Washington Claims School

Presented by Reinisch Wilson Weier PC

June 14, 2017 Lake Oswego, Oregon

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LAW OFFICES

Impairment Rating - How to begin to know, what you don't know, about the AMA Guides, 5th Edition

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LEVELS OF EVIDENCE

Rating of Therapeutic Article	Rating of Diagnostic Article	Rating of Prognostic Article	Rating of Screening Article
Class I: Prospective, randomized, controlled clinical trial with masked outcome assessment, in a representative population. The following are required: a) primary outcome(s) clearly defined b) exclusion/inclusion criteria clearly defined c) adequate accounting for drop-outs and cross-overs with numbers sufficiently low to have minimal potential for bias d) relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences.	**Class I:** Evidence provided by a prospective study in a broad spectrum of persons with the suspected condition, using a reference (gold) standard for case definition, where test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy. All patients undergoing the diagnostic test have the presence or absence of the disease determined.	**Class I:** Evidence provided by a prospective study of a broad spectrum of persons who may be at risk for developing the outcome (e.g. target disease, work status). The study measures the predictive ability using an independent gold standard for case definition. The predictor is measured in an evaluation that is masked to clinical presentation and, the outcome is measured in an evaluation that is masked to the presence of the predictor. All patients have the predictor and outcome variables measured.	**Class I.** A statistical, population based sample of patients studied at a uniform point in time (usually early) during the course of the condition. All patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation that is masked to the patients' clinical presentations.
Class II: Prospective matched group cohort study in a representative population with masked outcome assessment that meets a-d above OR a RCT in a representative population that lacks one criteria a-d.	**Class II:** Evidence provided by a prospective study of a narrow spectrum of persons with the suspected condition, or a well designed retrospective study of a broad spectrum of persons with an established condition (by "gold standard") compared to a broad spectrum of controls, where test is applied in a blinded evaluation, and enabling the assessment of appropriate tests of diagnostic accuracy.	**Class II:** Evidence provided by a prospective study of a narrow spectrum of persons at risk for having the condition, or by a retrospective study of a broad spectrum of persons with the condition compared to a broad spectrum of controls. The study measures the prognostic accuracy of the risk factor using an acceptable independent gold standard for case definition. The risk factor is measured in an evaluation that is masked to the outcome.	**Class II.** A statistical, non-referral clinic-based sample of patients studied at a uniform point in time (usually early) during the course of the condition. Most patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation that is masked to the patients' clinical presentation.
Class III: All other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome is independently assessed, or independently derived by objective outcome measurement.**	**Class III:** Evidence provided by a retrospective study where either persons with the established condition or controls are of a narrow spectrum, and where the reference standard, if not objective, is applied by someone other than the person that performed the test.	**Class III:** Evidence provided by a retrospective study where either the persons with the condition or the controls are of a narrow spectrum. The study measures the predictive ability using an acceptable independent gold standard for case definition. The outcome, if not objective, is determined by someone other than the person who measured the predictor.	**Class III.** A sample of patients studied during the course of the condition. Some patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation by someone other than the treating physician.
Class IV: Evidence from uncontrolled studies, case series, case reports, or expert opinion.	**Class IV:** Any design where test is not applied in an independent evaluation OR evidence provided by expert opinion alone or in descriptive case series (without controls).	**Class IV:** Any design where the predictor is not applied in an independent evaluation OR evidence provided by expert opinion or case series without controls.	**Class IV.** Expert opinion, case reports or any study not meeting criteria for class I to III.

that the evaluator had also claimed were based on Table 13-8.

NOTE: The evaluator's documentation of the 4 impairment ratings that were reportedly based on Table 13-8 created additional concerns, including the following:

- The impairment rating that was supposedly based on the Neuropsychological Assessment and Testing line of Table 13-8 was not accompanied by any documentation of what method the evaluator used to translate the test results into that impairment rating. The documentation simply announced an impairment rating of 11% for that line of the table, without any explanation, thereby creating the impression that this was methodless guesswork, rather than professional expertise.
- Similarly, the impairment rating that was supposedly based on the Extended Mental Status Exam line of Table 13-8 was not accompanied by any documentation of what method the evaluator used to translate the evaluation results into that impairment rating.
- Impairment was claimed on the Extended Mental Status Exam line of that Table 13-8, even though the evaluator also documented that her mental status exam for the examinee failed to produce any evidence of impairment, and even though the documented mental status exam did not involve the type of mental status tests described in Section 13.3d (6th ed, 330) as detailed in Table 13-7, Mental Status Exam for the Neurologically Impaired Patient (6th ed, 330).

Additional Inconsistencies with *AMA Guides*, Sixth Edition, Methodology

1: The evaluator was identified as having a doctor-patient relationship with the examinee and yet provided an impairment rating without documenting discussion of this fact.

