Impairment Rating, Ambiguity

ALAN L. COLLEDGE, GREGORY KROH
Utah Labor Commission, International Association of Industrial Accident Boards and Commissions, Salt Lake City, UT, USA
farmboyac@msn.com

Synonyms

Workers' compensation; permanent partial impairment; permanent partial disability

Definitions

Permanent partial impairment – a permanent loss of or abnormality of psychological, physiological, or anatomical structure or function permanent

Permanent partial disability – a permanently reduced ability to engage in substantial gainful employment by reason of any physical or mental impairment

Characteristics

Permanent injury compensation is a large and growing component of workers' compensation system cost. In the US, it represents about two thirds of all indemnity benefits (Berkowitz and Burton 1987). Moreover, the frequency and cost of permanent injury is increasing as a share of all workers' compensation claims. Citing data from the National Council on Compensation Insurance, David Durbin states, "During the six-year period from 1988 to 1994, average PPD [permanent partial disability] costs increased 25%, an increase of approximately 4% per year, while the frequency increased almost 29% or 4.4% annually. These increasing average costs and frequencies have resulted in an increase in the permanent partial cost per worker of approximately 52% (over 7% annually) over the same six year period" (Durbin and Kish 1998).

Numerous wage-loss studies document that in virtually every state, and every classification of claimants, compensation awards are smaller than the actual or predicted wage losses that workers incur after an injury. Moreover, the correlation between impairment ratings and actual economic losses following injury are poor. For example, the statistical work by Durbin and Kish tries to measure the consistency of initial physician impairment ratings, disability ratings awarded, and final compensation given to injured workers across various US jurisdictions. They concluded that:

The results show that impairment ratings are only one of a variety of factors that systematically influence the size of a final disability award. Specifically, even for cases with benefits awarded for non-economic loss, in addition to the treating physician's determination of physical impairment, the determination of the degree of permanent disability appears to take into account factors such as age, sex, pre-injury wage, weekly temporary total benefits, and whether an attorney is involved in the case. Moreover, even after these other factors are considered, a less than one-to-one relationship exists between impairment and final disability ratings, which might be expected.

Similar results were found by Park and Butler (2000). They found that degrees of permanent impairment assigned by physicians, even under Minnesota's relatively well

administered guidelines, were not statistically related to the reduction in pre-injury wages after the injury. Even after adjusting permanent injury awards for age, occupation, and other economic factors, they found that the impairment ratings had a very poor statistical relation to the actual wage loss. This finding is consistent with mainstream belief by medical and non-medical researchers in workers' compensation.

Several factors account for this lack of correlation between permanent disability compensation and wage loss. First, most jurisdictions do not consciously or deliberately set out to provide benefit levels that match the future loss of earnings. The statutes and rules that establish permanent injury compensation do not equate impairment with disability, nor do they explicitly state what the PPD award is intended to compensate. Rather, benefit levels are set in a political arena. The employer’s cost of workers' compensation, and how that affects the competitive position of one jurisdiction relative to its competitors, is a far more common metric in the political debate than statistical measures of wage loss from permanent injuries.

Second, differences across workers cause the permanent disability formulae to be relatively more generous to some injured workers and relatively prone to under compensate others. Especially in pure impairment states, the rules for scheduled injury benefits impose uniform awards for each degree of physical loss, e.g. a 5% loss of the wrist is the same for a concert violinist and cement finisher. These uniform awards do not address the fact that relatively minor impairments often cause severe job limitations for construction workers, but minimal or no job limitations for office workers. In addition, younger workers tend to be under compensated for permanent injury relative to workers nearing retirement.

The focus of this paper is on the third reason for lack of predictability of impairment ratings: the physical measurements of bodily loss are not reliably and consistently measured by doctors. Doctors do not set benefit levels for specific injuries, but the measurement of physical loss they provide translates directly into dollar benefits. This lack of consistency among rating physicians is widely observed (for a review see Colledge 1994).

