-448.

The only commentary from the AMA or those interviewed by the Iowa Task Force came from Dr. Rondinelli who suggested that given the lack of cultural sensitivity in these tools, the questionnaires simply not be utilized with members of a minority population. However, the result of Dr. Rondinelli's suggestion would be to endorse disparate methodologies for rating permanent impairment for persons of different cultures, ethnicities, and educational ability. Simply rejecting use of these modifier questionnaires would eliminate a potential mechanism for such a person to have her or his impairment rating legitimately modified. Such blatant disparate treatment is not only unfair, it is possibly legally discriminatory.

Iowa has long been at the forefront of equal protection for all its citizens. The Iowa Division of Workers' Compensation cannot endorse the use of a rating system that has a high likelihood of discriminating against classes of persons. Other jurisdictions should refuse to do so as well.

Costs to the Iowa Division of Workers' Compensation and Others

There are numerous costs to state jurisdictions and others resulting from alterations of impairment guidelines. In addition to state workers' compensation agencies it is necessary to focus on the costs to unrepresented workers, medical professionals, and also the federal government.

The primary cost to state workers' compensation jurisdictions will be borne in increased levels of litigation. Workers who are dissatisfied with the level of voluntary disability payments will seek to petition for additional benefits. There is a likelihood that those litigation claims may include complex issues such as whether the Guides' standards for causation and apportionment are applicable or overturn case law precedent and whether the permanent partial impairment ratings comport with the factors of permanent disability inherent in the state's own workers' compensation act. As litigation increases it results in longer timelines from the date a petition is filed until a final agency decision is produced. The longer it takes for litigation to occur the greater the likelihood that injured workers will be forced to seek alternate means of support including support from the federal government.

As was previously mentioned, the Iowa system requires good faith claims handling to fulfill the self-effectuating payment model. Most workers will simply agree to the voluntary payment made by the employer or insurance company without seeking attorney representation. If it is likely that voluntary payment levels are reduced there will be a significant increase in applications for other benefit programs. Furthermore, workers in rural areas of a state may be required to travel greater

distances for an impairment rating as the number of doctors trained in the use of the Sixth Edition is greatly limited. For significantly disabled workers the increased travel may result in significant hurdles to obtain benefits that should be voluntarily paid by the employer or insurance carrier. Such hurdles may result in driving greater numbers of workers to apply for social security disability benefits or to seek other government programs.

Medical professionals who are called upon to provide expert opinions as to matters in workers' compensation claims face significant costs in use of the Sixth Edition. Due to the complete paradigm shift and the complexity of the new paradigm, it was estimated that a medical professional would need to attend a minimum 8 hour training course or spend 28-30 hours of self-study. The costs of such training are increased as the training often occurs out of state and requires an absence from day to day duties with patients. Many doctors will opt out of the workers' compensation system if they are required to seek certification or prove they have obtained extensive training. For rural doctors it is not cost efficient to seek training as they see so few workers' compensation patients that they cannot recoup their investments. Hence workers in rural areas will have less access to proper ratings under the Sixth Edition. Any increase in costs associated with training and increased medical examination fees will be passed along to employers and insurance carriers.

As has been shown consistently throughout the testimony provided, when injured workers face hurdles caused by amendments to state workers' compensation programs they will seek assistance from the federal government. The cost shifting that can occur can be extensive. A common example of cost shifting which is already a significant federal concern is the shifting of medical costs from workers' compensation insurers to Medicare. Without strict scrutiny of settlements by the federal government there is the dramatic risk of having Medicare make medical payments that are the clear liability of the responsible insurer. An insurer may choose to pay a premium settlement to a worker with the understanding that they waive any further obligation to make medical payments, thus leaving the worker to seek Medicare coverage for future care. Likewise, if monetary value of injury payments is reduced either through legislative changes or through indirect means such as the new AMA Guides it is apparent that there will be a corresponding increase in the number of workers who will submit applications for Social Security disability benefits.

Conclusion

Thank you for your interest in the probable impact on the state of Iowa, other workers' compensation jurisdictions, and the federal government resulting from the publication of the AMA Guides, Sixth Edition. The information provided will hopefully spur further interest in this topic that can have a significant impact on participants in workers' compensation systems throughout the United States. I have greatly appreciated the opportunity to share my thoughts with you and I welcome further questions on an individual basis as your investigation moves forward.

Chairwoman WOOLSEY. Thank you very much. Each one of you brought to light a lot of what we are concerned about. I have a question. We have a lot of questions. Just for the record, assume I am a worker that got injured on the job. Why do I care about this at all? What difference will that make to me, starting with you, Dean.

Ms. SPIELER. There is some variation among States, but in many States, the number that is assigned to the impairment will be in a fairly straight line to the benefits. So there is a formula in State statutes. In West Virginia, the time that I was in charge of the program, it was a—4 weeks per each percentage point based upon a calculation of wages that relate to the preinjury wages with a cap of the State average weekly wage. So there is a direct line between, in many States, between the number that is given as a result of the guides. In an additional number of States, it seriously impacts the ultimate, although the formula may not be quite as lengthy.

Chairwoman WOOLSEY. Is it the duration of coverage also, how long I will be covered for my injury?

Ms. SPIELER. Again, that depends a bit on States, but in the majority of States, yes, and it affects in particular the compromising release agreements that are worked out between the parties in these cases, because it helps in the quantification of the amount of money that the injured worker receives. That is why the numbers in the guides, as opposed to the process of evaluation, are so critical and should be scrutinized.

Chairwoman WOOLSEY. So Mr. Uehlein, this is very important to the worker.

Mr. UEHLEIN. This is very important to the worker.

Chairwoman WOOLSEY. So my question is, if there wasn't any great significance from the fifth to the sixth edition, why was it necessary in the first place?

Mr. UEHLEIN. Well, there were numerous criticisms, as we look at—as the AMA looks every 4 or 5 years, they keep looking to how to improve the system.

Chairwoman WOOLSEY. But it doesn't appear it was improved. It went backwards.

Mr. UEHLEIN. I would submit to you and my associate, Dr. Christopher Brigham will be submitting testimony on this, that the sixth edition is simpler to use. The training is easier when it is applied. It is more consistent and fairer, especially when you get—go between different body parts.

Chairwoman WOOLSEY. Well, speaking of training, okay, Dr. Nimlos virtually has said you have to be a mathematician to be able to work out the formulas for the ratings. So, is it true that one of the developers of this rating system is now a trainer? Did this person set up their own future career by having it so complicated that now training is sort of necessary?

Mr. UEHLEIN. Well, training, there are many companies in the country that perform training, including the one I am a director on. I would say that training is an essential function in any system. The fact of the matter is that what we can tell you about training is that we find it easier to train doctors under the sixth edition than we do under the fifth edition.

And just for the record, let me make it clear, that in doing this, to the extent that we benefit as a company, we would benefit more from the higher error rates that our statistics demonstrate, which are very considerable statistics, under the fifth edition, rather than the sixth edition. Contrary to what I heard testified to earlier, the sixth edition has a lower error rate, therefore, it is fairer to employees across the board.

Chairwoman WOOLSEY. Dr. Nimlos and Mr. Godfrey, would you like to respond to this?

Mr. GODFREY. I would like to respond. Within our task force you will see testimony from Dr. Robert Rondinelli, whose name is on the front of this book. He is associated with Dr. Christopher Brigham. And again, you can look at Dr. Brigham's Web site, which is part of my written testimony. They estimated that it would take up to 30 hours of self-study and an 8-hour course.

Now we are talking about doctors closing down their day-to-day practice to go to a 8-hour full day course or over the course of 2 days, plus travel. That is a significant cost. When we had workers within the Iowa workers' compensation system, most of these peo-

ple that are going to be responsible for doing impairment ratings are going to be local doctors that are not going to have the need to become actual IME doctors. They are going to be asked, someone came to you, broke their arm, what is their impairment rating?

This new system is definitely not easier. We had two doctors on our task force from both sides, and they agreed that it is much more difficult and time consuming, and that it costs the employers more because it takes longer for a doctor to do the examination.

Chairwoman WOOLSEY. Dr. Nimlos, did you want to add to that?

Dr. NIMLOS. Well, actually, there is an article in the IAIABC Journal, which 15 people read, but Dr. Reinhorn, who was involved in the development of the guide, wrote in his personal observations in the spring of 2009 edition, I think about the extra time taken to do AMA guides sixth edition ratings and he asserted that there were seven expert examiners who taught other people how to do sixth edition ratings, and it is from that study that I drew the 5 minutes and 25 minutes for the sixth. These were people who were teaching other people how to do the ratings, so I think that suggests that they do take longer. They are more complicated for me. I know I would have trouble dictating or discussing such a thing over the telephone with attending doctors. And I really have no trouble with that under the fifth.

Chairwoman WOOLSEY. Thank you.

Congressman PAYNE.

Mr. PAYNE. Thank you very much.

Dr. BURTON, your testimony describes claimants who are eligible for both SSDI and State workers' compensation and under Federal law are limited to 80 percent of their preinjury earnings. SSDI reduces its liability offsetting workers' compensation payments from what it owes a claimant. However, in 15 States, including our State of New Jersey, there is a so-called reverse offset where States reduce the amount that has to, that has to be paid by workers' compensation, by the amount paid first by SSDI.

Are these 15 States getting a competitive advantage over States that do not have it? And should Congress examine costs to the SSDI fund from the reverse offset?

Mr. BURTON. I think they are. We will probably need bodyguards going back to New Jersey after saying this. But I think it is the case that, because what the reverse offset does essentially is reduce the cost to the employers and the carriers in the States that are allowed to take advantage of that reverse offset. And those 15 States got a break. Congress, I think, woke up essentially too late on this issue and felt it was too late to do the right thing for those 15 States. But I think the logic of this would be you ought to get rid of the reverse offset for all States and just let Social Security reduce the amount of benefits that are paid by Social Security rather than reducing the workers' compensation benefits.

Mr. PAYNE. Let me also ask you, some have described the desire of States to compete based on lower workers' compensation benefits as a "race to the bottom." Can a State have a modern workers' compensation system which adheres to the recommendations made in 1972 by the National Commission without losing out to pressures and threats by employers to move to another State with lower workers' compensation insurance costs? Does this race to the bot-

tom lend to inevitable pressure on the SSDI fund, which is running a deficit?

Mr. BURTON. No, I think it is a two-step process. The race to the bottom involves workers' compensation. And almost every State feels those pressures, regardless if a State that is ranked 38th or 40th in the country in terms of their cost to the workers' compensation program, you go to the legislative hearings there and they always find the 45th ranked State to compare themselves to and therefore justify having to cut back their benefits some more. So what happens is you cut back on workers' compensation, and the more workers' compensation is cut back, the more there is left to pick up by the SSDI program.

Mr. PAYNE. Thank you. Mr. Uehlien, the new edition rejects ratings for what is called subjective factors such as pain, yet pain can be severely disabling with regards to functionality. The fifth edition allows for additional rating for pain, yet the sixth edition simply treats it as one-size-fits-all factor and it fails to consider how pain affects individuals.

Does this reflect a bias against injured workers? We have always had this question about pain, how do you measure pain, and so I just wonder if you would respond to that.

Mr. UEHLEIN. Absolutely. I am glad you asked that question, because pain, the issue of pain in disabilities systems is one of the most complex issues there are. If you, in fact, look at blind studies, and you would find that it is very difficult to objectively measure pain. My belief is that the sixth edition does address pain, but it also recognizes that it is subject to abuse and attempts to come up with a consistent way of utilizing it in the context of creating a grid for medical functionality.

Mr. PAYNE. Mr. Godfrey, you mentioned it is interesting about ethnic and racial differences. And just take pain, for example, and you mentioned immigration from central Europe, say, Bosnia or from Somalia or Sudan, would you say that maybe pain is endured more by different ethnic groups having something to do with the previous experience or where they are from, and that, perhaps, pain is supposedly part of life and you endure it rather than speak out against it?

And secondly, if it is a feeling that you may lose your job. In many developing countries, the rights of the workers certainly are not where they are here, and the fear may be that recrimination may be taken against a person who complains about a legitimate problem?

Mr. GODFREY. I think both of those can be addressed in the same sort of response. I don't think that the individuals necessarily experience their pain differently, but the response to that pain is obviously different. Those who maybe do not speak English as their first language may want to go to a physician and emphasize their pain, and the only way they can do that is to be very reactive. It may come across as being overemphasizing the pain. Other cultures may have shame in feeling pain or reporting pain to an employer, so then they underreport the level of pain that they are actually experiencing. So that is also likewise a concern.

One of the things that the sixth edition does that has not been done in previous versions, and maybe Dr. Nimlos or Dr. Uehlein

can describe this as well, but one thing that is troubling to me is as we talk about these cultural biases within the DASH and the other testing, if there is a movement because of increased scores that would be considered out of the norm, they bring in the concept of malingering, and that is not a term that has been used in the previous editions of the guides. And I think that that speaks to discredit an entire claim of an individual because of the way that they react to their pain.

And when we talk about the reactions based upon culture, I think that is a very significant concern, because if you have somebody that perhaps is not speaking because of their culture, and they overreport their pain perhaps, once you get that term “malingering” in a workers’ compensation case, let us say your claim is pretty much over with. So I think that the AMA guides brings up that term. I think that is a dangerous encroachment within the system to bring that in.

Chairwoman WOOLSEY. Thank you.

Congressman Sablan.

Mr. SABLON. Thank you very much, and good morning.

Commissioner, the editor of the AMA guides, Dr. Christopher Brigham, Mr. Uehlein’s associate—did your task force, the Iowa task force, have concerns with the potential for conflict of interest here? And would you please describe this concern?

Mr. GODFREY. Well, obviously the issue of conflict of interest was not our primary concern. Our primary concern is this sea change between the fifth edition and sixth edition. It was a concern as we spoke with Dr. Brigham and continued to be recipients of advertisements and the like from impairment.com. It seems as though much of this sea change came about because of Dr. Brigham and his associates, and it appears as though much of the training that is provided, many of the resource books and the like which are provided, and many of even the peer reviews tend to be articles that are either Dr. Brigham or his associates. I think that the authors of this book, or if we are enabled to have some other organization, perhaps a governmental organization, step up to the plate, I think the contributors to the book should step away from the training and especially the peer review of it. I think that that does lead to some potential for a serious conflict of interest.

Mr. SABLON. All right. Thank you.

I come from—I am a very simple man. I come from a very simple place where, if we are having a conversation and I am saying no to you, I would be nodding my head to you like this, because it means a yes. But I am beginning to get it that this sixth edition has actually created a situation where it is saying yes, and people would be turning their heads this way. There is a huge difference that Dr. Nimlos has even said that it has become complicated.

So, Commissioner, I will go back to you. How do you respond to Mr. Uehlein’s contention that the sixth edition is fair to all stakeholders.

Mr. GODFREY. Well, I think that our task force report, if you read through that, it is very clear that it is not. An example of that, I believe, is found on page 2 of my written testimony. In Iowa we have a schedule where an arm is worth 250 weeks of disability benefits. If your impairment rating under the fifth edition, just as a

generic example, would have been 10 percent impairment, and it is reduced to 5 percent, that can cut your benefits in half.

Now, one other thing that the sixth edition does, and again, I am not the physician testifying here, so I would welcome either of the other two physicians to explain it, but I think it would be fair to explain how impairments of the nerves in the upper extremities, you can have three nerve impingements or three nerve involvements, and only two of them are rated, wherein from the fifth edition all three would be rated. I don't understand how that could be fair to an injured worker who has three nerves impacted by an injury to only get a rating for two of them. That is not the way that our work comp system in the State of Iowa has been set up, and if that is going to be a change, I think it should be a legislative change that is determined by our Representatives and our Governor.

Ms. SPIELER. May I say something?

Mr. SABLON. Sure. I yield back my time to the Chair.

Ms. SPIELER. Yes, I know that Mr. Uehlein indicated that these guides are more fair in this sixth edition. And I think it is important to look at what "fair" means. There is fairness in that each worker might be treated the same who comes in to someone for an evaluation. That is a consistency across workers. There may be an argument that the fifth—the sixth edition increases that, leaving aside the complexity of it.

