



Unraveling the Mysteries of Ratings

Medical and Legal Insights to Driving Accurate Ratings

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Welcome to our Webinar Series

- Goal is to provide insights to the challenges encountered in managing California workers' compensation cases – therefore providing you with solutions that result in better outcomes.
- Provide opportunity to interact with highly regarded legal and medical experts who will educate, offer guidance, entertain, and answer your questions.

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California Ratings

What You Don't Know **Will** Cost you

- 1 9/13 Untangling *Ogilvie*
- 2 10/20 Unraveling the Mysteries of Rating
- 3 11/17 Apportionment – Every Defendants' Friend
- 4 12/14 Doctor Cross-Examination



Leading Medical and Legal Experts on the *Guides*



Chris Brigham, MD

Christopher R. Brigham, MD is Chairman of Impairment Resources and has dedicated his medical career to understanding the complexities of impairment and disability. He is the Editor of the *Guides Newsletter*, Senior Contributing Editor of the Sixth Edition, and authored over 200 publications. He is a board-certified occupational medicine licensed in California who understands the uniqueness of California workers' compensation.

Impairment Resources, LLC and its predecessor have provided expertise on the use of the *Guides* since 1995. The goal of the organization is to drive accurate ratings and serves clients internationally.

www.impairment.com



Don Barthel, Esq.

Donald R. Barthel has dedicated his legal career to the defense of employers' rights in the arenas of labor law, employment law and workers' compensation. During the last dozen years, his practice has exclusively focused on workers' compensation defense. With many years' experience in southern and northern California, he has appeared at virtually every WCAB District Office in the state.

Bradford & Barthel has provided quality legal services in California since 1997. We specialize in Workers' Compensation claims and Personal Injury.

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Unraveling the Mysteries of Rating



- What are the underlying reasons for inflated ratings?



- What is the process that should be followed?



- How do you intervene?



Stakeholders – Differing Agendas, Inherent Conflict



Workers Compensation Challenges

- 1 Participants may define their "realities" consistent with their belief systems (and what provides them with personal [financial] gain).
- 2 Workers' compensation system incentives focus on the negative, and maximizing impairment / disability.
- 3 Diagnostic labels that lack scientific basis and are typically harmful to the patient.
- 4 Science and guidelines should trump individualized, unsupportable opinions.

Pain vs. Impairment vs. Disability

Gap between what can do and what needs to do

Disability: Loss of, loss of use, or derangement. Medical determination using the AMA Guides.

Pain: Subjective

Impairment

Medical treatment should diminish or resolve impairment. Impairment reflects failure.

AMA Guides to the Evaluation of Permanent Impairment

The Problem: Erroneous Ratings

Majority of impairment ratings are erroneous, with errors more commonly resulting in over-rating
(CA error rate is 81%. Average original 19.1% WPI vs. corrected 8.4% WPI)

High Error Rates in CA

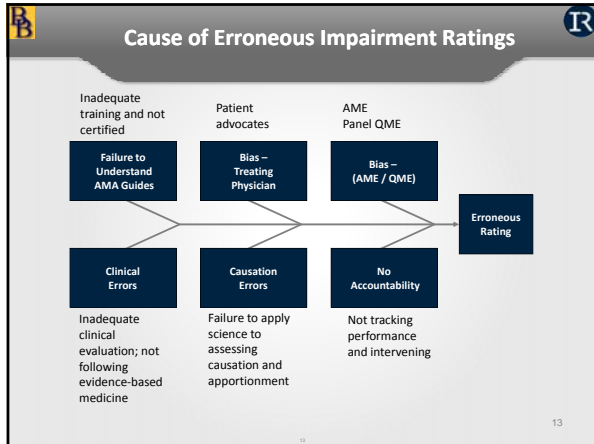
Professional Degree	State	Average WPI, %			Error Rate, %	Nos. of Cases
		Original	Revised	Difference		
MD	CA	18.8	8.5	10.3	30	3775
MD	NV	17.8	15.6	2.2	42	33
MD	HI	11.5	8.4	3.1	36	226
DC	CA	25.5	7.1	18.4	95	201
DC	NV	11.9	7.8	4.1	56	77
DC	HI	7.9	2.3	5.6	39	18

Type of Examiner	Average WPI, %			Error Rate, %	Cases, %	Diagnoses/Cases
	Original	Revised	Difference			
AME	24.5	10.9	13.6	91	31	2.7
QME	19.5	8.2	11.3	83	26	2.2
Treating physician	12.6	5.8	6.8	70	39	1.9
Other or not specified						4

Why is the error rate so high in California, and in particular for AMEs?