Much anecdotal evidence and a few formal studies suggest that a major problem with the system revolves around the consistency and defensibility of permanent impairment ratings made by physicians. Complaints in this area are routinely reported in the trade press. From the anecdotal evidence, the problem seems to exist in many jurisdictions.

Inconsistencies have been demonstrated when similar injury cases have been presented to multiple practitioners, and when the same practitioner has evaluated similar cases through time.

For example, in a 1999 study by the State of Texas, a significant number of the cases with multiple impairment ratings for the same injury showed disparities of 5% or greater: Specifically, the study found that 24% of injured workers with multiple impairment ratings had no difference between the first and last ratings, 29% had a difference of 5–10 percentage points, and 14% had a difference of 10 percentage points or more. One of the authors has documented similar inconsistencies in the State of Utah prior to that state’s recodification of impairment rating guides (Colledge 2001).

Multiple factors contribute to these inconsistencies. A major source of the problem is that state laws and regulations related to impairment and disability evaluation are often poorly crafted and are inconsistent in awarding payment, how benefit levels are set, and the formulas and procedures for guiding physician impairment ratings. Victor and Boden (1991) contend that the clarity of law on evaluating permanent injury helps control disputes. Even if laws and regulations are consistent within states, there are often

inconsistencies in methods and expectations across states. This is problematic for doctors who have multi-state practices or attempt to deal with these issues from a national perspective. Another challenge for doctors is that state laws, regulations, and administrative law judges are sometimes out of step with the best available medical evidence.

Finally, injuries differ greatly in the ease with which they can be rated. A wide variety of common injuries are amenable to reasonably concrete and precise formulae, which convert measured losses to percentages of loss of use of a limb or the whole body. This type of injury is often classified as a scheduled injury. The rating of many scheduled injuries is not particularly difficult or ambiguous for a reasonably trained practitioner. For example, amputations or total loss of use of extremities are not a major source of error or inconsistency. They are objective and relatively easy to measure.

Problems can arise, though, in the evaluation of partial loss to an extremity. At what point does nerve, tendon, joint, or muscle damage render an arm or hand functionally useless? The rules on rating such partial disabilities are variable from jurisdiction to jurisdiction. A much greater problem arises in rating injuries to the spine, which are governed by much more general and subjective guidelines.

Psychological or mental injury and all the related behavioral and motivational consequences are another intractable problem. Psychological injury is real, but it is very difficult to differentiate from pre-existing psychological illness not related to the workplace and it is difficult to rate or measure. For these reasons psychological injury is a lightning rod where it is being compensated by workers' compensation. New South Wales is one recent example: "...the rights of the people of NSW have been gravely compromised by the Government's subsequent decision to use the very flawed and unfair Psychiatric Impairment Rating Scale (PIRS) to measure such impairments, and by excluding psychologists from assessment of psychological and psychiatric impairment. Apparently the Government is attempting to save on compensation payouts at the expense of psychologically impaired workers. This is a dangerous election ploy. (Lynette Shumack, NSW Executive, The Australian Psychological Society, April 5, 2002)

Rating pain is the greatest problem of all. Some jurisdictions take the position that pain is not compensable in workers' compensation. Others hold that the pain must be directly linked to the loss of use of body part, e.g. acute pain limiting the range of motion on a limb. Policy makers in such jurisdictions apparently hold the belief that workers' compensation is a no fault system that tries to get away from the problems of measuring pain and suffering that are so difficult to assign values to in civil tort cases. Other jurisdictions make some allowance for pain, if only in an indirect or implicit way. For example, some jurisdictions assign minimum impairment ratings for surgery even if the outcome was rated as 100% successful in restoring function. This might implicitly be regarded as a reward to the injured worker for the uncertainty and trauma of the surgical procedure.

In the ideal situation, a skilled practitioner using a well-defined set of criteria might be able to fairly rate the intangibles of an injury, most importantly pain. However, there is ample evidence to suggest that pain is difficult to evaluate and subject to a host of psycho-social overlays that have nothing to do with the injury itself.