On the other hand, "fair" could be viewed as the question of adequacy in terms of the rating and how it relates to the functional capacity of the individual in the office. I don't think that is how Mr. Uehlein is using the word "fair," nor is it the way it is used in any of the secondary literature where—of the people who believe that the sixth edition is an improvement. There is never any correlation that is discussed between the numbers and the adequacy of the rating in relation to actual functional capacities to do the things that matter. And across the board where there is an attempt to increase consistency, it seems to be achieved by reducing numbers as opposed to by reexamining them and deciding what their adequacy is.

And so I would suggest that this is fairness in terms of consistency, but not in terms of accuracy, in terms of adequacy.

Chairwoman WOOLSEY. And, Dr. Burton, you wanted to respond.

Mr. BURTON. Yes. I want to follow up on Emily's point and go back to something that Mr. Uehlein said. It is true the AMA guides makes a clear distinction between an impairment, which is a medical condition, and disability, which is more simply measured by wage loss. And the AMA guides talk a lot about we are not rating disability, we are rating impairment.

The reality is that most States use the AMA guides as if they were rating disability, and that is the difficulty we have got—one of the fundamental difficulties we have got with AMA guides. And when he talks about fairness, he is talking about fairness. As Emily said, he may get more consistent impairment ratings, but that doesn't mean that you are doing a better job of getting ratings that reflect the reality of what happens to workers in the labor market.

Now, the sixth edition says you can't do that essentially, to oversimplify. But, in fact, Emily and I have coauthored an article in

JAMA, the Journal of American Medical Association, on the fifth edition in which we pointed out that there are data, and have been data for many years, that could be used by the American Medical Association if they really, seriously wanted to recognize what this guide is being used for, which is to rate disability, not impairment; there are ways they could make this a much more useful and much more accurate publication. They have essentially ignored that advice, and that is why my own view is I don't think the AMA is capable of doing a guides for disability the right way. It has to go to something like the Institute of Medicine.

Chairwoman WOOLSEY. Mr. Uehlein.

Mr. UEHLEIN. Just as I said, a lot of discussion confuses the issues between the adequacy of rates and the use of the guides. The guides are a tool for doctors. The problem that Dr. Burton discusses here is that legislatures have not completed the job of deciding what is adequate rates and how we are going to go from medical functionality to the determination of the rates. It is not the problem with the guides, it is the problem with deciding in individual States how we are going to get there.

Chairwoman WOOLSEY. Dr. Nimlos, did you want to say anything? And then Mr. Godfrey, and then Dean Spieler, and then we will wrap up.

Dr. NIMLOS. Thank you. I would like to say a lot of things, but I will try to keep it short.

With regard to the malingering issue, it does sound unfair to me to bring that up when the incidence in injured workers of malingering is about 1 percent. If you approach it from that standpoint of suspicion over malingering so intently, then 99 percent of injured workers become treated as if they were malingering, which is a very bad way to deal with the claim.

With regard to the statistics about the error rate, these have appeared to me to only be found in articles I found through Google. I haven't found anything in the medical literature except for 1 study where it was 17 patients comparing a doctor who reviewed outside exams compared to his own assessment, which interestingly came to the same number of statistics that I had on a selection of over 400 cases that I reviewed where the error rate overall in independent medical examinations was 55 percent. That didn't include only independent examiner errors in rating, it had other errors in with it. But among those errors in rating, in distinction to those that Dr. Brigham has reported where he essentially says that all of the ratings that he found that were in error were too high, or nearly all of them, all of the ratings that I found were too low, except one. I frequently found that the examiners came to a zero rating when plainly in their report there was actually evidence for a clear-cut impairment rating.

Chairwoman WOOLSEY. Okay.

Dr. NIMLOS. So I don't disagree with the error rate, but I am concerned these ratings aren't always too high—my experience was too low—and that the groups that were selected are ones that came to Dr. Brigham's practice because there was some worry about them, which I think greatly would overstate the actual amount of errors and the degree of error.

Chairwoman WOOLSEY. So that leads me, in the wrap-up with Mr. Godfrey and Dean Spieler, will somebody tell me what went wrong with this process? How did we get here?

Mr. GODFREY. Well, I think that I can address that by kind of addressing what Dr. Uehlein said—oh, I am sorry, Mr. Uehlein said. He said, the guides are not the problem, it is the State workers' compensation systems which are the problem. And that is actually a quote that Dr. Brigham gave to our task force. He said, the more significant problems do not lie with the guides, but rather with how the impairment ratings are used by the workers' compensation system or systems. The AMA guides will continue to evolve and improve. The systems that make use of the guides must also evolve.

If I was going to evolve in terms of how we compensate injured workers, that is a determination that should be made by the people in the State of Iowa. For a consensus that refuses to identify itself, it refuses to tell us how they come to the numbers which are arrived at, it refused to tell us who was involved in the process of how it was even determined that we had to have this change from one system of finding impairment or disability to another, those aren't decisions to be made by that group. They are to be made by the people of Iowa, or, more broadly, they should have some guidance from the Federal Government to tell us what boundaries should be set for each State so when they determine how we get to how we find impairment and resulting disability, that we have that framework there so we don't violate that. And I think perhaps it has been this reliance upon the AMA since the early 1970s, we have allowed them to play that role. And I think that with the sixth edition, it really brings home the fact that maybe that is not where we should look anymore.

Chairwoman WOOLSEY. Thank you.

Dean Spieler.

Ms. SPIELER. I wanted to make two specific comments and one general one, if you don't mind. One is that Mr. Uehlein just suggested that the guides is a tool for doctors, but, in fact, treating physicians have no need to quantify the impairments of their patients. It only becomes necessary to quantify impairments if you are looking at a compensation system. And so I think it is—the word that comes to mind is disingenuous for anyone who is involved in the development of the guides to suggest that it is only for doctors, because you wouldn't have a guide unless had you to quantify for compensation systems.

So it is inevitably used within compensation systems, and the problem with the numbers is that they don't correlate with anything. They don't correlate with the original percentages in the original workers' compensation laws. They did not refer to that when the percentages were originally developed. They don't correlate at all with any of the economic studies in terms of what kinds of impairments actually lead to workplace disability. They don't correlate with studies that have been done about people's view of quality of life. They are simply numbers that some small group of physicians have invented.

And on the "what is to be done" side of this, I think that at this point it is very unlikely that all States are going to be able to push

back on this whole process. It has become a kind of assumed gold standard in a situation where it clearly should not be, and the race to the bottom encourages that.

So I think that the problem is a twofold problem when you start looking at the costs being referred to Social Security Disability. One is that you need a better guide, and that clearly needs to be done by an independent group like the Institute of Medicine, perhaps with the assistance of NIOSH; and second, that maybe there does need to be some recommendations with regard to the minimum standards for State workers' compensation programs in order to stop the bleeding from workers' compensation—from workplace injuries into DI, which has been going on for a very long time, and not just as a result of this recent trend.

Thank you.

Chairwoman WOOLSEY. Thank you.

Congressman PAYNE.

Mr. PAYNE. Yes. Ms. Spieler, your testimony recommends that Congress make a request to the Institute of Medicine to review the AMA guides. What are your views on having the National Institute for Occupational Safety and Health review the AMA guides and develop a more evidence-based system?

Ms. SPIELER. I think if it went to the Institute of Medicine, it would be a more transparent process to some extent. And I am not certain that NIOSH has the kind of multidisciplinary people internally to do this on their own. It might make sense to have NIOSH manage an Institute of Medicine process, but I would leave that to the—obviously to people who are more familiar with the way these things work in the system.

Mr. PAYNE. Mr. Burton.

Mr. BURTON. There is a model that I think suggests the IOM is an ideal place to assign this task. The only other ratings system for partial disability, that is permanent partial disabilities that is in widespread use in the U.S., is the one for veterans. And the veterans disability rating system was looked at.

I happened to serve on an IOM committee about 3 years ago, and I think that it was an extremely useful process. I don't know all the consequences of those recommendations, but it was quite thorough. They have an excellent staff. They put together a really representative group of people.

So it is not that we are picking the IOM out of ether, it is they have got a track record of looking at a disability rating system.

Incidentally, they consider whether or not they should substitute the AMA guides in place of the disability rating system, and said with all the problems with the disability rating system, we are still better than the AMA guides. So it is another reason why I have some skepticism about the AMA guides.

Anyway, that is what I would encourage you to do would be to try the Institute of Medicine.

Mr. PAYNE. Just quickly, Mr. Uehlein, in Kentucky the legislature voted to delay adoption of the sixth edition, and Iowa has voted not to accept it. Why have States chosen not to accept this edition, in your opinion?

Mr. UEHLEIN. Like the other members here, I am a very practical person who deals in the real-world practice. As I go around, the

largest group I see advocating about the issue is the plaintiffs' bar. And I believe in my heart of hearts that that has something to do with the fact that the fine, which accounts for 30 to 40 percent of the rating, is rated higher under the fifth edition than the sixth edition.

There is a lot of misinformation. This is a complex topic. I like the idea of using facts to make your determination.

Mr. PAYNE. Do you agree with that, Mr. Godfrey?

Mr. GODFREY. I would point you to the makeup of our task force in the State of Iowa. We had two claimant's attorneys, which would be considered the plaintiffs' bar. We had two defense attorneys. We had two doctors that work quite often with insurance companies. We had two former deputy commissioners who used to work for the Division of Workers' Compensation, who are no longer involved with the system, but had knowledge of the fifth and fourth edition and took the time to review the sixth edition.

The vote was 7 to 1 to say that Iowa should not subject its workers to the sixth edition. That is a pretty broad consensus. It is not plaintiffs' bar. These are medical professionals that have looked at this, these are attorneys on both sides of the issues, these are people that are impacted day to day and know how this affects the Iowa Workers' Compensation System, and it was pretty across the board.

Chairwoman WOOLSEY. All right. Unless somebody would like to add something to that, I think we have gotten both sides.

Dr. Nimlos.

Dr. NIMLOS. I would just like to briefly add my endorsement for the National Institutes of Occupational Safety and Health, maybe because that is my specialty, but also because I know that they have had experience in human factors assessment, and it may be a good idea for them to team with the Institute of Medicine, where I am not so familiar, but I think that NIOSH should have a role.

Chairwoman WOOLSEY. Well, I thank all of you for being magnificent witnesses, and I thank my subcommittee members that were here. This is a very important issue. And "Developments in State Workers' Compensation Systems" was the name of this hearing, and we have asked some of the questions. I don't think we have gotten all the answers, and I don't think we have come up with a solution that is going to turn that around, but I think we need to get very serious about this.

You have illuminated the problems facing workers who must deal with workers' compensation systems that are increasingly hostile to their claims. Clearly the latest edition of the AMA guides only exacerbates the problem. Our witnesses, as I said, have made great suggestions. We need to move on that, and it is my hope that NIOSH and/or the Institute of Medicine will take a closer look at the guides and come up with a better way to rate worker impairment. Probably they are going to have to be directed by their bosses here in the Congress to do just that, because they have—that is not one of the things that they have on their agenda right now. I think that is our job to do that, and I will be following up on that.

So going forward, I also recommend that the AMA develop a transparent and inclusive process when it engages in private rating

so that those who are affected by it can trust the results, or at least know where to question them.

And finally we need to explore the cost shifting from workers' compensation to the Social Security disability program. As I said in my opening, Chairman Miller and I asked the GAO to study this particular trend.

So again, I thank you. You have been wonderful. And before we adjourn, I want to submit, without objection, the following into the record, and it is a statement from the American Medical Association. They were invited; they sent a statement. So that is it.

[The information follows:]

Prepared Statement of the American Medical Association

The American Medical Association is pleased to submit this statement for the record of the Subcommittee's hearing "Development in State Workers' Compensation Systems."

Over the past several months, the committee staff has inquired into the development of the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition. We have been pleased to respond to those inquiries and hope that the information provided to date has assisted the committee's understanding of the development process. We feel that this work has enhanced the validity, improved internal consistency, promoted greater precision, standardized the rating process, and improved inter-rater reliability.

If we can be of further assistance or respond to additional questions from the Subcommittee, we would be pleased to do so.

Overview

The American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment (AMA Guides) is the most commonly used tool in the United States for rating impairment. The precursor of the AMA Guides originated in 1956, when the AMA Board of Trustees (BOT) created an ad hoc committee on Medical Rating of Physical Impairment to establish a series of practical guidelines for rating impairment of the various organ systems. From 1958 to 1970, the Committee published a series of AMA Guides articles in the Journal of the American Medical Association (JAMA). In 1971, these were published as a single volume, which has been revised in five subsequent editions.

The AMA Guides, 6th Edition, published in 2007, introduced a more contemporary terminology and approach. The 2001 International Classification of Function (ICF) developed by the World Health Organization was adopted in place of the previous 1980 terminology of the International Classification of Impairments, Disabilities and Handicaps (ICIDH). This new classification provided evidence-based concepts, terminology, definitions, and a conceptual framework. This framework was implemented and applied to each chapter to enhance the validity, improve internal consistency, standardize the rating process, and improve inter-rater reliability. Feedback from users of the 6th Edition, including the Department of Labor—which adopted the 6th edition in May of 2009 through the Federal Employment Compensation Act—indicates that these goals were achieved. In addition, users report that it is both easier to use and to teach.

With advances in medical science in recent years it follows that some impairment ratings have changed due to improved outcomes. Specifics of some of the changes are detailed in the statement below. In addition, the 6th Edition allows for ratings for some conditions that earlier editions of the AMA Guides did not.

The AMA Guides, 6th Edition also implemented a new process modeled after other AMA editorial processes in order to provide greater transparency and input from stakeholders. An Editorial Panel, Advisory Committee, contributors and peer reviewers comprised of over 200 individuals had input to this most current edition. These impairment professionals represented various stakeholders in the impairment process. The goal of the AMA Guides was to develop an impairment rating system that is fair and equitable to all parties.

Development of the sixth edition

On average the AMA Guides editions are updated every five to seven years, in response to new or emerging medical practices, research, and stakeholder needs. AMA staff of the Divisions on Professional Standards and Book Publishing, in con-

sultation with representatives from several medical specialty societies, undertook the project in 2004 to develop the AMA Guides 6th Edition.

Invitations were issued to national medical specialty societies, as well as state and county medical associations, to nominate disability or impairment physician experts to serve as authors, content contributors, and/or reviewers. Forty-five organizations submitted nominations. Participants were chosen based upon their past publications, evidence-based research experience, reputation in their field and the application of scientific methods to problems of impairment evaluation. An Editorial Panel comprised of eleven members was established. The members were selected based upon their reputations for knowledge and application of clinical medicine and science to the field of impairment evaluation. The Editorial Panel outlined a set of recommendations to revise the AMA Guides 5th Edition. The recommendations were disseminated to a group of sixteen additional physician nominees for review and input.

Based on these recommendations, the Editorial Panel identified a framework and adopted a set of axioms that would form the basis of the 6th Edition. These axioms were:

- Adopt the terminology, definitions and, conceptual framework of disablement of the International Classification of Functioning, Disability and Health (WHO, 2001) in place of the current and antiquated ICIDH terminology (WHO, 1980);
- Make greater use of evidence-based medicine and methodologies;
- Wherever/whenever evidence-based criteria are lacking, give highest priority to simplicity and ease of application, and follow precedent unless otherwise justified;
- Stress conceptual and methodological congruity within and between organ system ratings; and
- Provide rating percentages that are functionally based whenever possible, unless/until science supports otherwise.

Six of the Editorial Panel members were selected to be Section Editors. These individuals were charged with developing the 6th Edition in accordance with the axioms identified above. The remaining five Editorial Panel members served in a consultative role.

Each Section Editor was assigned to lead the revision of a section consisting of 2-4 related chapters. Nominees from the various state and county medical associations and national medical specialty societies were assigned to a section based on his/her specialty and expertise. The Section Editors worked with contributors who wrote the specialty specific chapters. This process assured that each chapter had contributors in that specialty.

Chapters in draft form were reviewed by the assigned Section Editor, then by all of the Section Editors. This approach ensured consistency across chapters and uniform adherence to the axioms established by the Editorial Panel. Next, chapters were disseminated for expert peer review including the remaining members of the Editorial Panel. Peer reviewers were selected based on past experience with the AMA Guides, reputation in the field of impairment, and recommendations from medical societies and other stakeholders.