Cost of Overstated Impairment and Disability

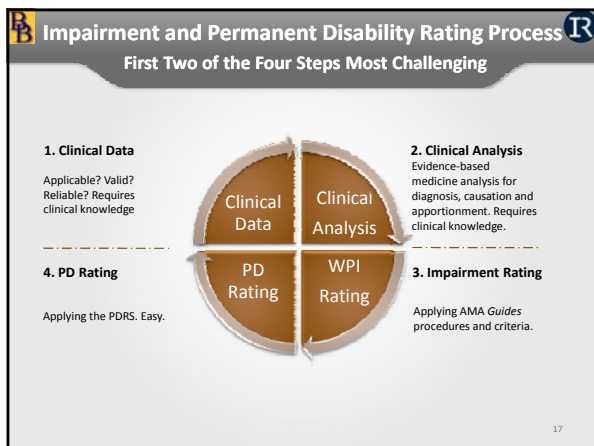
- 1 Human cost – a message of disability vs. ability.
- 2 Overstated ratings lead to overstated benefits.
- 3 Understated ratings lead to benefit inadequacy.
- 4 Erroneous ratings result in delay of claim resolution and friction costs.



- ### Purpose of the *Guides to the Evaluation of Permanent Impairment*
- Accurate, unbiased impairment assessments.
 - Uniformity
 - Consistency
 - Reliability
 - Created by physicians for physicians.
 - Includes consideration of interference in activities of daily living.
 - Consensus better than individual unsupportable opinions, e.g. Guzman for “unusual / complex”

- ### Rating Approach
- Structured Approach to Achieve Consistency
 1. Clinical Evaluation
 2. Case Analysis
 3. Impairment Rating Calculation
 - “California” Issues – Not Seen Elsewhere
 - e.g. using the *Guides* not as intended to inflate ratings
 - Structured Approach to Translate Impairment Rating into Permanent Disability Rating (PDRS Schedule)

- ### Guides Directives
- Rules provided in Chapter 1 (Philosophy, Purpose and Appropriate Use of the *Guides*) and Chapter 2 (Practical Application of the *Guides*)
 - Organ system chapters (Chapters 3 to 18) provide explicit directives in Principles of Assessment and rating process
 - Very few reports meet the standards defined in the *Guides*


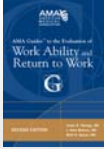


AMA Guides Essential Sources

- *AMA Guides to Evaluation of Permanent Impairment - Fifth and Sixth Editions*
- *Guides Newsletter* (Editor: Brigham, Associate: Talmage, Uejo)
- Authoritative Guidance

AMA Guides Essential Sources for Causation / Apportionment and Disability Analysis

- *Guides to the Evaluation of Disease and Injury Causation* (Melhorn, Ackerman)
- *Physician's Guide to Return to Work* (Talmage, Melhorn, Hyman)

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Positive approaches to address impairment ratings

1. Design and implement a best strategies program which is proactive to provide accurate impairment ratings.
2. Integrate claims, legal and *Guides* experts to work as a team in managing ratings.
3. Encourage physicians and other stakeholders to be trained on the use of the *Guides*, as written.
4. Recognize that this is an area of complexity that warrants working with an experienced *Guides* expert.

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Impairment Rating Strategies

1. Pre MMI	2. MMI	3. Post Rating
When approaching MMI have AMA <i>Guides</i> experts provide an estimate of impairment and/or guidance to the physician on rating process.	Have treating physician and/or IME physician: a) obtain data and provide to expert for completion of PR-4 / rating and/or b) use technology systems to validate rating prior to issue report.	Have ratings screened by technology systems and/or experts to determine if correct. If not correct, intervene. Review requires both medical and <i>Guides</i> expertise. Interventions: negotiation, feedback, rating evidence, cross-ex.

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Identify Erroneous Ratings



Red Flags – Short List

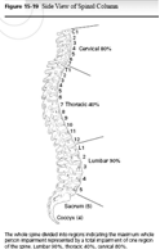
1. Rating > 10% WP
2. Rating > Expected for diagnosis
3. Multiple diagnoses
4. Guzman rating
5. Questionable Physicians

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Guzman – Abuse of the AMA *Guides*.

