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CLINICAL CARE UPDATE

# REDUCING ERRONEOUS IMPAIRMENT RATINGS

**By Christopher Brigham, M.D.**

The *AMA Guides to the Evaluation of Permanent Impairment* is the recognized international standard used to quantify the impact of an injury and disability.

The goal of the *Guides* is to provide consistent ratings, therefore reducing conflict. The *Guides* state: "Two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions." (*AMA Guides,* Fifth Edition, p. 17) Yet, studies show that most of the time this is not the case.

There are many instances of erroneous ratings, including bias, differences in clinical and causation assessment, and misapplication of *Guides* criteria. The nature of the errors is such that most erroneous ratings will be higher, rather than lower.

Most medical schools and residency training programs do not include instruction on the assessment of impairment, disability or causation. Therefore, many physicians lack an adequate ability to assess these and other medico-legal issues.

## Evaluators Disagree

A recent study reveals continuing problems with erroneous impairment ratings. For a two-year interval, from June 2006 to June 2008, experts in impairment assessment associated with Brigham and Associates, Inc. (now known as Impairment Resources, LLC) reviewed 2,798 impairment-rating reports written by other physicians and chiropractors. The experts disagreed with 2,169 of the ratings (78 percent). Among the reports judged to be incorrect, the average original rating was 20.4 percent whole person permanent impairment and the average re-rating by the expert was 7.3 percent whole person permanent impairment.

The vast majority of the disagreements were associated with failure to follow specific protocols defined in the *Guides,* not differences in judgment. Some of the more common errors included:

- rating clinical data that was unreliable (e.g., rating for motion or neurological findings inconsistent with other documentation);
- rating by the wrong method (e.g., rating spinal injuries by the range-of-motion method when the diagnosis-related estimates method was required;
- rating by methods prohibited for specified conditions (e.g., rating carpal tunnel syndrome on the basis of grip strength loss);
- combining multiple methods that cannot be combined (e.g., combining lower extremity impairments for motion and strength loss);
- adding values that should be combined; and
- evaluating physician bias.

Of the 629 ratings that were felt to be appropriate, the ratings averaged 8.9 percent whole person permanent impairment. Therefore, for the cases reviewed, 57 percent of the total value assigned to impairment ratings was not supported by the data provided.

Meanwhile, a California-specific review of 95 sequential, unselected impairment evaluations performed in 2008 revealed an error rate of 93 percent. Of these cases, the average original rating was 16.7 percent whole person permanent impairment and the average expert rating was 5.9 percent whole person permanent impairment.

In California the impairment value is adjusted by future earning capacity factors, occupation, and age. For these 95 cases, the difference in dollar value assigned for the permanent disability rating based on the original ratings versus the corrected ratings was $1.2 million dollars. This suggests that undetected erroneous ratings are a significant problem. The California study confirms the need to ensure accurate and unbiased impairment ratings as well as the need for expert review.

## Using the *Guides*

While the most current edition of the *AMA Guides* is the Sixth Edition, the Fifth Edition is more widely used, and references contained in this article come from the Fifth Edition. The principles of assessing impairment are provided in Chapters 1 and 2 of the *Guides.* However, it appears that physicians often do not familiarize themselves with the rules presented in these chapters. Instead, they tend to focus their attention on chapters specific to the region they are rating.

Chapter 2, *Practical Application of the Guides,* is a particularly important one for both rating physicians and attorneys. This chapter specifies rules and standards for the impairment evaluation. It also provides superb content for an effective cross-examination of a physician who has performed an erroneous rating.

Section 2.1 defines impairment evaluations, Section 2.2 discusses who performs impairment evaluations, Section 2.3 identifies the roles and responsibilities of the examiner, Section 2.4 explains when ratings are performed, Section 2.5 provides critical rules for the evaluation, and Section 2.6 outlines standards for reports. Failure to follow the defined procedures will result in a questionable report and rating.

The rating physician must be "independent and unbiased." This can be challenging for any evaluator. However, it is more likely to be problematic for the treating physician since there is an inherent patient advocacy role. (Barth RJ, Brigham CR, Who is in the better position to evaluate, the treating physician or an independent examiner? *Guides Newsletter,* November – December 2005).

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

A skilled independent medical evaluator typically spends more time with a patient than a treating physician at a single visit and is likely to obtain additional clinical information. It is probable that the treating physician will not consider alternative or new diagnoses at the time of rating. It is also possible that the treating physician will causally relate problems to an injury if this appears advantageous to the patient and/or the physician.

For example, if a treating physician receives referrals from plaintiff counsel, it is not unexpected that this physician will causally relate problems to the defined injury, and may be inclined to inflate a rating. Or, a treating physician caring for a patient in a managed care environment may be more likely to relate a problem to an injury if this provides an additional source of revenue. The treatment role also may influence how and when the physician defines maximal medical improvement (MMI).