For the 6th Edition, an Advisory Committee was established, modeled after other AMA editorial committees and processes. Nominations for this committee were solicited from the various specialty, state, and county societies, as well as other stakeholders. The mission of the Advisory Committee was to solicit comments from their various societies and agencies and submit them to the Editorial Panel for its deliberations and final decision. The Committee had a charter with well-defined rules and procedures in place to facilitate sound decision-making.

The six Section Editors met via conference call at least monthly to review questions and issues that required resolution. Section Editors met individually with their author teams to achieve uniformity and consensus on individual chapters. When consensus could not be reached, the issue was brought to the Editorial Panel for resolution.

The review process chart is attached to illustrate the flow of editorial activities.

Impairment vs. disability

The AMA Guides, 6th Edition is very clear about differentiating between impairment (determined by diagnosis) and disability, which is a legal term. The ICF model refers to both impairment and disability, but section 1.3d (page 5) of the Guides 6th Edition clearly describes the differences between the Guides terminology and ICF terminology. Disability is a determination made by administrative law judges in most jurisdictions and may or may not have a relationship to an impairment (e.g., you could have an impairment but no disability).

All editions of the AMA Guides state that an impairment rating is not equal to a disability rating and is not intended to be a measure of disability since disability

has to do with limitations or restrictions in job function rather than the actual anatomic limitation.

Additional information on specific chapters

Mental and Behavioral Disorders

The Mental and Behavioral Disorders chapter now provides a method for rating permanent impairment resulting from mental and behavioral disorders. Only impairments for selected well-validated major mental illnesses are considered. Impairment rating under the Mental and Behavioral Disorders chapter is thus limited to the following diagnoses:

- Anxiety disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive-compulsive disorder.
- Mood disorders, including major depressive disorder and bipolar affective disorder.
- Psychotic disorders, including schizophrenia.

To assess impairment using the Mental and Behavioral Disorders chapter of the Sixth Edition, the clinician must first make a definitive diagnosis using standard psychiatric criteria, including history, and adjunctive psychological, neurological, or laboratory testing. The Sixth Edition also supports the use of well-standardized psychological tests that may improve accuracy and support the existence of a mental disorder. The diagnosis (with the associated factors of prognosis and course) will form the basis by which one assesses the severity and predicts the probable duration of the impairment.

The Guides Sixth Edition also uses three scales by which mental and behavioral impairment is rated: 1) the Brief Psychiatric Rating Scale (BPRS); 2) The Global Assessment of Functioning Scale (GAF); and the 3) Psychiatric Impairment Rating Scale (PIRS). The BPRS measures major psychotic and nonpsychotic symptoms in patients with major psychiatric illnesses. The GAF evaluates overall symptoms, and occupational and social function. The PIRS assesses behavioral consequences of psychiatric disorders within various areas of functional impairment. The purpose of including all three of these scales is to provide a broad assessment of the patient with mental and behavioral disorders as the individual scales focus on symptom severity and/or function. The objective of making a reliable diagnosis and coupling it with the assessment of these three scales is to arrive at a strongly supportable impairment rating.

Central and Peripheral Nervous System

The Central and Peripheral Nervous System (CNS) chapter of the Sixth Edition was also revised to provide a consistent method for the assessment of permanent impairment. The CNS chapter provides criteria for evaluating permanent impairment due to documented dysfunction of the various parts of the nervous system, emphasizing the deficits or impairments that may be identified during a neurologic evaluation. Neurologic impairments are assessed as they affect Activities of Daily Living (ADLs) and correlated(?) function.

The Sixth Edition of the Guides describes a clear method for rating impairments due to nervous system disorders. The first step in assessing CNS impairment is to assess the most severe category of cerebral impairment, if any, from 4 categories: 1) state of consciousness and level of awareness; 2) mental status evaluation and integrative functioning; 3) use and understanding of language; and 4) influence of behavior and mood. The rater then assesses impairment of other organ systems (due to neurogenic problems), and combines this impairment with the single most severe category of cerebral impairment to arrive at a strongly supportable impairment rating. This method of assessing impairment is used for nervous system-related conditions, including epilepsy and traumatic brain injury.

Spine

Significant changes were made to the spine chapter to make spinal evaluations consistent with current medical science and evaluation approaches. Among the most common lumbar and cervical spine conditions that require rating are intervertebral disk (IVD) herniation at one level with or without resolution of radiculopathy (lumbar and cervical) and fusion at a single level with or without resolution of radiculopathy.

Impairment ratings in the Sixth Edition are both more specific and intended to reflect a lesser impairment in cases where symptomatology has improved with appropriate treatment. Sixth Edition grids include impairment ratings for multiple level conditions, so that an alternative rating system (range of motion method in the Fifth Edition) is not necessary. This change acknowledges that range of motion assessed in a clinical setting is neither an accurate assessment of outcome nor pre-

dictive of function. Surgery should result in functional improvement for patients and therefore decrease impairment (the inverse of function); however, with the Fifth Edition, typically spinal surgery would increase impairment.

The Diagnosis-Related Estimate (DRE) Categories described in the Fifth Edition were modified and expanded to create the Regional Grids used to rate spinal impairments in the Sixth Edition. The grids are designed to provide clearer categorization of many conditions and to be more consistent with clinical outcomes. The Sixth Edition ratings reflect the results of treatment, rather than the method of treatment (e.g., non-operative or conservative care vs. surgical treatment).

DRE Lumbar and Cervical Category 1 in the Fifth Edition includes conditions with no significant clinical findings resulting in the assignment of 0 percent whole person impairment (WPI). In the Sixth Edition, a similar category, e.g., Class 0 with assignment of 0 percent WPI, is provided in Table 17-2 Cervical Spine Regional Grid: Spine Impairments (6th ed, 564-566) and Table 17-4 Lumbar Spine Regional Grid: Spine Impairments (6th ed, 570-573).

In the Fifth Edition, DRE Lumbar Category II (associated with a rating of 5-8 percent WPI) includes cases with findings such as muscle guarding and spasm, asymmetric loss of range of motion and non-verifiable radiculopathy. In clinical practice it may be difficult to validate one physician's findings of muscle guarding and spasm at another examination, leading to controversy ("dueling doctors") with respect to rating those patients with questionable physical examination findings. In the Sixth Edition, the creation of Class 1 under the heading "Soft Tissue and Non-Specific Conditions" is intended to provide a category for rating those patients, and notes that similar findings must be present on multiple occasions (1-3 percent WPI in the lumbar spine and 1-3 percent WPI in the cervical spine, based on Functional History Grade Modifier). The impairment ratings acknowledge an injury and persistent symptoms and also reflect that findings are mostly subjective. Since Functional History is the only grade modifier used in this Class 1 illness (page 563), the lowest possible Net Adjustment is -1, and the lowest possible rating is Class 1, Grade B.

Symptomatic herniated nucleus pulposus (HNP) is defined by the presence of radiculopathy at a level consistent with findings on imaging studies or non-verifiable radicular complaints at the clinically appropriate level(s). In the Fifth Edition, a HNP with a history of radiculopathy that has responded to conservative/ non-surgical treatment or persistent non-verifiable radicular complaints is rated in the same category as nonspecific findings (Category II, 5-8 percent WPI). In the Sixth Edition, these two conditions are distinguished. Non-specific findings are rated in Class 1 under Soft Tissue and Non-Specific Conditions, with an impairment range of 1-3 percent WPI. For IVD herniation with resolution of radiculopathy or persistent non-verifiable radicular complaints at the clinically appropriate level(s), the results of treatment are taken into account and regardless of the type of treatment these cases are rated in the range of 5-9 percent WPI in the lumbar spine and 4-8 percent WPI in the cervical spine. According to the Fifth Edition, non-specific findings would typically be rated at the lower end of the range (5 percent WPI) and conservatively resolved radiculopathy that had improved following non-operative treatment would be rated at the higher end (8 percent WPI). Impact on activities of daily living is also considered. The Sixth Edition distinguishes between these two diagnoses and provides different cells in the regional grids for each. In these cases, the actual ratings in the Sixth Edition are similar to the Fifth Edition.

In the Fifth Edition, DRE Lumbar Category III covers a broad range of conditions, ranging from significant signs of radiculopathy (without a specific etiology) to surgically treated IVD herniation that are, as a result of surgery, asymptomatic. The outcomes of treatment are given less consideration than the treatment in the determination of impairment ratings in the Fifth Edition. In contrast, in the Sixth Edition, Classes 1 and 2 differentiate between cases in which radiculopathy has resolved, regardless of the treatment method and persistent radiculopathy after treatment. Comparing Fifth Edition ratings to Sixth Edition ratings, a patient with resolved radiculopathy would be rated typically at the lower end of DRE Lumbar Category II (5 percent WPI) and the patient with persistent radiculopathy would be rated at the higher end of DRE Category III (13 percent WPI). In the Sixth Edition, resolved radiculopathy from an HNP, regardless of treatment, is rated in the range of 5-9 percent WPI, based on function. Persistent radiculopathy, regardless of treatment, is rated in the range of 10-14 percent WPI. The approach used in the Sixth Edition is more consistent with clinical experience, in which radiculopathy generally results in more functional limitation. Thus, radiculopathy that persists at MMI would be appropriately rated in a higher class, and resolution of radiculopathy would result in a lesser impairment rating, regardless of the treatment method.

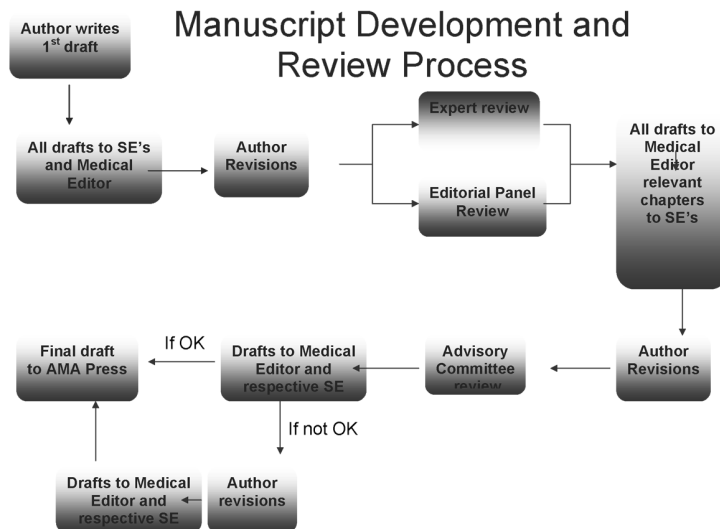
A more significant difference in impairment ratings occurs with respect to classification of diagnoses of Alteration of Motion Segment Integrity (AOMSI), which includes fusion and, in the Sixth Edition, motion preserving technologies. In the Fifth Edition, AOMSI at a single level is rated in higher categories, regardless of treatment outcome. Impairment is in either DRE Lumbar Category IV (20-23 percent WPI) when no radicular findings are present or DRE Lumbar Category V (25-28 percent WPI), when there is persistent radiculopathy. Multiple level fusions are rated using the ROM method.

In contrast, the Sixth Edition differentiates between treatment outcomes. If appropriate treatment has resulted in improvement of the condition and better function, regardless of AOMSI, the condition is rated in Class 1 (5-9 percent WPI). In the case of persistent radicular complaints, regardless of AOMSI, the number of levels involved is the differentiating factor in the Sixth Edition, and impairment ranges from 10 percent WPI for persistent radiculopathy at a single level to 33 percent WPI, accounting for the greater impairment presumed to be present in the case of multiple level radiculopathy, instability, or after multiple level fusion.

Cervical disc herniations are most commonly treated with anterior cervical discectomy and fusion. In the Fifth Edition this catapults ratings into DRE Cervical Category IV (25-28 percent WPI) for a condition that is effectively treated with fusion. The Sixth Edition rating methodology, which is driven by diagnosis (IVD herniation) and outcome, rather than treatment method (in this case fusion), takes into account the generally good results and improved function after treatment for cervical disc herniation, regardless of the treatment method. Therefore, in the Sixth Edition, single-level disease with resolution of symptoms is rated in Class 1 (4-8 percent WPI) and persistent radicular symptoms at a single level are rated in Class 2 (9-14 percent WPI). Multiple level herniations or stenosis-associated persistent l radiculopathy is rated in Class 3 or 4 (15-30 percent WPI), with increased impairment assigned in multiple level disease that remains symptomatic after treatment. In the Fifth Edition, DRE Category III provides rating for persistent radiculopathy without surgery or improved radiculopathy with surgery, and therefore, does not differentiate between outcomes from intervention (although decompression of cervical radiculopathy is more commonly accomplished with an anterior fusion than a posterior decompression).

In the Fifth Edition, DRE Cervical Category V requires “significant upper extremity impairment including the use of upper extremity external functional or adaptive devices” with total neurologic loss at a single level or multiple level neurologic dysfunctions. In the Sixth Edition, Class 4 describes bilateral or multiple level radiculopathy, without requiring dysfunction to the same degree as DRE Category V.

In summary, although there are some differences in the impairment ratings assigned to the most common spine-related conditions, the Sixth Edition grids are designed to permit more specific and accurate classification of conditions by diagnosis, to reflect the outcome of treatment rather than the method of treatment, and to provide the same rating methodology for single or multiple level conditions, facilitating consistency in those ratings.



Chairwoman WOOLSEY. In order to finish this, as previously ordered, Members will have 14 days to submit additional materials for the hearing record. Any Member who wishes to submit follow-up questions in writing to the witnesses should coordinate with majority staff.

Without objection, the hearing is adjourned. Thank you.

[Questions submitted and their responses follow:]

[VIA E-MAIL],
U.S. CONGRESS,

Washington, DC, November 17, 2010.

Mr. JOHN BURTON, Ph.D.,
56 Primrose Circle, Princeton, NJ 08540-9416.

DEAR DR. BURTON: Thank you for testifying before the Subcommittee on Workforce Protections at the hearing on, "Developments in State Workers' Compensation Systems" held on Wednesday, November 17, 2010.

Representative Lynn Woolsey (D-CA), the subcommittee chair, had additional questions for which she would like written responses from you for the hearing record:

1. Your research has indicated a cost shifting from state workers' compensation to SSDI as a result of changes enacted in the 1990s. The Committee intends to follow-up by having the GAO conduct such an assessment to quantify the costs and develop policy options.

A. What data is needed and what analytical methods could be used to best quantify the degree and extent to which there is cost shifting from workers' compensation into Social Security Disability for workers who cannot qualify for state workers' compensation?

B. As part of this assessment, should there be sampling of actual case files?

C. What criteria should be used in filtering cases to be used in a sample?

D. What states should be selected? Should states with a reverse offset be included?

E. What years should be selected? Is there a baseline time frame against which such cost shift should be measured?

F. What kind of legal review should be conducted?

G. How large should the sample be?

2. Beyond case file reviews, are there other means to quantify the dollar amount of the cost shift from state workers' compensation to SSDI, and project what these costs might be on a going forward basis over the next 10 years?

3. Are there any estimates on the annual cost to SSDI from the “reverse offset”? Please send an electronic version of your written response to the questions in Microsoft Word format to Lynn Dondis and Richard Miller of the Committee staff at lynn.dondis@mail.house.gov and richard.miller@mail.house.gov by close of business Wednesday, December 1, 2010, the date on which the hearing record will close. If you have any questions, please do not hesitate to contact Ms. Dondis or Mr. Miller at 202-225-3275.

Sincerely,

GEORGE MILLER,
Chairman.

Responses by Prof. Burton to Questions Posed by Ms. Woolsey

1. *Your research has indicated a cost shifting from state workers' compensation to SSDI as a result of changes in the 1990s. The Committee intends to follow-up by having the GAO conduct such as assessment to quantify the costs and develop policy options.*

(A) *What data is needed and what analytical methods could be used to best quantify the degree and extent to which there is cost shifting from workers' compensation into Social Security Disability for workers who cannot qualify for state workers' compensation?*

Study Design. There are several decisions that must be made in designing a study to determine the extent of cost shifting from workers' compensation into the Social Security Disability Insurance (SSDI) program.

(1) Decision one: what level of aggregation of data should be used? My research with Professor Xuguang (Steve) Guo relies on state-level data for variables such as the application rate for SSDI benefits, the disability prevalence rate, and the expected amount of workers' compensation benefits for workers with permanent disabilities. There are virtues of studies using this level of aggregation and I discuss such studies further in my answer to your question 2. However, for the purpose of your Question 1, I propose a study of individuals who have applied for and/or received SSDI benefits. The information from a study at this level of disaggregation will provide valuable information on the extent of cost shifting from workers' compensation to SSDI.