Ratings Based on Section 15.13 Criteria for Converting Whole Person Impairment to Regional Spine Impairment


- Used solely to convert whole person impairment into regional impairment for jurisdictions, such as Connecticut, that rate for regional spine impairment.
- Never to be used to convert a physician's individual opinion of loss of function of the spine to develop a whole person permanent impairment rating.



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Flaws in Assessment Process

Defining Total Loss	Defining Percentage Loss	Defining Work Ability
<p>What does total loss of the lumbar spine mean?</p> <ul style="list-style-type: none"> •Unable to stand, sit and move. •Unable to use lower extremities. •No bowel, bladder or sexual function. 	<ul style="list-style-type: none"> • Cannot base on subjective complaints. • Physicians lack ability to adequately assess functional loss if not using a consensus derived document. • No reliable basis to define baseline. 	<ul style="list-style-type: none"> • Need to determine <ul style="list-style-type: none"> • Risk • Capacity • Tolerance • Most physician assessments are unreliable. • Work ability better predicted by behavioral and psychosocial issues.



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Questions and Answers

Criteria for Converting Whole Person Impairment to Regional Spine Impairment Using the AMA Guides, Fifth

Christopher R. Brigham, MD, Gunnar Andersson, MD, Marjorie Eskay-Auerbach, MD, JD, James B. Talmage, MD, and Craig Ueji, MD, MPH

Question: Recently, in California applicant attorneys are encouraging physicians to use Figure 15-19, Side View of Spinal Column (5th ed, 427) in Section 15.13, Criteria for Converting Whole Person Impairment to Regional Impairment (5th ed, 427) to convert a physician's estimate of loss of function of the spine into a whole person rating. A February 7, 2011, California Workers' Compensation Appeals Board panel decision in the case of *Laury v. R&W Concrete Contractors* (Case No. ADJ3400378) based impairment on a physician's clinical estimate of a 60% loss of use of the lumbar spine. This estimated impairment loss was multiplied by 90% (the relationship with the Range of Motion (ROM) method that a whole person estimate is converted into a regional impairment should occur by dividing 0.90 for the lumbosacral spine) to determine a 54% whole person permanent impairment. Is this approach appropriate?

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Answer: No. Such approaches are markedly inconsistent with the methodology in the *Guides* and are fraught with problems. A primary goal of the *Guides* is that "two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions." (5th ed, 17). Physicians lack the ability to independently define current injury capacity for body part, and there is no reasonable basis to define a preinjury status. It has been clearly demonstrated that self-reported history in the context of litigation is unreliable.¹ Therefore, the individual's statements or the physician's opinions of reduction in pre-injury capacity are speculative. Katz² showed that the typical patient with paraplegia from a thoracic spinal cord injury rates at 58%-60% whole person impairment for the multiple consequences of devastating spinal injury, so a 54%-60% rating for back pain alone is ludicrous, and clearly a misuse of the *Guides*.

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In this case, there was no reasonable basis to support the physician's conclusion that there was 60% loss of the lumbar spine. The resulting value of 54% is nearly twice the maximum value assigned in the Diagnosis-Related Estimates (DRE) approach; the maximum for a DRE Lumbar Category V is 28% whole person permanent impairment. It is also higher than the maximum value assigned in the Sixth Edition; the maximum specified in Table 17-4, Lumbar Spine Regional Grad. Spinal Impairments (6th ed, 570-574) is 33% whole person permanent impairment.

The reason for Section 15.13, Criteria for Converting Whole Person Impairment to Regional Spine Impairment (5th ed, 427) is that certain jurisdictions (Connecticut, for example) may need to convert spinal impairments from whole person to impairment of the spine. The conversion factors differ depending on whether the impairment was obtained from the DRE method or from the ROM method. Since neither approach was used to obtain the estimated 60% lumbar impairment, application of Figure 15-19 is moot.

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Whole person permanent impairment ratings should never be based on Section 15.13, as this section is solely for converting a whole person value to a regional value. Impairment assessments must be performed in accordance with the procedures defined in the *Guides*. Such creative misinterpretations are clearly not "within the four corners" of the *Guides* and thwart the purpose of having standards to define impairment.

References

1. Barth RJ. Claimant-Reported History is Not a Credible Basis for Clinical or Administrative Decision-Making. *Guides Newsletter*, September/October, 2009.
2. Katz, R. Impairment Rating and Spinal Cord Injuries: Revisiting the *Guides*. *Guides Newsletter*, May/June, 2010.

