2008 IOWA AMA GUIDES TASK FORCE PROCESS REPORT

INTRODUCTION

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 system, 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 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 evidence-based and ratings under the Guides did not accurately or adequately reflect loss of function.

Concerns were expressed within the task force that inclusion of a functional loss factor in assessing impairment inserts the concept of disability into impairment ratings and raises the possibility that deputies in litigated claims may give greater weight to impairment ratings and lesser weight to other evidence relevant to assessment of disability.

IMPAIRMENT RATING METHODOLOGY

Chapter 1 of the Sixth Edition also sets forth the impairment rating methodology that the edition uses in all chapters but for Chapter 13, the "Central and Peripheral Nervous System", which continues to use the Fifth Edition rating methodology. The rating methodology

that the Sixth Edition generally uses is derived from the ICF model. That model created a functionally based taxonomy that links the level of clinical severity of specific health conditions, as measured on a zero to five scale, with percentage of function lost. Table 1-3 sets forth the taxonomy of functional levels: individuals with no or negligible problems as a result of their health conditions are coded at 0; individuals with slight or low problems are coded at 1 mild; individuals with medium functioning at 2 moderate; individuals with a high degree of problems with their function at 3 severe; and individuals whose problems with function as a result of their condition is total as 4 complete.

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.

DIAGNOSTIC IMPAIRMENT CLASS

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 matter 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 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 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** plus (4-2) = **2** 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 SIX 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. Principle 10 requires careful assessment of range of motion and strength measurement techniques if the evaluator has concerns that "self-inhibition secondary to pain or fear" exists. Principle 11 prohibits the rating of projected future impairment. Principle 13 plainly states that subjective complaints alone are generally not ratable under the Guides.

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. Section2.3b 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 individual'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 impairment 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 improvement 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 o 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