(2) Decision two: should the study involve applicants for SSDI benefits, persons who were just awarded SSDI benefits, or persons who were awarded SSDI benefits in previous years? There are advantages and disadvantages of each of these choices. A study of persons who have just applied for SSDI benefits can more closely observe the interaction between the workers' compensation and SSDI programs as the case proceeds. However, there are disadvantages, including the long delays for many cases between the date of application and the date when the decision about the award is made. A study including persons who were awarded SSDI benefits in previous years provides a better estimate of how statutory or administrative changes in the workers' compensation programs affected the applications for and awards of SSDI benefits. However, it is more difficult to administer a questionnaire to the SSDI beneficiaries if they are no longer actively involved in the administrative process. My recommendation is a study of persons who have just been awarded SSDI benefits. These persons are more likely to be accessible to complete questionnaires from which information not included in the SSDI application can be obtained.

Decision three: which persons who have been awarded SSDI benefits should be included in the study? Each person who is awarded SSDI benefits in a state included in the study would complete an initial brief questionnaire. A stratified sample would be drawn that includes (1) persons whose disabilities do not appear to be partially or totally caused by work² and (2) persons whose disabilities appear to

¹Helpful comments on an earlier draft of the Proposed Study were received from Richard Burkhauser, Xuguang (Steve) Guo, Douglas Kruse, Melissa McInerney, Virginia Reno, Emily Spieler, and David Stapleton. I express my appreciation and absolve them of any remaining errant ideas.

²I recommend including persons whose disability does not appear to be partially or totally caused by work in the study in order to allow the study to determine if persons affected by the offset are typical of all SSDI applicants. In addition, the legal review of the case folder (described below) may find some cases where the beneficiary is not aware that work was a possible cause of the disability.

be partially or totally caused by work.³ For those persons whose disabilities appear to be partially or totally caused by work, a stratified sample would be drawn that includes (1) persons who are currently receiving or previously received workers' compensation benefits and (2) persons who are neither currently receiving nor previously received workers' compensation benefits. Additional criteria for selecting and stratifying the sample are discussed in the answer to Question 1(C). Those persons who are included in the study will be required to complete an expanded questionnaire.

Decision four: what information should be collected for the SSDI beneficiaries in the sample from administrative records or from an expanded questionnaire? The administrative records can provide information on demographic information and on the amount of benefits affected by the offset provision for workers' compensation and SSDI benefits? The expanded questionnaire can also ask questions on a variety of other matters. For example, for SSDI beneficiaries who are neither currently receiving nor previously received workers' compensation benefits, questions will be asked about the extent of the applicant's knowledge of the workers' compensation program and whether the person applied for workers' compensation benefits. If the worker is currently receiving or previously received workers' compensation benefits, the questionnaire can determine if the workers' compensation benefits were for the same disability that resulted in the award of the SSDI benefits. The expanded questionnaire could also obtain information on the reasons why the person applied for SSDI benefits. Was the application encouraged by the employer, the workers' compensation carrier, another insurance company, and/or an attorney? The expanded questionnaire could also ask the set of questions on the Health and Retirement Study (HRS) about the accommodations at work offered by the employer, which may affect the disabled worker's propensity to apply for workers' compensation and SSDI benefits.

Analysis. One aspect of the study will be an analysis by a lawyer or person familiar with the workers' compensation law in the state where the SSDI award was made of the information from the administrative records and the questionnaires completed by the SSDI beneficiary. For those persons who had disabilities that appear to be partially or totally caused by work and who never received workers' compensation benefits, the analysis will examine how many of these persons (a) should have qualified for workers' compensation benefits using the compensability rules in the state in which they applied for SSDI benefits, or (b) would have qualified for workers' compensation benefits using the tests for compensability contained in the Workmen's Compensation and Rehabilitation Law (Revised), [Model Workers' Compensation Law], which was published by the Council of State Governments in 1974. For the persons in (b), to the extent feasible, the analyst will identify the reasons why the persons did not receive workers' compensation benefits (such as a restrictive definition of occupation disease included in the state workers' compensation statute). A similar analysis of persons who had disabilities that do appear to be partially or totally caused by work and who never received workers' compensation benefits will be conducted based on the information in the administrative records or the expanded questionnaires in order to identify possible cases where the information suggests the cause of the disability was partially or totally caused by work but the SSDI beneficiary was not aware of the possible link of the disability to work.

The analytical methods include an extended qualitative analysis of the legal review of the outcomes of the analysis described in the previous paragraph. The study will also involve examinations of the samples of workers included in the study using standard statistical methodology, including regression analysis.

(B) As part of this assessment, should there be sampling of actual case files?

Yes, there should be a sample of actual case files. At the time of the award, an initial questionnaire should be administered asking the beneficiary about whether the disability was partially or totally caused by work. Depending on the answers to the initial questionnaire, the beneficiary may be asked to complete an extended questionnaire.

(C) What criteria should be used in filtering cases to be used in the sample?

The first criterion should be whether the disability was partially or totally caused by work, using the definitions included in the 1992 Health and Retirement Study (HRS). These definitions were used by Robert Reville and Robert Schoeni in a re-

³Any case in which the SSDI award includes an offset for workers' compensation benefits would automatically be included in the category of cases for which the disability appears to be partially or totally caused by work.

cent article.⁴ This criterion could be subdivided into those persons who satisfied Definition 1 (The impairment or health problem was the result of an accident or injury and work was the place where the injury occurred.) and Definition 5 (The disability was caused by work using any of the four previous definitions.)

The second criterion should be whether the SSDI beneficiary is currently receiving or previously received workers' compensation benefits.

The third criterion should be whether the SSDI beneficiary is male or female.

(D) What states should be selected? Should states with a reverse offset be included?

The initial phase of the research could involve four states, with the expectation that additional states will be added based on the results from this phase. Two of the fifteen states with reverse offset provisions and two states with the normal offset provisions should be selected. Two states in which workers' compensation compensability rules have been significantly tightened since 1990 should be included, as well as two states in which workers' compensation compensability rules have not been significantly tightened since 1990. Possible choices are:

Oregon: reverse offset and significant tightening of compensability rules.

New Jersey: reverse offset and no significant tightening of compensability rules.

California: normal offset and significant tightening of compensability rules.

North Carolina: normal offset and no significant tightening of compensability rules.

(E) What years should be selected? Is there a baseline time frame against which such cost shift could be measured?

This study will require persons who were awarded SSDI benefits to complete an initial questionnaire and the results will be used to draw the sample. As a result it will be easier to confine the study to current awards since the beneficiaries will be involved with SSA offices as part of the benefit determination process.

The results will allow comparisons to be made among states which differ in the stringency of their compensability rules and the type of offset provision. In all four states in the initial phase of the research, an estimate can be made of the extent to which SSDI beneficiaries who have disabilities caused by work but who neither currently nor previously received workers' compensation benefits.

The possible changes over time in the extent of cost shifting from the workers' compensation program to the SSDI program can be examined by the type of study discussed under heading 2) below.

(F) What kind of legal review should be conducted?

Each case in the sample should be examined by an attorney or other person familiar with the workers' compensation law in the state in which the SSDI beneficiary is located to determine if there is information indicating that the person may have been entitled to workers' compensation benefits in the state either using the state's current compensability rules or the compensability rules used in the Model Workers' Compensation Law. The legal review will rely on administrative records and on questionnaires completed by the SSDI beneficiary.

(G) How large should the sample be?

The sample size in each state will depend on the number of variables (or categories) that the GAO decides should be used in the analysis. A study may want to distinguish within each state the experience of:

(a) SSDI beneficiaries who differ by cause of the disability: (i) beneficiaries who do not indicate that their disability was partially or totally caused by work; (ii) beneficiaries who indicate their disability was partially or totally caused by work using Definition One from the HRS, but not by the other definitions; and (iii) beneficiaries who indicate their disability was partially or totally caused by work using Definition Five from the HRS;

(b) SSDI beneficiaries who differ by their receipt of workers' compensation benefits: (i) beneficiaries who are currently receiving or who previously received workers' compensation benefits; and (ii) beneficiaries who never received workers' compensation benefits.

(c) SSDI beneficiaries who differ by their sex: (i) beneficiaries who are male; and (ii) beneficiaries who are female.

This sampling design will result in 12 cells ($3 \times 2 \times 2 = 12$). A stratified sample will be drawn in each state so each cell contains 25 SSDI beneficiaries, in order to satisfy confidentiality and statistical validity requirements. The total sample for each state will contain 300 SSDI beneficiaries (12×25), and the total sample for the four

⁴Robert T. Reveille and Robert F. Schoeni. "The Fraction of Disability Caused by Work," Social Security Bulletin, Vol. 65, No. 4 (2003/2004). The article may be accessed at the following Internet address: <http://www.ssa.gov/policy/docs/ssb/v65n4/v65n4p31.html>

states will be 1,200 SSDI beneficiaries. Oversampling of some of the cells or particular interest—such as SSDI beneficiaries who indicated their disability was partially or totally caused by work using Definition One from the HRA and who never received workers’ compensation benefits—may be desirable, which would increase the sample size.

2. Beyond case file review, are there other means to quantify the dollar amount of the cost shift from state workers’ compensation to SSDI and project what those costs might be on a going forward basis over the next 10 years?

Analysis of State-Level Data. As discussed in my testimony to the Subcommittee on Workforce Protections on November 17, there two studies underway concerning the determinants of applications for SSDI benefits using state-level data. Professor Xuguang (Steve) Guo and I have preliminary results indicating that reductions in the amounts of workers’ compensation permanent disability benefits and the tightening of eligibility rules for workers’ compensation permanent disability benefits during the 1990s accounted for about 3 to 4 percent of the growth of SSDI applications during the decade. However, these findings need to be used with caution. Professor Guo and I just began to analyze the determinants of SSDI applications in the years through 2006 and we did not find that changes in the workers’ compensation programs during the current decade are associated with more SSDI applications. In addition, Professors Melissa McInerney and Kosali Simon have not found that workers’ compensation changes in the 1990s resulted in more SSDI applications.

While the evidence indicating that changes in workers’ compensation programs resulted in more SSDI applications is mixed, the studies are continuing and I anticipate that the recent availability of data on SSDI applications for the current decade will help us clarify the relationship between workers’ compensation and SSDI applications during the next year or so. Once the effect of the workers’ compensation program on SSDI applications is clarified, it should then be possible to quantify the impact of the changes in the compensability rules and level of cash benefits in the workers’ compensation program on the costs of the SSDI program. Professors Guo, McInerney, Simon, and I will share our research results with you as soon as we are confident of our results.

An Intensive Investigation of California. California significantly amended the state’s workers’ compensation program in the middle of the current decade in order to reduce costs of the program. The effects were so large that the National Academy of Social Insurance reports in recent years has shown national data with and without California included because of the steep decline in costs and benefits in the state.⁵ While some of these changes involved medical benefits and other provisions of the workers’ compensation program that are unlikely to have resulted in increased applications for SSDI benefits, there were significant reductions in permanent partial disability (PPD) benefits that appear likely to have encouraged some workers to apply for SSDI benefits.⁶ Given the importance of California, a separate study of the state comparing SSDI applications in the period prior to the major changes in PPD benefits in 2004 and 2005 with the SSDI applications subsequent to these changes is warranted. The GAO should be encouraged to see whether a longitudinal data base using SSA administrative records, possibly supplemented with questionnaires sent to SSDI beneficiaries, is feasible.

3. Are there any estimates on the annual cost to SSDI from the “reverse offset”?

Table 17 of *Workers’ Compensation: Benefits, Coverage, and Costs, 2008*, published by the National Academy of Social Insurance in September 2010, has information on the number of Social Security Disability Insurance beneficiaries who have some connection with workers’ compensation (or public disability benefit) programs. The data indicate, for example, that as of December 2009, there were 57,807 SSDI cases with a current connection to workers’ compensation programs involving the reverse offset provision. The National Academy does not, however, have information on the annual cost to the SSDI from the “reverse offset.” The Office of the Actuary at the Social Security Administration should be able to provide this information.

⁵ An example is Table 1 in Ishita Sengupta, Virginia Reno, and John F. Burton, Jr., *Workers’ Compensation: Benefits, Coverage, and Costs, 2010*, published by the National Academy of Social Insurance in September 2010, which showed that employers’ costs dropped by 12.1 percent between 2007 and 2008 in California, but only 5.7 percent outside California.

⁶ Major permanent partial disability (PPD) benefits were reduced in California by 20.8 percent on January 1, 2004, by 8.8 percent on April 10, 2004, and by an additional 48.1 percent on January 1, 2005. Somewhat smaller reductions were also made in minor PPD benefits. National Council on Compensation Insurance, *Annual Statistical Bulletin, 2010 Edition*, Exhibit III.

Mr. Uehlein's Responses to Questions Submitted by Mrs. McMorris Rodgers

1. Mr. Uehlein, you touched on this briefly in your testimony, and that is the issue with respect to the AMA Guides being used to make determinations on an individual's wage-earning capacity. Could you elaborate on the role of the AMA Guides as they relate to the amount of benefits paid?

In workers compensation disability entitlement systems, workers are paid temporary benefits during periods of disability necessary for restoration of their functional capacity to return to the workplace. Upon reaching maximum medical improvement, they may have residual functional loss (impairment) and they may have residual loss of earning capacity (disability).

Benefits are paid either for the impairment alone, usually called "scheduled losses" or, more commonly, for the disability.

The theory behind the payment of these benefits is what Chairwoman Woolsey describes as the "grand bargain" by which employees surrender their right to sue employers in tort in exchange for their rights to workers' compensation.

Workers' compensation is primarily designed to put a financial safety net under injured workers while they restore themselves to health and the work place.

It is also used as a financial hammer to encourage employer safety to reduce injuries.

When the employee is unable to recover fully from injury, legislatures have had great difficulty in determining how much employers should have to pay as part of the "grand bargain" to avoid the possibility of tort suits. That issue remains for the purview of legislators.

However, in designing entitlement programs for payments for permanent disabilities, legislators have generally agreed that a process should be adopted that supports the goal of keeping such systems "simple and summary" with as little friction cost as possible and a process that at least begins with an analysis of the injured employee's functionality (impairment) at maximum medical improvement. This analysis should be fair and apply equally to all injured workers.

The role of the AMA Guides has been to assist in accomplishing this task of keeping medical analysis of impairment fair, and as simple as possible, having in mind that the issues of injury and disease are extremely complex.

It provides to the users, and ultimately to the judges who make final determinations, a consistent scale expressed as a percentage from 0 to 100% to rate the loss of functionality. It reduces subjectivity that creates inequality and unfairness and it promotes objectivity.

Thus, the AMA Guides complete the physician's role in the entitlement system in determining relative functionality (impairment) so that a benefit can be paid as determined by the legislature.

2. Mr. Uehlein, in your written statement you noted the Guides are updated every five or so years by the medical profession. When there are criticisms of the Guides, and I understand there were some when the Fifth Edition of the Guides was released, are those criticisms addressed—or taken under consideration—as the next edition of the Guides is being prepared? Could you talk about what that process entails?

This is a question that is best answered by those who have been directly involved in the process, so I refer your to their testimony and my answer directly borrows from comments and testimony of the AMA and Dr. Christopher Brigham. The Guides are an evolutionary document, building on constructive criticism to obtain their goals of representing the best medical science, ease of use, consistency and inter and intra-rater reliability. Each of the six editions has taken such criticism into account and worked to develop a better set of Guidelines. I am aware of no equal to the effort managed by the AMA to accomplish this with any other set of Guidelines in the world.

For instance, in addressing the 6th Edition, over 500 state, county and specialty societies, along with other stakeholders, were invited to nominate an author, reviewer or contributor to the process. Over 200 individuals were called upon in these various roles and/or to be a member of the Editorial Panel or Advisory Committee. These impairment professionals represented various stakeholders in the impairment process. The editorial process used an evidence-based foundation when possible, primarily as the basis for determining diagnostic criteria, and a Delphi panel approach to consensus building regarding the impairment ratings themselves. When there was no compelling rationale to alter impairment ratings from what they had been previously, ratings provided in prior editions were the defaults.

