IMPAIRMENT RATINGS

Impairment ratings provide a necessary tool for the smooth function of the workers' compensation system. Inconsistencies in the evaluation process, however, leads to widely varying levels of compensation among injured employees. The guidelines for impairment ratings need to be clarified so examiners can deliver more predictable decisions.

By Alan Colledge, MD

The concept of compensation for on-the-job injuries has been around for a long time. Even pirates who roamed and plundered in the 17th century had their own elaborate code of "compensation."[1]

If a ship was plundered, but no booty taken, there was no payday. However, if the plundering resulted in booty, the profits were divided evenly among all pirates.

Before the loot was divided, however, salaries and compensation were allocated. The captain took out a predetermined percentage for his services and expertise. The ship's doctor, the busiest man on the vessel, then took his wages. Those injured in the plundering then received compensation. For example, a pirate who lost a right arm received 600 pieces of 8 (or gold) and six slaves. The loss of an eye was compensated with 100 pieces of 8 and one slave.

Of interest, the loss of a hand resulted in no provision. This is because, in the pirating business, it was felt that a hand loss did not represent any loss of potential income or impairment. In fact, a pirate with a hook was actually perceived to have enhanced abilities because, in addition to replacing the hand functions, the hook doubled as a weapon.

It wasn't until the early 20th century that workers' compensation became a legislated right in the United States with established parameters. Although compensation programs vary from state to state and employer to employer, they all must provide four basic entitlements:[2] medical benefits, indemnity, impairment and death benefits.

Of all these entitlements, impairment is the most widely misunderstood and increasingly the most expensive. One state recently noted that impairment rating costs increased 200 percent from 1989 to 1991.[3]

The rising costs and frustration associated with impairments can be attributed to several factors. Perhaps the most frustrating to risk managers and third party administrators is the inconsistency in impairment ratings. This, in turn, has been attributed to several non-medical factors, such as the rating process, the examiners and examiner training, medical reports and apportionment. Each of these factors will be discussed in some detail below.

RATING PROCESS. Before inconsistencies can be alleviated, it will be necessary to standardize the actual rating process and require uniform criteria for all raters.

Much of the difficulty with the rating system stems from confusion over the terms impairment and disability. *Impairment* (the lasting effects of injury) is not interchangeable with *disability* (the impact of impairment on the life of the patient).

The American Medical Association's *Guides to Evaluation of Impairment* (fourth edition) provides an excellent illustration of this concept: "An individual who is 'impaired' is not necessarily 'disabled.' Impairment gives rise to disability only when the medical condition limits the individual's capacity to meet the demands of life's activities. For example, losing the distal phalanx of the little finger, right hand, will impair the functioning of the digit and hand of both a concert pianist and a bank president, but the bank president is less likely to be disabled than the pianist. An individual who is able to meet a particular set of demands is not 'disabled,' even if a medical examination shows impairment."

In many states, industrial ratings are for impairment only and do not address disability.

To clearly understand the impairment concept, it is helpful to review the normal healing process experienced in response to any injury or illness. Most body injuries result in rapid healing, resulting in 100 percent restoration to the body's prior condition. Other injuries are severe enough that complete restoration is impossible (such as with the loss of an extremity, or loss of vision). Impairment is the gap between where the body was prior to the injury and where it is at the completion of healing.

The most widely used text for the calculation of impairment ratings is the AMA's *Guides to the Evaluation of Permanent Impairment* (third edition). Many experienced examiners and compensation administrators feel that the current guides, as found in the 1990 edition, are a major reason for impairment inflation.

Raters, administrators and patients should understand that the AMA guides are just as the name implies — suggested guidelines. It is not a cookbook with clear-cut solutions for every scenario. As such, the examiner has the prerogative to interpret the guidelines and modify them as indicated. The AMA recognizes that the current guidelines are not perfect, and they are, in fact, releasing a fourth edition soon that will address inconsistencies.

EXAMINERS. A significant problem with impairment ratings is those providing the ratings. Medical schools do not provide training in the rating process. As a result, physicians often make rating decisions based on subjective interpretation with

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Physical Demand Characteristics of Work

Physical Demand Level	Occasional	Frequent	Constant	Energy Required
Sedentary	10 lbs	Negligible	Negligible	1.5-2.1 METS
Light	20 lbs	10 lbs	Negligible	2.2-3.5 METS
Medium	50 lbs	20 lbs	10 lbs	3.6-6.3 METS
Heavy	100 lbs	50 lbs	20 lbs	6.4-7.5 METS
Very Heavy	>100 lbs	>50 lbs	>20 lbs	>7.5 METS

Rules and Regulations. Equal Employment Opportunity Commission, Civil Service Commission, Department of Justice, Department of Labor. Federal Register August 25, 1978; 43(166): 38290-38307.

little objective uniformity.

This was recently illustrated in California, where a study was done to evaluate the effectiveness of examiners doing impairment ratings. In this study, a single written case was given to 65 independent examiners, who were asked to determine the level of impairment represented.[4] The result was multiple ratings ranging from zero to 70 percent.

This wide disparity not only demonstrates a lack of consensus on ratings criteria but also suggests that ratings often are influenced by factors other than just clinical finds. These may include the competency and experience of the examiner, the particular criteria used, the patient's personality and even financial motives.