Inconsistencies develop not only over the severity of impairment associated with an injury, but also over causation of the impairment. Disagreements regarding causation are particularly likely to occur when workers sustain covert injuries (such as repetitive strain injuries of the upper extremity) rather than overt ones (such as an upper extremity fracture), when an injury is superimposed on a chronic musculoskeletal condition,

workers present with symptoms that do not have a clear cause or etiology, e.g. sick building syndrome or stress claims.

The consequences of the Inconsistencies described above are substantial. They tend to lead to “deuling doctors” (that is, differences of opinion between the treating physician and an expert hired by the payer of the claim), delays, and high cost litigation. In general, disputes over medical evidence are very expensive. The personnel and the support system needed for hearings tend to be among the most expensive parts of a workers’ compensation agency budget. State agencies are continually experimenting with techniques to reduce case backlogs and speed decisions. Delays and other inefficiencies stimulate legislative inquiries, and as constituent frustration levels rise, lawmakers are inclined to “reform” the system. Some states go through a cycle of reform-dissatisfaction-reform

For these reasons it is vital that permanent injury benefits be managed better in most states. The keys to success:

- Fixed conditions under which permanent injury benefits can be awarded.
- A clear trigger for when permanent injury can be evaluated.
- Well defined responsibilities for the physician who is to make the legally required medical determinations.
- Uniform procedures for the measurement and evaluation of the parameters of permanent impairment to the body.
- An objective way to express the basis for the impairment rating.

Whenever any one of these is lacking, doubt and mistrust by workers or their employers enters into the benefit award. Also, opportunists find ways to exploit the ambiguity to maximize gains by “gaming” the system. Gaming the system or adversarial disputes are signs of system failure in workers' compensation.

The State of Wisconsin presents an example of a very smoothly functioning impairment system for scheduled injuries. Wisconsin Administrative Rule 80.20 specifies quite clearly how impairments from scheduled injuries translate into percentages of body part loss. Loss of motion of fingers is a good example: the physician need only measure the loss of flexion and extension at each joint of the injured finger(s) to produce a precise measure of impairment under Wisconsin law. Even more serious/complex injuries to the knee have explicit standards. Finger and knee impairment ratings by treating physicians are almost never challenged by claims adjusters and virtually never litigated.

The role of physician or administrative judgment has been circumscribed by many jurisdictions. They have reacted to ambiguity in various ways: 1) eliminating the compensability of a class of injuries, 2) constraining the range of judgment about certain injuries, or 3) assigning a narrow range of estimates. These understandable responses to uncertainty have the undesirable consequence of introducing inequity. Some workers are simply not compensated as much as they should be relative to other workers with more tangible and specific injuries. This is a political, not medical, issue.

Clearly, simple and direct rules work. They mete out compensation with efficiency and speed. Of course, some would object that “cookie cutter” justice is unfair. Yet, the very basis of workers' compensation is accepting administrative simplicity in benefit delivery for the individualistic tort based approach to equitable benefit determination.

In a companion essay (Impairment – Ambiguity, Part 2 –the IAIABC System), the work of the International Association of Industrial Accident Boards and Commissions (IAIABC) to improve the process of rating injuries is described.

References

Berkowitz, Monroe, Burton J (1987) Permanent Disability Benefits in Workers' Compensation. W.E. Upjohn Institute for Employment Research, Kalamazoo, Mich

Colledge A (1994) Impairment Ratings. Occupational Health and Safety, July 1994

Colledge A, Sewell J, Hollbrook B (2001) Impairment Ratings in Utah, Reduction of Variability and Litigation within Workers' Compensation. Disability Medicine, ABIME 1

Durbin D, Kish J (1998) Factors Affecting Permanent Partial Disability Ratings in Workers' Compensation. J Risk Insur Mt. Vernon; Mar 1998

Park Y-S, Butler R (2000) Permanent Partial Disability Awards and Wage Loss. J Risk Insur 67:331–350

Shumack L (2002) NSW Executive. The Australian Psychological Society, April 5

Victor R, Boden L (1991) Model States Show Lawsuits Can Be Prevented. National Underwriter, Chicago