Criticism and the search for improvement in the Guides are positive. A process exists by which such criticism is received, analyzed and taken into consideration for

each new version of the Guides, and when significant, addressed between publications by the AMA Guides Newsletter.

3. Mr. Uehlein, what are the alternatives to using the AMA Guides for impairment ratings?

There are three alternatives to using the AMA Guides for impairment rating.

The first alternative is to have no guide for physicians to use in addressing medical functionality (impairment). The physician is expected to describe medical functionality in terms he chooses based on his individual learning and experience. A judge or insurer would then assess this clinical evaluation and consider the relative weight he or she wishes to place on it in making a decision offering or awarding a benefit for permanency.

Significant problems are apparent with respect to this choice as it leads to massive disparities in descriptions of functionality with respect to the same injury and with respect to injuries to varying body parts. It also relies on judges, not trained in medicine, to interpret the doctor's opinion and translate it into a benefit. Again, this will inevitably lead to conflict, cost and disparity, and places an unfair burden on judges. It reduces the likelihood of benefits being determined and paid quickly to injured employees.

The second alternative is to develop a different guide. States such as Florida, Arizona and New York have done this. The problem with this approach is that it is grounded in a belief that a different set of "experts" can come up with a better set of guidelines.

Without going into detail, I question whether a small subset of state physicians, lawyers or administrators are likely to be able to arrive at a set of guidelines as objective, grounded in consensus of the best medicine, and free of politics as the AMA has in utilizing over 200 physicians and other experts in arriving at its Guides. Certainly, a state-created guide process is an alternative. But, in layman's terms, it is reinventing the wheel, and one that is not entirely round.

Finally, another national organization could step up to provide a set of guidelines. Without clear evidence as to why such an organization would create a better process, I can see no reason to substitute for the process managed by the premier organization of physicians in the United States.

There are those who would advocate for a comprehensive set of guidelines that combine a guide to assessment of medical functionality (impairment) with a guide to assessment of loss of earning capacity (disability). In essence, such suggestions seek to use science and data to substitute for the judgment of judges as to a person's loss of earning capacity. While building on the model created in California to address such an issue may be beneficial, it will not replace the need for AMA-type guidelines for physicians.

4. Mr. Uehlein, could you explain why it is so important to have consistency and uniformity throughout the process of assessing impairment?

It is essential to have consistency and uniformity throughout the process of assessing impairment because our democratic principles demand equality and fairness of treatment. This applies to injured workers no less than any other person within our court systems.

Why should a person with a herniated cervical disc that has resulted in residual functional loss be treated one way by one judge or insurer and, if he is with another judge or insurer, be treated another way?

Why should the subjective view of one physician, conservative or liberal, be able to influence the benefits of an injured worker?

Why should one physician's opinion on impairment with respect to a specific condition be allowed to result in a higher or lower award for his patient than another physician looking at another patient with the very same condition?

[Additional submissions of Mrs. McMorris Rodgers follow:]

**Prepared Statement of Gregory Krohm, Executive Director,
International Association of Industrial Accident Boards and Commissions**

The following testimony is submitted to the Members of the Subcommittee on Workforce Protections of the Committee on Education and Labor in response to the hearing held on November 17, 2010. My name is Gregory Krohm and I have served as the Executive Director of the International Association of Industrial Accident Boards and Commissions for the last ten years. From 1992-1998, I served as the Division Administrator of the Wisconsin Division of Workers' Compensation and

prior to that I served in various capacities at the Wisconsin Department of Insurance.

I am submitting these comments as my personal opinion. They are not an official statement of the International Association of Industrial Accident Boards and Commissions, any of its members or its Executive Committee. I am not expressing any opposition to the notion of federal study and review of state workers' compensation, nor consideration of reforms. In particular, I am sympathetic to the testimony presented on November 17, 2010 regarding the deficiencies of permanent injury impairment rating and the need for a better set of guidelines.

Founded in 1914, the IAIABC is an association of government agencies that administer and regulate their jurisdiction's workers' compensation acts. Since its inception the IAIABC has worked to improve and clarify laws, identify model laws and procedures, develop and implement standards, and provide education and information-sharing.

As Chairwoman Woolsey mentioned in her opening statement, workers' compensation in the United States is administered and regulated at the state level. While this system has resulted in differences across state lines, the various agencies do not operate in a vacuum. Organizations like the IAIABC regularly bring together policy-makers and administrators to discuss shared concerns and work toward harmonization.

The mechanisms to regulate and deliver workers' compensations by the states have had a dynamic history over the last 100 years. Since the passage of the first constitutional workers' compensation act in 1911, public policy has undergone many changes to respond to shifting societal attitudes toward employment, safety, return to work, medical treatment and more.

Workers' compensation today covers a much broader segment of the workforce, more causes of injury, and offers a wider array of benefits than the founders could ever have imagined in the original state systems. For example, occupational disease was seldom covered, vocational and rehabilitation benefits did not exist, and medical care was basic and limited. As the nature of injuries shifted and social attitudes changed, the scope of benefits and coverage has generally expanded.

While workers' compensation was founded as the "great compromise" between labor and management, determining equitable terms for both parties has required refinement and continued collaboration. It is important to understand that the standard for what is compensable under workers compensation has been in continuous development, mostly expanding but sometimes limiting the nature of rights and benefits. Negotiating the appropriate balance between benefits and costs for employees and employers is under the purview of each state's legislature. In addition, many states have formal mechanisms that require labor and management to work together to refine administrative and regulatory systems. Whether through labor-management advisory boards or labor and management representatives on agency commissions many states promote system changes that balance the needs of labor and management.

After reviewing the testimony submitted by Dr. John Burton, I concur that workers' compensation systems have undergone cycles of legislative changes. One of the most active periods for change came following the 1972 National Commission Report which reported significant system inequities across the United States. States responded by making significant changes in benefit levels and the percentage of the workforce covered in an attempt to meet guidelines suggested by the commission.

As Dr. Burton correctly notes, another period of major change began in the 1990's when workers' compensation was under considerable strain as benefit payments began to grow rapidly relative to collected premiums. These market conditions caused employer premiums to increase rapidly. At the same time it increased the number of insurance company insolvencies and withdrawals from the workers' compensation market. Pressured by employers due to rising costs of workers' compensation, state legislatures once again went through a period of adjustment in order to rebalance benefits to injured workers and costs to employers. As Burton notes, the clear thrust of most of these changes was to limit claims and the cost of benefits. Whether or not this was the only, or best, way to fix the challenges in the workers' compensation insurance system is open to debate, but the changes indisputably restored the private insurance mechanism to a fiscally healthy condition and instituted a period of decline in employer costs of workers' compensation.

The opening statement to the subcommittee hearing and testimony of Dr. Burton offered as a statement of fact that state law changes in recent years have eroded access to workers' compensation benefits by injured workers. The principle point of my testimony is to offer an alternative representation of these law trends. My review of statutory changes from 2000-2010 shows that laws have not appreciably re-

stricted access to benefits for those totally disabled by work injuries.¹ My findings indicate:

- The benefit formula, limits, and length of “Permanent Total” injury benefits are very seldom mentioned in any law changes.
- Annually, most states increase the maximum weekly benefit because they are tied by statute to some fraction of the State Average Weekly Wage
- The few states that have explicitly mentioned the formula or limits of Permanent Total Injury benefits have produced a mixed change in benefit levels. For example, Florida reduced the length of PT benefits in 2003 and Montana increased the maximum weekly benefit in 2009.

State workers’ compensation system are under relentless review and fine tuning by state legislatures. According to an analysis of EK Health, in 2009 there were over 161 separate bills enacted to change state workers compensation law; from January through July 2010 there were over 90 bills enacted into law. While most of the successful law changes are narrow in focus, some are multi-faceted reforms that modify coverage or benefits in many different ways. Very rarely are the sweeping reforms completely one sided, i.e., totally favoring labor or employers. To win legislative approval most reform packages must contain some degree of compromise and balance. Good examples of this were the sweeping reforms passed in Florida in 2003 and California in 2002-03. Each of those state reforms contained a wide mix of changes which sometimes improved the position of the claimant, sometimes reduced benefits and claimant rights, and modified a host of things with system administration.

Over the time studied, I found a few states modified the criteria for a compensable claim. These changes did reduce the number of claims in those states. But in my opinion these isolated law changes produced only a very small change in the overall volume of workers’ compensation claims in the country as a whole. Put in perspective, these restrictions should be considered along with many law changes that expand claimant rights and penalize employers/insurers for unreasonable claims handling.

In conclusion, the scope of coverage and claims handling practices in workers’ compensation has been under continual scrutiny by state legislatures. Law changes and court decisions have substantially changed the benefits and rights over the entire history of the system. My study of law changes indicates that restrictions in benefits by states are largely an exception in the past 10 years and tend to have a very narrow focus. Recent trends in law have largely, though not entirely, helped to expand and balance the benefits paid to injured workers.

**Prepared Statement of Douglas J. Holmes, President,
UWC—Strategic Services on Unemployment & Workers’ Compensation**

Chairman Woolsey, Ranking member McMorris Rogers, and members of the Subcommittee on Workforce Protections, thank you for the opportunity to submit comments with respect to Developments in State Workers’ Compensation Systems.

I am Douglas J. Holmes, President of UWC—Strategic Services on Unemployment & Workers’ Compensation (UWC), a national membership organization dedicated to research and policy development on behalf of business in the areas of unemployment and workers’ compensation. UWC tracks developments in state and federal workers’ compensation law, provides comparisons of state and federal workers’ compensation laws and analyzes and researches the primary features of state and federal workers’ compensation law, policy and administration. I am a member of the National Academy of Social Insurance and serve on its Workers’ Compensation Data Study Panel.

UWC’s National Foundation for Unemployment Compensation and Workers’ Foundation publishes an annual update of changes in state workers’ compensation laws and a fiscal data bulletin comparing the costs associated with state workers’ compensation laws.

The following comments are submitted to add to the record of the hearing held on November 17th, with a particular focus on the issues that were the primary subjects of testimony during the hearing; 1) the use of the 6th edition of the Guides published by the American Medical Association to evaluate the medical impairment

¹My review consisted of analysis using the following publications, IAIABC/WCRI Inventory of State Laws (2007-2010); Summary of Workers’ Compensation Laws published in the Monthly Labor Review each January 2000 through 2004 by Glenn Whittington; Legislative Analysis Reports prepared by Todd Brown of EK Health; and various state legislative summaries prepared by state workers’ compensation agencies.

of individuals, and 2) the relationship between trends in state workers' compensation and Social Security Disability Insurance (SSDI).

AMA guides

In December 2007 the American Medical Association published the 6th Edition of the AMA Guides to Evaluation of Permanent Impairment. The AMA Guides 6th Edition is one of several editions that form the basis for impairment rating in most workers' compensation systems. Depending on the jurisdiction, the 3rd Edition revised, 4th Edition, 5th Edition, and now the 6th Edition may be required or permitted in whole or in part.

The determination of whether to use the AMA Guides, which edition to be used, and any deviations specific to the law in a particular state have developed in recent years with the experience, case law and statutes unique to each state.

The most recent 6th edition of the AMA Guides receives the support of the majority of physicians who have been trained in the appropriate use of this edition. As might be expected, there are differences in the most recent edition in comparison to previous editions and the practices in each state. The learning curve among physicians is a factor to be addressed in each state in determining which edition to be used.

The AMA 6th edition is one choice available to states in setting a foundation for ascertaining permanent impairment, and seeks to use impairment as an objective basis for the determination of permanent disability and payment of permanent disability benefits. One of the uses of the Guides is to help determine monetary awards to individuals injured at work.

A comparison of the various editions of the AMA Guides discloses a range of differences in impairment ratings. Although these impairment ratings do not by themselves determine the percent of partial disability, they form the basis for the evaluation of disability and therefore become controversial to the extent that the resulting disability is greater or lesser and therefore generates a lesser or greater workers' compensation monetary award.

The workers' compensation system should strive for the most accurate determination of medical impairment and properly apply this information to the determination of disability of an injured worker under the applicable law.

Studies of the AMA Guides are best performed by medical doctors who are expert in determining medical impairment. As methodology used in determinations of medical impairment improves, the information upon which determinations of disability should become more accurate, but judgment on the part of elected officials and adjudicators will still be required with respect to the appropriate application of impairment in the ultimate determination of disability.

Such determinations as a matter of state law should be left to the state workers' compensation system.

Workers' compensation and Social Security Disability Insurance

The State Workers' Compensation system is a mature social insurance system, with initial state workers' compensation programs enacted in 1911. Coverage of the workforce under the state system has increased over the years to the point now that only 3 percent of all employees who worked for employers who participated in the Bureau of Labor Statistics National Compensation Survey (NCS) were employed in establishments that reported zero workers' compensation costs.

The determination of awards for medical care and cash benefits for lost work time is made in each state as the workers' compensation state statutes, case law and practice have evolved over a period of decades. The terms of benefit eligibility, medical costs, indemnity, strategies to assist injured workers in returning to work, costs of the system and insurance premiums are set on a state by state basis with the recognition of exclusive remedy protections for employers and insurers in exchange for a system under which individuals are assured coverage and compensability if their illness or injuries are in the course of employment.

It was not until the Social Security Amendments of 1965 that Social Security Disability Insurance (SSDI) benefits were required to be offset so that the combined totals of workers' compensation and social security disability benefits did not exceed 80 percent of the workers' prior earnings.

This offset provision enacted as a savings measure for SSDI was overlaid on top of the already mature workers' compensation system in which some states had adopted provisions under which social security benefits were to be deducted in whole or in part from workers' compensation benefits.

In both "offset" provisions there was also the recognition as a matter of policy that individuals should not receive more in income when disabled than when employed in their previous employment.

It strains credulity to conclude that a federal program, SSDI, which was enacted in part as a federal overlay of the state workers' compensation system would be said to be suffering from cost shifting from the state workers' compensation programs. Fifteen states currently have "reverse" offset laws, including Colorado, Florida, Hawaii, Illinois, Louisiana, Minnesota, Montana, Nevada, New Jersey, New York, North Dakota, Ohio, Oregon, Washington, and Wisconsin.

Disregarding the offsets in place in these states for decades in determining SSDI benefit amounts would shift costs from Social Security to employers and insurers doing business in these states and disrupt balances in state WC costs and benefits in each of these states. The result of such a shift would not only be to increase the costs of workers' compensation, discouraging employers from hiring, but also result in state legislative measures to reduce benefits in other ways to assure the solvency of workers' compensation plans and funds.

A more appropriate analysis should review the increases in SSDI benefit eligibility, increased costs, and the aging workforce as the primary drivers of program insolvency to be addressed.

As of December 2009, only 7.9 percent of SSDI beneficiaries had a connection to workers' compensation or public sector disability programs. The percent specific to state workers' compensation is less than 7.9 percent and the percent with reverse offset provisions is an even smaller percentage.

As noted in the testimony of John Burton before the subcommittee, citing recent as yet unpublished results of a study by Mr. Burton and Professor Guo, "the aging population was the largest contributor of the growth in SSDI applications during the period we examined (1981-1999), and can explain more than half the growth in SSDI rolls in the 1990s." Mr. Burton also notes that "The share of female employment is another factor, which was associated with almost 18 percent of the change of SSDI applications between the 1980s and 1990s." Finally, Mr. Burton suggests, based on unpublished results of a study of data from 1981 to 1999, that "the reduction in the amounts of workers' compensation permanent disability benefits and tightening of eligibility rules for workers' compensation permanent disability benefits during the 1990s accounted for about 3 to 4 percent of the growth of SSDI applications during the decade.

This conclusion that a very small part of the growth in SSDI applications during a period 20 to 40 years ago is associated in some way with state workers' compensation is hardly compelling evidence of a need to rush to federal legislative action. In fact, it is just as likely that the relationship between SSDI applications and the state WC system is reversed and that reductions in WC applications during this period were caused in part by federal policies increasing the availability of SSDI.

Professor Burton notes that in an unpublished article by McInerney and Simon (2010) of the determinants of SSDI applications concluded that it was unlikely that state workers' compensation changes were a meaningful factor in explaining the rise in SSDI applications and SSDI new cases during the period from 1986 to 2001.

Despite the paucity of data suggesting a need for new federal legislation to address the relationship between the state WC system and SSDI, Professor Burton backs into a series of conclusions consistent with the underlying assumption that federal standards are needed for the state WC system.