Minor impairments can sometimes inflict significant disability. However, because impairment ratings should not reflect disability, some examiners will "help" the patient by altering the rating, using their own criteria to reflect his higher level of "disability." Still others, fearful that a high disability rating reflects poorly on the success of their medical treatment, will underrate the patient. These subjective approaches just add to the confusion, often necessitating costly independent medical examinations to clarify the rating.

EXAMINER TRAINING. It is now widely recognized that experience and a certain skill level are necessary to calculate impairment ratings accurately and consistently. These skills are seldom taught as part of the curriculum for any health care provider. As a result, most examiners are left to interpret the guidelines as they want, often inconsistently.

There is significant controversy concerning who is qualified to do impairment ratings. Within the medical profession, physicians of various specialties argue that their field of medicine best qualifies them for the process. Added to this are impairment ratings given by alternative health care providers, including chiropractors, physical therapists or physician extenders. These non-physician examiners bring widely varying backgrounds and underlying clinical philosophies.

In at least one state, this issue has been appropriately and simply addressed. The Nevada State Industrial Commission has required all medical examiners who provide ratings to attend a two-day course and demonstrate proficiency in utilizing a revised edition of the AMA guidelines. Such a requirement eliminates providers who are only marginally interested, allowing them to refer 'medically stable and ratable' patients to more qualified examiners.

In addition to obtaining the necessary skills and experience, examiners must be made accountable for their rating decisions. If ratings fall outside of an acceptable range, the examiner should be required to credibly document the reason for the variance.

MEDICAL REPORT. Once an injured worker is medically stable, a comprehensive report must be prepared. This final report is an important administrative document and, as such, final disposition should be made by the examiner in each of the six areas listed below:

- *Diagnosis* — In many cases, specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnosis as valid as the clinical findings allow, clearly stated and substantiated.
- *Stability* — The examiner must declare the patient medically stable. The examiner must state that it is his/her medical opinion that all medical treatment that can be done has been completed. This declaration should also note that the patient is not expected to improve with further medical care and/or time. It is important to note that 'medical stability' does not always mean that ongoing care is not needed.
- *Calculation of impairment* — Using valid, standardized rating criteria (such as the AMA guides used in 29 states and territories), the examiner should calculate the residual impairment, based on clinical finders established in the medical record.
- *Apportionment* — The examiner must identify and list any factors, physical and non-physical, which add to the impairment but are not directly resultant from the injury (see the apportionment section below).
- *Capabilities assessment* — Following the U.S. Department of Labor's guidelines, a limited functional capacity assessment should augment the medical record. Not only does this clearly establish physical abilities but also facilitates the patient/employer relationship for return to work (see chart titled, "Physical Demand Characteristics of Work," on page 33).
- *Future medical treatment* — The examiner should identify future medical treatment that may be required to maintain the stability of the patient's medical condition.

APPORTIONMENT. The concept of apportionment, though controversial, is eminently fair to both the employer and employee. Apportionment allows the examiner some latitude within a controlled range to provide for the effects of pre-existing injuries, congenital disorders, effects of the normal aging process and personal motivation. It therefore finds the employer financially responsible for only that portion of the claim attributable to the workplace, and the employee receives benefits for only that portion.

The AMA guides are vague regarding apportionment of pre-existing conditions to the total impairment, but they do recognize that an incident can aggravate a pre-existent condition. They state that the condition must be "substantive and not speculative." Given that the guidelines were designed to be applied to a healthy, youthful individual, apportionment must take into account personal factors such as the following:

- *Symptom magnification* — Symptom magnification refers to those patients whose symptoms far exceed what clinicians are expecting, given their organic findings. Certain measures of illness behavior and psychological distress have been identified in the medical literature. These include the Waddell, which objectifies abnormal physical behavior during the evaluation process[5] and abnormal pain drawing.[6] Identification of these factors may help clarify how symptom magnification may be contributing to reduction in spinal motion and illness behavior.

• *Physical* — Personal physical characteristics and/or habits such as obesity, tobacco abuse, alcohol abuse and chemical addiction all have lasting negative effects on an individual's health. These effects often have little relationship to the individual's employment. Therefore, any effects from these factors should be identified and objectively rated out.

• *Motivation* — If it is established during chart reviews or the rehabilitation process that compliance with the rehabilitation program has been an issue, then it may be appropriate to apportion some of the impairment. This can best be objectified by attendance to the rehabilitation program, the effort put forth, the general attitude of the individual while there, and the therapist's opinion.[7]

If an individual has not given full effort to the rehabilitation program, he or she may be the limiting factor. This often results in reduced range of motion and, therefore, a fictitiously higher impairment rating.

• *Pre-existing* — From the medical record and the patient's personal interview, it should be clearly stated whether any other injury or illness is present or has occurred in the past which may have left some permanent residual effects. This should include but not be limited to prior medical visits, chiropractic visits, X-rays and other diagnostic studies, motor vehicle accidents, etc.

• *Aging* — The concept of apportioning impairment to an individual's aging process is controversial. It is very apparent, however, that as our bodies age we cannot do what we once could (even though we may be totally asymptomatic and highly motivated). Therefore, age does limit us, or impair us, significantly from what we once could do.

SUMMARY. Impairment ratings provide a necessary tool for the smooth function of the compensation system. Impairment also provides financial compensation for injured workers who have suffered permanent loss. However, to be fair, the rating system must be clarified with guidelines and criteria more specifically outlined. Once this occurs, examiners can be held accountable for their rating decisions, and ratings will become more consistent and fair. OHS

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References available upon request.