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Team Approach

Integrated Approach

- Need to cover all aspects and combine expertise.
- More successful outcomes if claims works in conjunction with rating, medical and legal experts.

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Team Approach Needed for Success

Claims Professional
Adjuster skilled in claims management and resolution, achieving goals of organization.

Legal Counsel
Defense counsel skilled in legal strategies.

Rating Expert
Experienced in use of AMA *Guides* and PDRS.

Medical Expert
Consultant providing medical insights to case issues and strategies.

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Slaying the PD Dragon: Tactics That Work

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Managing Erroneous Ratings

Erroneous Report?

- First make sure a qualified person did the review, e.g. medical issues (IR) or legal issues (BB).
- Rating review by a "true" *Guides* expert determines that the rating is incorrect.
- What do you do?

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You Determined The Rating is Wrong!

INCORRECT RATING

CORRECT RATING

Are you willing to intervene? Note, overall average Return on Investment is several fold – if do this correctly.

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What are your options? (It depends.)

- 1 Supplemental?
- 2 Deposition?
- 3 DEU?
- 4 Expert testimony?

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Option 1: Supplemental Report

Dr. Friendly?

- MPN doctor willing to list.
- Provide rating review report and/or have your expert draft a letter to be sent to the doctor.

Dr. Know It All?

- If biased and/or qualifications suspect, likely waste of time.
- Likely will justify indefensible positions and muddy the waters.
- Results in delay.

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Option 2: Cross Examination

Dr. Friendly?

- A sure bet.

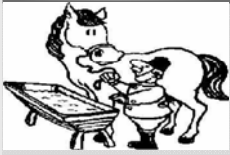
Dr. Know It All?

- First, make sure defense counsel is skilled in performing cross-examination on medical and *Guides* issues. Consider consulting with a medical / *Guides* expert to assure most effective strategies and questions.


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What happens when you lead a horse to water....?

He drinks



Or swims with the fishes



Not substantial evidence!

DEU to the rescue!?!?

- Trained in the *AMA Guides* – although take directives from Judge.

DEU Example

Facts:

- pro per
- Panel QME...DC ☹️

Uncorrected =	64% PD
	= \$40,000+
Corrected =	19% PD
	= \$7,000
At issue =	\$33,000

EXAMPLE (cont'd)

Supplemental Request Response:

“With all due respect, you are not a doctor”

What do they say about people who live in glass houses?

DEU weighs in

Not 64%

Not 19%

- Answer: 22% (\$9,000)
- Savings: \$31,000

DRAFT THAT C&R!

APPROVED!

- Careful -
 - Pro per?
 - Rating has issued?
- Don't get burned!

BB **R**

4061(g) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the [appropriate] procedures...

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BB **R**

WATCH OUT!

- 30 day count down (from receipt of rating)
- Request “shall be in writing”
See eg, DEU Form 103
- Shall specify the reasons the rating should be reconsidered
- Shall be served on the other party

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BB **R**

Potential Issues

- QME/TP failed to address all issues
- IMC procedure not followed by QME/TP
- QME/TP failed to completely address issues
- Rating was incorrectly calculated
- “Other”


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BB **R**

Monday Morning Quarterbacking

How do QMEs enjoy having their work reviewed...

“California Society of Industrial Medicine & Surgery (CSIMS) sent a three-page letter...the Division of Workers’ Compensation...asking for guidance about the review practice...”



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BB **R**

Is the DWC sympathetic?

NO!

Susan Gard, DWC spokesperson says:

“The simple answer is we don’t think we have authority to prohibit a defense strategy.”

“If a secondary evaluation shows problems in an [AME’s] or [QME’s] report, that’s something they should correct...”


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BB **R**

Source: WorkCompCentral 10/19/06
“Reviews of Med-Legal Reports Have Docs Wary”

“If the purpose is to get an inaccurate report corrected, they (the defense) should do that...”

“[I]t’s the right of the insurers to look for evidence that strengthens their case...”



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Next Steps

- Proactively manage impairment and permanent disability ratings, as well as clinical, apportionment, and work ability issues.
- Challenge the status quo.
- Measure your return on investment.

Assess current status
Define vision
Develop strategy
Define team
Take action
Evaluate results

Thank you.

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