Any study of the state WC system and/or SSDI must address the costs and premiums and the impact on employers and job creation. A series of suggestions that eligibility should be expanded and/or benefit levels should be increased, without evaluation of costs will result in benefit pay-out and costs that are unsustainable. As we have seen with Medicare and Social Security, the expansion of entitlement to respond to political constituencies without addressing long term solvency creates an unsustainable imbalance which results in an inequitable shift of costs to future generations of claimants, taxpayers and businesses.

Instead of studying the impact of state WC systems on SSDI with the suggestion that the state WC system should be federalized, the focus of research should be on the array of state WC system reforms that have improved the sustainability of the state WC systems and facilitated the rehabilitation and return to work of workers who became ill or were injured while on the job.

We appreciate the opportunity to submit a statement for the record and would be pleased to provide further comments from employers and insurers with hands on experience in the review of policy options by the Governmental Accountability Office (GAO) or research conducted by the National Institute for Occupational Safety and Health (NIOSH) and the National Institute of Medicine.

[Additional submission of Mr. Godfrey follows:]

2008 Iowa AMA Guides Task Force Process Report

Iowa Workers' Compensation Commissioner Christopher Godfrey convened a task force regarding the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition, in May 2008.

Members

The task force was comprised of eight voting members intended to represent a broad spectrum of the Iowa workers' compensation community. Members were: Donna Bahls, M.D., a physical medicine and rehabilitation specialist; Matthew D. Dake, attorney-at-law who generally represents employees in workers' compensation matters; Teresa Hillary, administrative law judge and former deputy workers' compensation commissioner; John Kuhnlein, D.O., an occupational medicine specialist; Marlin Mormann, administrative law judge and former deputy workers' compensation commissioner; R. Saffin Parrish-Sams, attorney-at-law who generally represents employees in workers' compensation matters; Sara J. Sersland, attorney-at-law who generally represents employers and insurance carriers in workers' compensation matters; and Peter J. Thill, attorney-at-law who generally represents employers and insurance carriers in workers' compensation matters. Helenjean M. Walleser, deputy workers' compensation commissioner, served as task force moderator and was not a voting member.

Task force objectives

A May 8, 2008, letter of invitation from the Commissioner to potential members set forth the task force objectives, namely:

- a. Review the AMA Guides To the Evaluation of Permanent Impairment, Sixth Edition.
- b. Overview methodology for determining permanent impairment in the Sixth Edition.
- c. Determine if impairment assignments under the Sixth Edition differ substantially from impairment assignments under previous editions of the Guides or from other impairment rating sources.

Task force assignments

That letter also outlined the task force assignments, namely:

1. Analyze the Sixth Edition's impairment rating methodology.
 - a. Compare and contrast it with earlier editions and other rating guides.
 - b. Identify the Sixth Edition methodology's advantages and disadvantages.
 - a. Identify and document potential problems and areas of concern within the Sixth Edition.
 2. Address errors within the Sixth Edition.
 3. Analyze the significance of using the Sixth Edition within the Iowa workers' compensation system.
 - a. Compare impairment ratings for like conditions under the Fifth and Sixth Editions.
 - b. Analyze the impact of ratings differences between the Fifth and Sixth Edition on voluntary benefit payments.
 4. Make recommendations concerning the use of impairment rating guides in the Iowa system.
 - a. Should Iowa adopt the Sixth Edition of the Guides?
 - b. Should Iowa adopt some individual chapters of the Sixth Edition?
 - c. Should Iowa adopt another existing impairment guide?
 - d. Should Iowa develop its own impairment guide?
 - i. What would this entail?
 - ii. How long would it take?
 5. Other considerations regarding the use of impairment ratings.
- The letter of invitation and assignment is Exhibit A in the addenda to this process report.

The task force met on June 26 and June 27, 2008, July 30 and July 31, 2008, and August 26, 2008. All members were present at each task force meeting.

Task force proceedings on June 26 and June 27, 2008, centered on reviewing and contrasting the Fifth and Sixth Editions of the Guides and addressed task force work assignments 1, 2, and 3.

Philosophy and rationale—ICF model

Chapter 1 in both the Fifth and Sixth Edition of the Guides sets forth the philosophy and conceptual rationale that underlies each edition. The rationale of the World Health Organization's "1980 International Classification of Impairments, Disabilities and Handicaps" undergirds the Fifth Edition's philosophy. Under that sys-

tem, the progression from impairment to disability and/or handicap is viewed as linear. Disability, the inability to perform certain activities or roles, directly proceeds from impairment, the loss, loss of use, or derangement of a body part, organ system or organ function that results from an identified pathology.

The Sixth Edition replaces the 1980 model with the World Health Organization's more recently adopted model of disablement: "the International Classification of Functioning, Disability, and Health" (ICF). Adaption of its terminology and conceptual framework of disablement is the first axiom of the "paradigm shift" the Sixth Edition entails. The ICF model has three components, 1) body function and structures, 2) activity, and 3) participation. Adaption of the ICF terminology and conceptual framework of disablement is the first axiom of the Guides, Sixth Edition.

Per ROBERT D. RONDINELLI, M.D., Medical Editor of the Sixth Edition, who spoke with the task force on June 27, 2008, adaption of the ICF model, is consistent with current international understanding of disablement. Adaption of the model also should facilitate funding of research concerning the Guides' use, and methodology. Major grant providers, such as the Institutes of Health, have not supported research proposals using the Fifth Edition of the Guides because many grant funders view the 1980 classification system as outdated.

Within the Sixth Edition and consistent with the ICF model, impairments are losses, deviations or variations from normal health of body functions and body structures. Additionally, the Sixth Edition requires that such losses be significant before they are considered impairing. Activities are tasks that individuals carry out; activity limitations are difficulties experienced in performing tasks. Participation is defined as involvement in life situations; participation restrictions are barriers to involvement.

The ICF model is an attempt to recognize that impairment does not lead directly to disability and that the relationship between having a health condition and becoming disabled is dynamic, with environmental and personal factors as well as activity limitations and participation restrictions impacting on overall human functioning and disability. Impairment rating is defined as a consensus derived percentage estimate of the loss of activity that reflects the severity of a given health condition and the degree of associated limitations in activities of daily living.

Table 1—1 sets forth activities of daily living. These are basic self-care activities that individuals perform. Included among them are bathing, showering, dressing, eating, functional mobility as well as personal hygiene, toilet hygiene and management, sleep, and sexual activity. Task force members recognized that most individuals alleging work injuries are largely independent in activities of daily living, even when their health condition produces a functional disability or measurable loss of earning capacity. For that reason, a medical impairment rating may not well reflect the actual functional disability from a scheduled member loss and is only one of multiple factors that is legally appropriate to consider in determining actual loss of earning capacity under Iowa Code section 85.34 (2) (u).

Additionally, consensus derived estimates may well be influenced by the composition of the consensus group. Therefore, knowledge of that composition is important. Dr. Rondinelli stated that the consensus group members for each ratings chapter within the Sixth Edition consisted of physicians who both were members of the national group for that medical specialty and were interested enough in the development of an impairment rating process to volunteer their time and efforts. In order to address this concern, the task force asked the American Medical Association (AMA) to specify the contributing editors and chapter contributors to the Sixth Edition. The AMA did not do so. Instead, it directed the task force to pages vi-vii of the Sixth Edition, which set forth participants in the Sixth Edition development process but do not specify the precise role or level of involvement of each participant.

Other important sixth edition axioms

Chapter 1 of the Sixth Edition sets forth four additional axioms that provided direction and set priorities in developing that edition's new paradigm: 2) The Guides should be diagnostic based and diagnoses should be evidence-based. [In contrast, the Fifth Edition and earlier editions of the Guides largely were anatomically-based and assigned impairment based on losses of motion or strength or other physical capacity.] 3) The Guides should be easy to use and, where applicable, should follow precedent in order to optimize rating reliability within and among persons evaluating impairment under the Guides. 4) To the fullest extent possible, rating percentages are to be functionally based. 5) The Guides should utilize congruent concepts and methodology within organ systems and between different organ systems. The axioms are intended to address perceived problems and stated criticisms of the Fifth and earlier editions of the Guides; namely, the Guides were not comprehensive, reliable or evi-

Impairment rating methodology

Table 1-4 sets forth five generic functional impairment classes also ranging from zero through four. Individuals with health conditions that produce no symptoms with strenuous activity are assigned to functional impairment class 0. Individuals who have symptoms with strenuous activity but do not have symptoms with normal activity are assigned to functional impairment class 1; those with symptoms with normal activity to class 2; persons with symptoms with minimal activity to class 3 and persons with symptoms at rest to class 4. Persons in classes 0 through 2 are considered functionally independent whereas persons in class 3 are considered partially functionally dependent, and persons in class 4 are considered totally dependent. Persons in classes 1 through 3 may well be within the workers' compensation system because they have compensable work related disability even though they are functionally independent or only partially dependent. Again, a task force CONCERN was that the concept of medical ratable impairment not be confused with or substituted for the concept of legally compensable disability.

An evaluator is to consider an individual's clinical presentation, physical findings, objective testing, and associated functional losses when assigning the diagnostic impairment class (DIC). Proposed functional assessment tools for the various organ systems are set forth in the rating chapters. The Sixth Edition acknowledges that "no well-accepted, cross-validated outcomes scales exist "for the musculoskeletal organ system. Self-reporting functional assessment tools are recommended for the spine, upper extremities and lower extremities. They are the Pain Disability Questionnaire (PDQ), the Disability to the Arm, Shoulder and Hand (DASH), and the Lower Limb Outcomes Questionnaire, respectively. In the Sixth Edition methodology, evaluators may use reliable results from these tools "to adjust the impairment percentage to reflect different functional outcomes." Unfortunately, no data exists demonstrating that these tools are culturally sensitive. A task force concern was

that self-reports received from members of various ethnic groups might well be skewed in a manner that reflected the particular groups' approach to functioning with pain or other limitations.

Each diagnosis within an organ system is to be placed within one of the five 0 through 4 classes. An impairment percentage range has been assigned to each impairment class. The four criteria of clinical presentation, physical findings, clinical studies or objective tests, and functional history or assessment, all are to be considered in determining the impairment class. However, the Sixth Edition designates one of these four criteria as the "key factor", which is the "primary determinant of impairment" [class] for each diagnosis the Sixth Edition rates.

Impairment grades/adjustment factors

Each impairment class has five impairment grades within it, designated as A through E. A is the lowest impairment grade assignable within an impairment class; E the highest. C is the default assignment. "After the key factor has led to a preliminary impairment rating, it will be adjusted based on the results from rating the other impairment criteria (non-key factors) (adjustment factors)." (Sixth Edition at page 12)

If the evaluator judges the other criteria as in the same class as the key factor, the final rating generally will stay at that class and grade. On the other hand, if other criteria—adjustment factors—are either numerically higher or lower than the key factor, the impairment grade within the assigned impairment class may change. The impairment class, itself, will not change, as it was determined by the key factor, however. The initial assumption is that the individual being evaluated is in the C impairment grade for the class, which is scored as 2. The ultimate impairment grade within an assigned diagnostic impairment class is achieved mathematically. The 0 through 4 score for each of the three non-key/adjustment factors individually is subtracted from the numerical score, again 0 through 4, for the diagnostic impairment class. The resulting numerals are then added to determine whether any net adjustment in the impairment class grade is appropriate.

As an example, the injured worker is assigned to diagnostic impairment class 2 based on the designated key factor of physical findings. At that point, the individual is placed in the C, moderate/2 or default grade within the impairment class. The three non-key factors then are: the history of clinical presentation, the objective test results and the functional history or assessment. The clinical presentation is assessed at 3/severe, as the worker has constant moderate symptoms despite continuous treatment. The objective test results are assessed at 1/minimal, as over time testing has demonstrated only intermittent mild abnormalities. The functional assessment is 2/moderate, as the individual is symptomatic with normal activities.

At that point, the arithmetic begins. The impairment class score of 2 is subtracted from the clinical presentation score of 3, with a result of 1. Next, the impairment class score of 2 is subtracted from the objective test assessment of 1, with the result of -1. Finally, the impairment class score of 2 is subtracted from the functional assessment of 2, with the result of 0. The three resulting numerals are then added to achieve any 0. The three resulting numerals are then added to achieve any 0. The three resulting numerals are then added to achieve any net grade adjustment within the impairment class. In this instance, 1 plus -1 plus 0 equals 0, which indicates that no grade adjustment is appropriate. The worker's impairment rating would remain that set forth by diagnostic impairment class 2, grade C impairment.

Suppose, in the above example, the clinical presentation had been assessed at 1, intermittent, mild symptoms despite continuous treatment, while the diagnostic impairment class remained 2 and the objective test assessment and functional assessment adjustment factors remained at 1 and 2, respectively. The clinical presentation adjustment score obtained by subtracting 1 from class score 2 is -1. The addition formula then is -1 plus -1 plus 0 or -2. As negative 2 is two grades lower than the default grade C, the worker's impairment rating would decrease to that appropriate for a diagnostic impairment class 2, grade A impairment. Conversely, had the clinical presentation score remained at 3 and the objective test assessment at 1, but the functional assessment score been 3, the ultimate net adjustment would be 1. $(3 - 2) = 1$ plus -1 plus 1 = 1. The grade within the class would move one level above the default grade C to grade D. Hence, the worker's impairment rating would increase to that appropriate for diagnostic impairment class 2, grade D.

Simply put, a negative net adjustment score will decrease the overall impairment rating given for the diagnostic class; a positive net adjustment score will increase the overall impairment rating given for the diagnostic class; and a net adjustment score of zero will keep the individual in the middle range of potential impairment ratings for that diagnostic class.

A number of the impairment rating examples in the Sixth Edition on their face are inconsistent with the results to be obtained using this methodology. Even if it is assumed that these are arithmetic and editorial errors, which were corrected in the AMA's August 2008 Corrections and Clarifications to the Sixth Edition, a task force concern is that evaluators and reviewers will not consistently use both the Sixth Edition and the Corrections and Clarifications when assessing impairment.

The complexity of the Sixth Edition methodology is a task force concern. If only physicians who have had formal course training in the Sixth Edition methodology can use it appropriately to assign impairment, both the number of treating physicians and the number of evaluating physicians willing to assess impairment may decrease. Additionally, the overall costs of obtaining impairment ratings might increase to reflect practitioner training cost.

On the other hand, a standardized impairment assessment methodology across body organ systems theoretically qualifies practitioners who have learned the methodology to assess impairment within multiple organ systems. Dr. Rondinelli has conducted several training workshops for use of the Sixth Edition methodology. He acknowledged that training attendees initially voiced concerns regarding the Sixth Edition methodology. Dr. Rondinelli also expressed his belief that, after learning the Sixth Edition methodology, his training attendees preferred the generic methodology of the Sixth Edition over the multiple methodologies across and within body organ systems contained in the Fifth and other earlier editions of the initially voiced concerns regarding the Sixth Edition methodology. Dr. Rondinelli also expressed his belief that, after learning the Sixth Edition methodology, his training attendees preferred the generic methodology of the Sixth Edition over the multiple methodologies across and within body organ systems contained in the Fifth and other earlier editions of the Guides.

The concrete and consistent Sixth Edition methodology may decrease the range of potential impairment ratings a worker receives from different evaluators. That fact potentially could reduce overall litigation and overall litigation costs. On the other hand, that different medical practitioners often arrive at different diagnoses when presented with similar clinical signs and symptoms is an expressed task force concern. It was pointed out that inconsistent diagnoses are very prevalent for musculoskeletal conditions, especially spinal problems, as well as for mental and behavioral disorders. For that reason, disputes over the appropriate clinical diagnosis for a worker may increase with use of the Sixth Edition.

The weight given to the designated key factor in assessing the impairment class for any given diagnoses was also a concern. The key factor always determines the assigned class. This is the case even if the key factor's numerical score substantially differs from the numerical scores for all of the other three adjustment factors. For example, if the key factor placed an individual in diagnostic impairment class 2 default grade C, but each of the other three adjustment factors was assessed at 4, very severe problem, the numerical net adjustment score would be 6. $[(4-2) = 2 \text{ plus } (4-2) = 2 \text{ plus } (4-2) = 2 = 6]$ The actual allowable adjustment could only move to impairment class 2, grade E, however. The additional severity of the non-key adjustment factors could not be used to justify moving the individual into the higher diagnostic impairment classes of 3 or 4. Conversely, an individual assessed in diagnostic impairment class 2, default grade C with an overall net adjustment score of -6, that is, scores of 0 on all three of non-key criteria, would only move to impairment class 2, grade A. The diagnostic impairment class could not be changed from 2 to 1. The inability to change the impairment class is important, as the numeric ratings appropriate in each diagnostic class is narrow.