## Errors in Analysis

The following are among the many potential rating errors resulting from inaccurate clinical or causation analysis:

**Inappropriate diagnosis:** Incorrect clinical assessment can result in the rating of impairment for a condition that is not present or unrelated to the alleged injury. For example, the physician may label a patient as having "complex regional pain syndrome" and rate for this disorder, whereas the more accurate diagnosis is "somatization." In the *Guides*, certain diagnoses are not typically associated with ratable impairment, i.e., tendonitis or psychiatric illness. Consequently, a physician attempting to inflate a rating may choose to provide another diagnostic label that would result in ratable impairment.

**Rating prior to MMI:** Assessing impairment prematurely will often result in an inflated impairment rating. The rating of permanent impairment cannot occur until the patient has achieved MMI, which is defined in the Fifth Edition on page 601 as "a condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment." Typically following an injury a patient will improve over time: Improved range of motion and neurological function and resolution of ratable findings will result in a lower impairment rating. MMI is often not achieved until a minimum of six-to-12 months post injury. Cases that often require a longer timeframe for resolution include carpal tunnel syndrome with ongoing neurological deficits, hand injuries, and head injuries.

**Unreliable findings:** The most common source of rating errors is traced to test administrator inexperience or lack of knowledge. Clinical findings must be reproducible if they are to serve as the basis for impairment rating. The *Guides* state in Section 2.5d on page 20: "Two measurements made by the same examiner using the *Guides* that involve an individual or an individual's function would be considered consistent if they fall within 10 percent of each other." Measurements should be consistent between two trained examiners or by one observer on two separate occasions, assuming the examinee's condition is stable.

In addition, many clinical findings are not totally objective. For example, with range of motion, the impairment rating is based on findings of active motion. Neurological findings, such as reports of diminished sensation, depend on self-report, and an individual may demonstrate less strength than true capability. Since an individual can demonstrate capability below their actual limit but can-

not do more than what they are truly capable of doing, inconsistent examination findings will nearly always result in greater impairment.

**What is "normal":** The *Guides* state on page 2: "When evaluating an individual, a physician has two options: consider the individual's health pre-injury or pre-illness state or the condition of the unaffected side as 'normal' for the individual if this is known, or compare that individual to a normal value defined by population averages of healthy people. The *Guides* uses both approaches."

Section 16.4c, *Method for Motion Impairment Calculation*,states on page 453: "The measurements reported in the impairment tables and pie charts reflect the accepted average range(s) of motion for each joint. However, certain people can have either lesser or greater joint flexibility than average. It is therefore most important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral 'normal' joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the report."

In this case the opposite extremity serves as normal for this individual. Losses should be determined in this context; extremity evaluations should always include examination of both sides.

**Causation analysis:** In assessing impairment, it is necessary to distinguish what impairment is related to the alleged injury as opposed to impairment that may be due to other injury, degenerative disease or illness. The premise of causation is that a given cause (A) and a given effect (B) are associated within a reasonable degree of medical probability. If the practitioner promotes the premise that "within a reasonable degree of medical probability (A) and (B) are causally related," all three of the following separate notions are assumed to be correct (medically probable):

1. (A) The cause is medically probable: (A) is more likely than not the cause and/or aggravator of the problem.
2. (B) The effect is medically probable: (B) is more likely than not the correct diagnosis/condition.
3. (A) and (B) are related in a medically probable manner. If either (A) or (B) or both are considered to be possible, but not probable, the causal association cannot be upheld as being medically probable. Further, no number of possible causes can be taken together and viewed as a probable cause. Once it has been established that both (A) and (B) are probable, then there must also be a probable relationship established between the two before a final positive causality conclusion can be promulgated.
4. A conclusion that a cause contributed to an effect or impairment must rely on the documentation of circumstances that were present and verification that the type and magnitude of the factors were sufficient and bore the necessary temporal relationship to the condition. Many ratings of impairment lack this essential analysis. Causation analysis is the critical first step to apportionment analysis. (For more information on apportionment, refer to Section 2.5h of the *Guides*.)

In summary, the reasons for erroneous ratings are multifold. Studies have conclusively demonstrated that the majority of impairment ratings are incorrect, and the average incorrect rating is nearly three times higher than is appropriate. The goal of physicians and all stakeholders involved in the process should be to increase their knowledge and awareness and take steps to deliver fair, reliable impairment evaluations.

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## Impairment Resources Targets Cost Drivers

Brigham and Associates, Inc., and Insurance Recovery Group, Inc., (IRG) recently announced the formation of Impairment Resources, LLC, a joint venture established to ensure accurate and reliable impairment ratings. Christopher Brigham, M.D., serves as chairman of the new company and has retired the name of his former company, Brigham and Associates.

Impairment Resources offers expertise related to interpretation of the *AMA Guides to the Evaluation of Permanent Impairment* as well as workers' compensation cost containment and recovery services. For information, visit www.impairment or contact Mindy Brigham, vice president of operations, 619-299-7377; mbrigham@impairment.com.

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