Principles underlying sixth edition use

Chapter 2 of both the Fifth and the Sixth Edition is titled, "Practical Application of the Guides". Chapter 2, Paragraph 1 of The Fifth Edition, simply states that the chapter describes how to use the Fifth Edition to obtain, use and communicate reliable, consistent, medical information. Paragraph 1 the Sixth Edition, chapter 2 makes very explicit that any evaluator using the Sixth Edition should be thoroughly familiar with its second chapter. The paragraph states:

"This chapter outlines the key concepts, principles and rationale underlying application of the AMA Guides to impairment rating all human organ systems."

It originally also had contained the sentence:

“Anything in subsequent chapters interpreted as conflicting with or modifying the content outlined [in Chapter 2] is preempted by the rules contained in [Chapter 2]. By analogy, [Chapter 2] is the “constitution” of the Guides.”

This sentence was deleted in the August 2008 Corrections and Clarifications to the AMA Guides, Sixth Edition, however. The question arises then as to whether Chapter 2 validly can be utilized for resolution of any perceived conflicts within or among the body system chapters.

Table 2-1 at page 20 sets forth the 14 fundamental principles of the Guides, Sixth Edition, with Principle 1 reiterating that Chapter 2 sets forth the fundamental rules of the Sixth Edition. Principles 2 through 5 prescribe the general rating formulae. Only permanent impairment is ratable and only after an individual has achieved maximum medical improvement. The chapter relevant to the bodily system where the injury primarily arose or where the greatest residual dysfunction remains is to be used for rating impairment. Impairment across all body systems cannot exceed 100 percent whole person; overall impairment of a member or organ cannot exceed its amputation value. Impairments in the same organ system or member initially are combined at that level and later are combined with impairments to other members or organ systems at the body as a whole level.

Principle 6 as set forth in the August 2008 Corrections and Clarifications states that impairment evaluation requires medical knowledge and physicians should perform assessments within their applicable scope of practice and field of expertise. Principle 6 had provided that only licensed physicians were to perform impairment ratings and that chiropractic physicians should rate in the spine only. An early clarification to the Sixth Edition eliminated the restriction on chiropractic rating. Chapter 2, section 2.3a states that non-physician evaluators may analyze an impairment evaluation to determine if was performed in accordance with the Guides. The task force discussed whether permitting this was appropriate.

Principle 7 provides that an impairment evaluation report is valid only if the report contains three elements: 1) a clinical evaluation, relevant medical history and review of medical records; 2) analysis of the findings as these relate to the concluded diagnosis/ses, the achievement of maximum medical improvement and confirmed loss of functional abilities; and 3) a thorough discussion of how the impairment rating was calculated. That an evaluator's incorporation of all the above elements into a report may increase the cost of obtaining impairment ratings and reports is a task force CONCERN. That valid reports would facilitate a reviewer's assessment of the accuracy of the diagnoses and rating has merit, however.

Principles 8 and 9 require that evaluations be conducted by accepted medical scientific community standards and that ratings be based on objective criteria and established medical principles for the pathology being rated.

Principles 8 through 11 and 13 apparently are intended to increase the objectivity of impairment ratings developed under the Sixth Edition. Nevertheless, objectivity is itself an elusive concept. Patients' presenting complaints are generally self-described and therefore subjective. Yet these are coupled with physical examination findings and clinical tests results to assess and diagnose. Likewise, patients' completed functional self-assessment tools represent their subjective report of abilities and limitations. Yet, the Sixth Edition prescribes the use of self-assessment tools, particularly so in the musculoskeletal chapters. Furthermore, the task force was aware of no current scientific rationale that undergirds medical consideration of functional loss. In the workers' compensation arena, assessment of functional loss and its impact generally has related more to the legal concept of compensable disability and not to the medical concept of physical impairment.

Principle 12 requires that an evaluator use the method producing the higher rating when more than one rating method is available for a particular condition. Finally, principle 14 requires that fractional ratings be rounded up or down to the nearest whole number, unless otherwise specified.

Issues related to the principles

The various sections of Chapter 2 further discuss issues related to the 14 principles. Section 2.3b states that the doctor'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 of limitations in the performance of ADLs. The section further states that, while treating physicians may perform impairment ratings on their own patients, such ratings may be subject to greater scrutiny as they “are not independent”. Task force members are aware that the senior contributing editor to the Sixth Edition operates a substantial private business that both performs impairment evaluations and reviews ratings from other evaluators.

Section 2.4d expressly states that the impairment ratings for each organ system include consideration of most of the functional losses accompanying pain [related to the impairment rating class].

Section 2.5a contains a discussion of the differences between legal and medical probability. Legal probability requires a more likely than not or greater than 50% association between an event and an outcome to establish a probable relationship. In contrast, science and medicine require an association between a potential cause and an identified effect that is greater than 95% before the relationship is recognized as probable. The task force believes that the explicit statement of these medical and legal differences is helpful.

Section 2.5b defines causality. It states that to opine that a cause relates to an effect within a reasonable degree of medical probability, it is necessary that the event occurred, that the individual who experienced the event must have the possible condition, that is, the effect which may relate to the event, and that medical probability exists for the event to have caused or materially contributed to the condition. If medical probability means a greater than 95% relationship, this definition of causality differs from the more likely than not legal probability standard in Iowa workers' compensation law.

The terms, "aggravation", "exacerbation", "recurrence" and "flare up", expressly are defined in section 2.5b. An aggravation is described as a permanent worsening of a pre-existing or underlying condition, which results from a circumstance or event. It is distinguished from an exacerbation, recurrence or flare up. Those three terms are said to imply a temporary worsening of a pre-existing condition that then returns to its baseline. Iowa workers' compensation law makes no such distinction between exacerbation and aggravation; each may be considered to result in a permanent, potentially compensable, substantial change in a pre-existing condition.

Section 2.5c provides a methodology for medically allocating or apportioning impairment between or among multiple factors. The final rating for the condition being evaluated is arrived at by determining total impairment and then subtracting the proportion of impairment, which pre-existed the event that produced the overall current condition, from the total impairment. This type of apportionment will not always be appropriate under the Iowa workers' compensation law.

Pain related impairment

Chapter 3 of the Sixth Edition discusses potential pain related impairment as does Chapter 18 of the Fifth Edition. The Sixth Edition and the Fifth Edition each allow an evaluator to assess up to 3% whole person impairment related to an examinee's reported pain. This is a departure from the Fourth Edition and its predecessors, which did not allow the assignment of impairment related to pain complaints. Significant differences exist as to how the Fifth and Sixth Editions approach pain, however.

First, the Fifth Edition allows an evaluator to provide an impairment rating for pain as well as an impairment rating for identified organ system dysfunction if the evaluator believes that the organ system impairment rating does not adequately reflect the overall impairment. The Sixth Edition permits an evaluator to separately assess pain for impairment rating purposes only if the individual being evaluated fits no other diagnostic impairment class. Under the Sixth Edition, any rating expressly assigned for pain is a "stand-alone" rating that cannot exceed 3% whole person impairment.

On the other hand, the Fifth Edition apparently is more restrictive as to the painful conditions that may be evaluated than is the Sixth Edition. The Fifth Edition requires that an evaluator determine whether pain related impairment is ratable or unratable. Under that edition, an individual's symptoms and physical findings are ratable for impairment purposes if these signs and symptoms typically are found with a known medical diagnosis, which physicians widely accept as having a well-defined pathophysiologic basis. The Sixth Edition permits pain related impairment to be assessed if, among other things, "the pain has a reasonable medical basis, for example, can be described by generally acknowledged medical syndromes." Sixth Edition, section 3.3d at page 40. That phrase suggests that ratings for pain related impairment may be appropriate for myofascial or fibromyalgia syndromes, which do not fit within any other diagnostic impairment class.

Mental and behavioral disorders

Chapter 14 of both the Fifth and Sixth Edition relates to mental and behavioral disorders. The approaches to assessing mental and behavioral impairment differ substantially within the Fifth and Sixth Editions, however. Chapter 14 of the Fifth Edition focuses on the process of performing mental and behavioral impairment assessment. Instructions are given for assessing how the disorder impacts an individ-

ual's abilities to perform activities of daily living. Numeric impairment ratings are not given. Instead, persons with mental or behavioral disorders are placed in one of five impairment classes, which are assigned based on the ability of the individual to take part in activities of daily living, social functioning, concentration and adaptation. Class 1 represents no impairment of useful functioning; class 3, moderate impairment, this is the ability to perform some but not all useful functioning; class 5, extreme impairment, indicates that the individual is precluded from all useful functioning.

The Fifth Edition apparently permits classification of functioning of an individual diagnosed with any mental disorder described in The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). In contrast, the Sixth Edition expressly states that it is not its purpose to rate impairment in all persons who may fit a DSM-IV diagnosis. Instead, the Sixth Edition allows ratings of only mood disorders, anxiety disorders and psychotic disorders. Mood disorders include major depressive disorder and bipolar affective disorder. Anxiety disorders include generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder and obsessive-compulsive disorder; psychotic disorders include schizophrenia.

Additionally, under the Sixth Edition, psychiatric impairment is to be based on Axis I pathology only. Axis II pathologies, such as personality disorders are considered pre-existing personality vulnerabilities and are not to be rated. Borderline intellectual functioning, which preexisted the event legally responsible for a ratable condition, also is not to be rated. Additionally, the sixth edition expressly states that the psychological distress associated with any physical impairment is included within the rating for that impairment; therefore, psychiatric reaction to pain is not to be rated. Page 349 of the Sixth Edition lists other disorders that are not to be rated.

Unlike the Fifth Edition, the Sixth Edition does provide numeric impairment ratings for those mental and behavioral disorders it considers ratable. Three scales that are intended to provide an assessment of an individual's mental and behavioral disorder are prescribed for use in the rating process. These are: the Brief Psychiatric Rating Scale (BPRS), the Global Assessment of Functioning Scale (GAF), and a modified version of the Psychiatric Impairment Rating Scale (PIRS). Essentially, each of these assessment tools is either taken by or administered to the individual being evaluated. Each is then scored. The Sixth Edition assigns a numeric impairment score for the summed score achieved on each instrument. The middle value among the three impairment scores then is assigned as the mental and behavioral disorder impairment rating.

The task force felt there may be some merit in attempting to provide numeric impairment ratings for mental and behavioral disorders. The task force sought input from a psychiatrist, James Gallagher, M.D., and a psychologist, John Brooke, Ph.D., each of whom has had experience within workers' compensation, in order to gain these practitioners' insights into both the feasibility of numerically rating impairment for mental and behavioral disorders and into the ease-of-use and appropriateness of use of the three assessment scales, across cultures and ethnic groups.

Task force members expressed concerns that some long-standing personality vulnerabilities, which may impact an individual's response to an injury or be impacted by the injury itself, are considered unratable.

Musculoskeletal chapters

The musculoskeletal chapters of the Fifth and Sixth Edition were reviewed. Dr. Rondinelli expressly advised the task force that the Sixth Edition editors had no intent to lower numeric impairment rating for any organ system. Furthermore, where ratings must be consensus-based because objective data is lacking, the Sixth Edition purports generally to follow precedent from earlier editions of the Guides. The Sixth Edition also attempts to normalize impairment ratings and impairment assessment methodology across organ systems in order to improve that edition's internal consistency. With or without intent, changes in the numeric impairment ratings for a variety of musculoskeletal conditions and ailments have resulted.

Impairment in the spine and pelvis

Chapter 15 of the Fifth Edition and Chapter 17 of the Sixth Edition relate to assessment of impairment in the spine and pelvis. Under the Fifth Edition, both the diagnostic related estimates (DRE) and the range of motion method were available for rating spinal conditions. The DRE method was considered the principle methodology to evaluate an individual who had had a distinct injury. The range of motion method was available for use in cases of recurrent disc herniation at the same spinal level and in cases of multilevel involvement within the same spinal region. The Sixth Edition permits final impairment to be assessed only with the diagnosis based impairment method. Furthermore, once the diagnostic impairment class has been

established, selected treatment for the condition and treatment outcomes are considered only as potential modifiers of grade within the diagnostic class.

Generally speaking, cervical spine disc or motion segment pathologies received higher impairment ratings in the Fifth Edition than these receive in the Sixth Edition. The impairment rating for lumbar region pathologies generally are increased from the Fifth Edition.

Impairment in the upper extremities

Chapter 16 the Fifth Edition and Chapter 15 of the Sixth Edition treat assessment of impairment in the upper extremities. Range of motion tables are an assessment features in both editions. Both editions discuss assessment of impairment with complex regional pain syndrome. The Sixth Edition contains what appear to be extraneous comments about that syndrome's prevalence in workers' compensation settings.

Appendix 15b of the Sixth Edition sets forth criteria to be used in interpreting electrodiagnostic testing for entrapment syndromes. The task force had concerns, that as a result of these criteria, doctors potentially would diagnose, treat and assign impairment ratings for work related hand and arm conditions in a manner different from the diagnosis and treatment of otherwise similar but non-work related conditions.

Another task force concern was that the Sixth Edition's DRI methodology unduly complicated the assessment process for relatively simple upper extremity diagnoses.

Impairment in the lower extremities

Chapter 17 the Fifth Edition and Chapter 16 of the Sixth Edition treat assessment of impairment in the lower extremities. Again, range of motion is a widely used assessment factor in both editions. The need to fit all upper extremity diagnoses into the Sixth Edition's DRI grid likely increases the time and complexity impairment assessment under it.

Sixth edition corrections and clarifications

The 52 page long August 2008 Corrections and Clarifications to the Sixth Edition, available at www.ama-assn.org/ama1/pub/upload/mm/477/guidesclarifications.pdf, were considered at the August 26, 2008 task force proceeding. The majority of the corrections and clarifications are to the musculoskeletal chapters. Reconciling the Corrections and Clarifications with the original printing of the Sixth Edition is difficult and time-consuming rather one does so by consulting the Corrections and Clarifications on line, by consulting a print copy of the Corrections and Clarifications placed at the front of the original Sixth Edition text, or by cutting and pasting the Corrections and Clarifications into the original text. This raises concerns as to whether all users of the original printing would utilize the Corrections and Clarifications. Given the significant extent of the Corrections and Clarifications, that fact raises a concern as to the reliability of any impairment rating achieved with use of the Sixth Edition original printing.

Additionally, questions arise as to what legally constitutes the Sixth Edition. Arguably, the Sixth Edition could be defined as the original printing without more. On the other hand, it could also be defined as the Sixth Edition original printing and the August 2008 Corrections and Clarifications, or even as the original printing and any and all corrections and clarifications to the date of impairment rating. An evaluator would need to explicitly state which assessment tools that evaluator used to arrive at an impairment assessment characterized as under the Sixth Edition. Potentially, a later correction to the Sixth Edition could invalidate a previous impairment assessment.

Dr. Rondinelli revisited with the task force on August 26, 2008. He acknowledged that corrections and clarifications to the Sixth Edition are likely to be ongoing. He agreed that perhaps circulation of a beta draft of the Sixth Edition would have been appropriate. The publishing deadlines to which the AMA had committed precluded doing so, however.

Medical practitioner presentations

On July 30 and 31, 2008, the task force devoted considerable time to presentations by various medical practitioners.

ALAN COLLEDGE, M.D., medical director for the Utah Labor Commission, Division of Industrial Accidents, discussed the development and use of the Utah Supplemental 2006 Impairment Rating Guides. He explained that the Supplemental Guides advise use of the Fifth Edition of the AMA Guides in some circumstances, but provide an alternative impairment rating for those organ systems, where the Utah Governor's Workers' Compensation Advisory Council has opined that the im-

pairment assessments under the Fifth Edition are not appropriate or where of the Fifth Edition does not assign impairment for the injurious condition.

Dr. Colledge stated that the Utah Supplemental Guides' intent is to provide very objective rating criteria based on an anatomic loss while simplifying the rating process for physicians. Dr. Colledge is compensated for four hours work for the Division of Industrial Accidents per week. He acknowledged that his work with the Supplemental Guides requires considerable more time and effort than that for which he is compensated. Additionally, other interested parties within the Utah workers' compensation system volunteer their time and expertise to the supplemental guide process. Utah is now developing 2009 supplemental guides that are intended to address mental injury.

The impairment rating is the only factor considered in compensating permanent disability across all organ systems within the Utah workers' compensation system. Compensation is not made for industrial disability/loss of earning capacity except in cases of claimed permanent total disability. Utah physicians receive training in using the supplemental guides by way of a physician's handbook that the Utah division of industrial accident publishes and by way of seminars that the division sponsors. Additionally, Dr. Colledge presents at medical professional seminars and personally consults with physicians.

Dr. Colledge was involved in the development AMA Guides, Sixth Edition. He chose to disassociate from that process, however. He expressed his belief that the Sixth Edition development process did not include adequate input from the industrial accident community, even though 80% of the overall use of the AMA Guides to Evaluation of Permanent Impairment is within workers' compensation settings. He also expressed concerns that the Sixth Edition methodology "crossed the bridge" from assessing impairment into assessing disability. He projected that, given the expertise and time required to properly evaluate impairment under the Sixth Edition model, only a limited number of physicians will be qualified to assess impairment under it, a result that raises a significant concern in rural jurisdictions, such as Iowa and Utah.

MARK MELHORN, M.D., spoke with the task force via telephone conference. Dr. Melhorn is a board certified orthopedic surgeon, who was primary author of the Sixth Edition upper extremity chapter. He speculated that his prior published work concerning upper extremity medical issues as well as his active involvement in the Academy of Evaluating Physicians and the Academy of Occupational and Environmental Medicine Physicians led to his selection as primary author of the that chapter. Dr. Melhorn spoke as an individual physician and not as a representative of the American Medical Association.

Dr. Melhorn advised the task force that the AMA appointed members to the upper extremity committee prior to his involvement. He was unaware of the organization's criteria for committee appointment. Dr. Melhorn stated that the decision to change the Guides' assessment methodology also was made prior to his involvement with the upper extremity committee. He did not believe that all chapter editors necessarily agreed with that paradigm shift/method change.

Dr. Melhorn stated that the Sixth Edition provides ratings for many conditions not ratable under the Fifth Edition. He favors the diagnosis based rating model over rating models used in earlier editions of the Guides. He believes the DBR model is likely to be used in subsequent editions of the Guides, as that model promotes overall rating consistency. The doctor expressed concern that the Sixth Edition five grid methodology makes rating of relatively simple medical conditions, such as trigger finger, unnecessarily complex and time-consuming. It is his belief that appropriate ratings in many cases could be assessed simply on the basis of whether the patient had had a good, an average, or a poor treatment outcome. He opined that the Sixth Edition methodology significantly increases the burden on physicians assessing permanent partial impairment; he would encourage physicians to attend formal training before attempting to do assessments under the Sixth Edition.

Dr. Melhorn acknowledged that both the Fifth and Sixth Edition of the Guides attempt to establish criteria as to what qualifies as carpal tunnel syndrome for impairment rating purposes. He explained that a perception exists in the medical community that the criteria for diagnosing carpal tunnel syndrome has become looser over time and that many diagnoses of carpal tunnel syndrome more properly should be rated as nonspecific musculoskeletal pain in the upper extremity. He agreed that use of rating criteria in the Guides could result in an individual receiving treatment for carpal tunnel syndrome while not qualifying for impairment rating for that condition.

Dr. Melhorn agreed with the Sixth Edition's permitting permanent impairment assessment from surgically treated carpal tunnel syndrome after two non-eventful post operative office visits. He explained that, even though maximum nerve im-

provement may only be obtained 12 to 18 months after surgery, early assignment of impairment was appropriate because early rating of impairment tends to promote early return to functioning and a better overall outcome for the treated individual.

Dr. Melhorn is doing preliminary studies comparing impairment ratings achieved when conditions are evaluated using both the Fifth and Sixth Editions. His initial impression is that although the Sixth Edition gives higher impairment ratings for some conditions and lower ratings for other conditions as compared to the Fifth Edition, average ratings within organ systems have not changed significantly between the two editions. The doctor suggested that jurisdictions may wish to continue to use the Fifth Edition for assessing impairment in most conditions while also using the Sixth Edition where the Fifth Edition provides no means for rating a condition.

MOHAMMED I. RANAVAYA, M.D., J. D., MS, spoke with the task force via telephone conference. His specialty is occupational and disability medicine. He is a Sixth Edition section editor and was primary author of its chapter 2. Additionally, he has conducted multiple training seminars on impairment assessment under the Sixth Edition. He spoke as an individual physician and not as a representative of the AMA.

Dr. Ranavaya stated that Chapter 2 exists to arbitrate any conflicts as to the appropriate rating method for a given health condition within or among the various organ system chapters. The rule of liberality requires that the method producing the greater impairment rating be used. Dr. Ranavaya stated that Chapter 2, as originally written, was intended to give workers' compensation administrators substantial ability to modify use of the sixth edition [to meet individual jurisdictional needs]. He acknowledged that the deletion of the preemption language from principle 1 in Table 2-1 may limit that ability, however.

Dr. Ranavaya stated that adopting the ICF model and changing the paradigm for impairment rating were editorial decisions that the AMA House of Delegates subsequently approved. He explained that the ICF model is well accepted outside of the United States, that is, in Europe, Australia, New Zealand and South Africa. He characterized the paradigm shift as "an idea that had been taught a long time by default", as instructors at impairment evaluation training courses have advised their physician students to look at modifiers to determine where a particular examinee should be placed within the impairment ranges set forth in earlier editions of the Guides. He characterized the five grid model of the Sixth Edition as a further definition of modifiers intended to enhance interrater reliability.

Dr. Ranavaya opined that an impairment evaluator with eight hours of formal training on the Sixth Edition methodology could competently use that edition to assess impairment. The doctor felt that an individual physician would need about 30 hours of self study of the Sixth Edition to understand its assessment methodology sufficiently to competently use that edition to assess impairment.

Dr. Ranavaya reiterated that the Sixth Edition's editors did not intend that ordinal impairment ratings for any medical condition be increased or decreased as a result of the edition's changed impairment assessment methodology.

DOUGLAS MARTIN, M.D., spoke with the task force in person. Dr. Martin is currently president of the Iowa Academy of Family Physicians. He practices occupational medicine in Sioux City, Iowa and has served on the Board of the American Academy of Disability Examining Physicians (AADEP). He was that organization's official representative to the sixth edition advisory committee and was a reviewer of the Sixth Edition's pain, upper extremity, lower extremity, and nervous system chapters. He spoke as an individual physician and not as a representative of the AMA.

Dr. Martin considers the Sixth Edition's adoption of the ICF model a positive change that both "brings the United States into the rest of the world" and facilitates research about impairment assessment. He characterized the Sixth Edition's focus on physical function as a "big change" that physicians "would need time to process". He agreed that the validity of functional assessment tools can be questioned, especially when those tools are administered to persons outside the dominant culture.

Dr. Martin expressed his belief that adaption of a DBR impairment assessment model will decrease evaluator assessment errors, which have resulted from improperly administered range of motion or other anatomic function tests. He agreed that the Sixth Edition methodology increases both the time required for impairment evaluation and the level of professional training or self-study necessary needed for an evaluator to be proficient in using that edition. He agreed that a physician likely would require 25 to 30 hours of self-study to gain proficiency in assessing impairment under the Sixth Edition.

Dr. Martin agreed that cervical spine fusion ratings set forth in the Sixth Edition generally are significantly lower than are ratings for like conditions in the Fifth Edition. He also noted, however, that the Fifth Edition ratings for those conditions

generally were significantly higher than had been the ratings in the Fourth Edition. He speculated that the Sixth Edition may have “gone overboard” in attempting to correct Fifth Edition cervical spine ratings that were perceived to be “too high”.

Dr. Martin advised that the variables within occupational medicine/work injury practice limit the possibility of controlled medical studies in that field. Therefore, information that can be classified as having a superior level of evidence basis is difficult to obtain. That fact impedes the goal of making any impairment assessment guide highly evidenced-based.

Dr. Martin’s perception was that nonmedical stakeholders had had limited involvement in the Sixth Edition development process. He noted that only two of the seven members of the editorial board practice clinical medicine. Given that, practical problems that could arise from evaluation and assessment of impairment under the Sixth Edition model may not have been well appreciated.

CHRISTOPHER R. BRIGHAM, M.D., MMS, spoke with the task force via telephone conference. Dr. Brigham was senior contributing editor for the Sixth Edition. His business, Brigham and Associates, Inc., conducts independent medical evaluations and reviews evaluations other providers have performed. Dr. Brigham spoke as an individual physician and not on behalf of the AMA.

Dr. Brigham stated that as senior contributing editor, he worked to achieve consensus among the various contributors to the Sixth Edition’s musculoskeletal chapters and was substantially involved in the [final] writing of those chapters. This doctor characterized the Sixth Edition as a fundamental improvement in supplying accurate, unbiased impairment ratings. He felt that physician response to the Sixth Edition overall has been positive and that physicians appreciate the Sixth Edition’s consistent impairment assessment process. Dr. Brigham acknowledged that some impairment ratings for surgically treated spinal conditions are lower in Sixth Edition. He explained that the purpose of spinal surgery is to improve function. That patient functioning should be decreased after surgical intervention and treatment is medically counterintuitive.

Dr. Brigham expressed his belief that the Seventh Edition will further refine the Sixth Edition paradigm shift in impairment assessment.

JOHN BROOKE, Ph.D., a clinical psychologist, spoke in person with the task force regarding the mental and behavioral disorders chapters in the Fifth and Sixth Editions. He provided an outline of his comments, which is Exhibit B of the addenda to this process report.

JAMES GALLAGHER, M.D., a psychiatrist provided written comments regarding the mental and behavioral disorders chapters in a July 10, 2008 report, which is exhibit C of the addenda.

Both Dr. Clark and Dr. Gallagher expressed concerns regarding the subjective nature of the multiple rating scales used to achieve an ordinal impairment rating in the Sixth Edition. Both had concerns as to whether and when mental and behavioral impairment could be assessed by assigning a particular percentage of impairment.

Recommendations re impairment guides

The balance of time available on July 31, 2008, was devoted to task force assignment 4, namely:

4. Make recommendations concerning the use of impairment rating guides in the Iowa system.

- a. Should Iowa adopt the Sixth Edition of the Guides?
- b. Should Iowa adopt some individual chapters of the Sixth Edition?
- c. Should Iowa adopt another existing impairment guide?
- d. Should Iowa develop its own impairment guide?

Various recommendations were moved, discussed and voted upon. All members of the task force approved the following resolution:

It is premature to determine how the Sixth Edition of the AMA Guides will change the ultimate impairment ratings assigned across all systems. Information has been presented that some ratings will go up; some will go down; some will stay the same. However, there is insufficient information to predict the overall change in ratings.

Seven of the task force members do not recommend that the Iowa Workers’ Compensation Commissioner adopt the Sixth Edition of the Guides, in whole or in part. Member, Sara Sersland, favors adoption of the Sixth Edition.

Whether the Sixth Edition should be adapted in those cases where the Fifth Edition either does not provide impairment rating or does not provide an ordinal impairment rating was discussed. Piecemeal implementation of the Sixth Edition would increase costs and complexity within the Iowa workers’ compensation system.

Additionally, concerns remain about whether ordinal impairment ratings for mental and behavioral disorders are appropriate.

Seven task force members approved adoption of the following resolution:

The task force recommends that the Iowa workers' compensation commissioner consider developing a rating system, either by rule or legislation, for recognized medical conditions that are not rated under the AMA Guides, Fifth Edition.

Member, Peter Thill, did not approve its adoption.

On August 25, 2008, member Sara Sersland clarified her vote on the foregoing resolution. Ms. Sersland stated:

I do not favor piecemeal adoption of the Sixth Edition of the Guides for some conditions, but not others, but, if the Commissioner decides not to change current rule 2.4 requiring use of the 5th Edition to rate conditions, I favor using the Sixth Edition to rate well-recognized conditions not rated under the Fifth, but rated under the Sixth. I do not recommend the Commissioner develop a new rating system apart from the Sixth Edition, either by rule or legislation, for recognized medical conditions not rated under the Fifth.

After Dr. Rondinelli's August 26, 2008 presentation, the task force completed its discussion of proposed recommendations regarding the use of the Guides and discussed its assignment 5, other considerations regarding the use of impairment ratings.

On motion, the question of whether Iowa should develop its own impairment guide was divided into discussion of whether Iowa should develop its own scheduled member impairment guide and into whether Iowa should develop its own body as a whole/whole person impairment guide.

Two members, Marlon Mormann and John Kuhnlein, D.O., voted in favor of Iowa developing a state specific scheduled member impairment guide; the balance of task force members voted against this proposition. Member Matt Dake voted in favor of Iowa developing a state specific body as a whole/whole person impairment guide. All other members voted against doing so.

Other considerations—Rule 876 IAC 2.4

The task force considered Rule 876 IAC 2.4 on August 26, 2008. That administrative rule adapts the Fifth Edition of the Guides to the Evaluation of Permanent Impairment as a guide for determining permanent partial disabilities under Iowa Code section 85.34(2), subsections a through s. The rule permits employers and insurance carriers to use the Fifth Edition to determine the extent of loss or percentage of permanent impairment resulting from an injury to any scheduled member and to pay weekly benefits accordingly. Benefits so paid are considered prima facie showing of compliance with the scheduled member compensation law. Within the task force, questions had arisen as to the overall appropriateness of this rule. The Iowa workers' compensation law compensates workers with scheduled injuries for the permanent disability that results from the loss of use or function of the injured member. A rating of impairment does not necessarily accurately reflect loss of function or loss of use. Therefore, it does not necessarily reflect the actual extent of permanent disability that has resulted from an injury to a scheduled member.

Whether the first sentence of rule 2.4 should be amended by striking the word "disability" and inserting in lieu of that word, the phrase "impairment for conditions compensable" was moved and voted upon. Six task force members voted in favor of amending the rule in that matter. Member Marlon Mormann voted against doing so. Member Donna Bahls, M.D., abstained from voting on the proposed amended language.

The amended first sentence would read:

The Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association are adopted as a guide for determining permanent partial impairment for conditions compensable under Iowa Code section 85.34 (2) "a" to "s."

Whether the January 2008 emergency amendment to rule 2.4 should be made permanent, with the recommended language substituted in the rule's first sentence, was moved and voted upon. Seven task force members voted to recommend that the January 2008 emergency amendment to rule 2.4, with the proposed substitute language, become permanent. Member Sara Sersland voted not to so recommend.

It was moved that rule 2.4 be amended to add language consistent with Miller v. Lauridsen Foods, 525 N.W.2d 417, 421 (Iowa 1994), to state that "The determination of functional disability is not limited to impairment ratings established by medical evidence." Members Matt Dake, Saffin Parrish-Sams, Teresa Hillary and Marlon Mormann voted in favor of so amending the rule. Members Peter Thill, Sara Sersland and Donna Bahls, M.D., voted against so amending the rule. Member John Kuhnlein, D.O., abstained from voting on the question.

Dr. Brigham expressed his belief that the Seventh Edition will further refine the Sixth Edition paradigm shift in impairment assessment.

All voting members of the task force were afforded the opportunity to write reports summarizing the member's understanding of the task force proceedings and expressing the reasoning underlying that member's votes. Members Matt Dake, John Kuhnlein, D.O., Marlon Mormann, R. Saffin Parrish-Sams, Sara Sersland and Peter Thill did so. These statements are attached as Exhibits D through I in the addenda to this report. Additionally, member Sara Sersland submitted a responsive concurrence, which is attached as exhibit J.

Contact information

The proceedings of the task force were digitally recorded and are available at the Division of Workers' Compensation, 1000 East Grand, Des Moines, IA 50319, for copies call 515-281-5387, for questions contact: HelenJean.Walleser@iwd.iowa.gov

Respectfully submitted,

HELENJEAN M. WALLESER,
Iowa Deputy Workers Compensation Commissioner.

[Whereupon, at 10:10 a.m., the subcommittee was adjourned.]