The examinee reported that the evaluator is his doctor and that the examinee is the evaluator's patient for healthcare purposes. There was no documentation of informed consent for an independent evaluation. This is inconsistent with Sixth Edition methodology, which specifies that the impairment rating evaluation is best done by an independent evaluator. Section 2.3b, Examiner's Roles and Responsibilities, states the following:

> The physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and of limitations to the performance of Activities of Daily Living, or ADLs (as listed in Table 1-1). Although treating physicians may perform impairment ratings on their patients, it is recognized that these are not independent and therefore may be subject to greater scrutiny. Performing an impairment evaluation requires considerable medical expertise and judgment. (6th ed, 23).

A doctor who has a doctor-patient relationship with the person being rated is not independent. The Sixth Edition's glossary explains that an independent medical examination means "usually one-time evaluation performed by an independent medical examiner who is not treating the patient or claimant, to answer questions posed by the party requesting the IME." (6th ed, 612).

The importance of an impairment evaluation taking place on an independent basis has previously been addressed in the *AMA Guides Newsletter*.[2] Such considerations are especially relevant for the evaluator of this misdirected rating, because that evaluator was identified as being a psychologist. A variety of publications from the American Psychological Association have specified that it is not credible for a psychologist who has a doctor–patient relationship with an examinee to address forensic issues such as impairment rating.[3,4,5] Similarly, this issue is addressed in Chapter 14 of the Sixth Edition, Mental and Behavioral Disorders, Section 14.3a, Physician Alliance, which states the following:

> Any examiner performing an IME is expected to have a neutral, unbiased position with regard to the patient. However, psychiatrists and psychologists who perform impairment or forensic evaluations that deal with work-related injuries have special requirements and limitations. Mental health clinicians align themselves closely with their patients; a commonly used phrase describing this alignment is "unconditional positive regard." Thus, for mental health clinicians, it may be even more difficult to reach the neutral, unbiased position that is expected of all examiners performing IMEs, but it is vital to do so.
>
> Treating psychiatrists and psychologists should avoid serving as an expert witness or IME examiner for legal purposes on behalf of their own patients. The dual role can be detrimental to the therapeutic relationship, can be a considerable source of bias for the examiner, and can compromise the patient's legal claim. (6th ed, 351)

2: The evaluator did not establish a specific diagnosis (or even a credible diagnosis).

Sixth Edition Section 2.3 Use of the *AMA Guides* (6th ed, 23) states:

> The *Guides* is of value only if the medical diagnosis is correct; an incorrect diagnosis leads to an incorrect impairment rating.

Sixth Edition page 20 specifies:

GUEST EDITORIAL

Two Faulty Beliefs about Independent Medical Evaluators and Impartial Physicians

Jennifer Christian, MD, MPH

Patients and their advocates tend to be skeptical about reports produced by independent medical evaluators (IMEs) and file reviewers. There are legitimate reasons for this skepticism. However, I want to point out two common but faulty beliefs that create unnecessary distrust in this aspect of disability benefits and workers' compensation claim management systems. First, despite patients' faith in their own doctors, treating physicians as a group are often not a reliable source of accurate and unbiased information. Second, although justice is even-handed, impartial physicians should not find for both sides equally.

Based on my experience leading teams on 3 consulting projects that audited the quality of more than 1400 reports of independent medical evaluations and file reviews, I definitely have many concerns about the quality of the reports, the process by which they are procured, and the physicians and other healthcare professionals who provide them.[1] But the 2 issues listed above are not among them.

Fact: As a Group, Treating Physicians Are Not a Reliable Source of Accurate and Unbiased Information

First is the incorrect belief that the treating physician is the best person to turn to for an "independent" opinion because he or she is a highly trained professional who is familiar with the patient's case. This is incorrect for the following 2 reasons:[2]

- There is considerable variability in the appropriateness and effectiveness of the care delivered by practicing physicians, and patients are not in a good position to assess it. Evaluation of appropriateness and effectiveness is admittedly a difficult and imperfect process. However, the best person to perform this evaluation is another physician who is equally or more expert in the matter at hand—and who has neither an axe to grind nor a financial stake in the outcome, as might be the case with a friendly colleague or a competitor.
- In medical school and residency, physicians are often told they should be "patient advocates," but that instruction may not include a definition of "advocating." (True for me and many others in physician audiences when I have asked about it.) Patient advocacy sometimes turns into doing or saying exactly what the patient wants, not what is actually in the best interest of the patient's long-term health and well-being. The data are clear: treating physicians may provide unnecessary antibiotics, pain medications, or inappropriate treatments or even be willing to shade the truth on reports in order to keep their patients happy. In today's world with fierce competition between medical groups for patients and the use of "patient satisfaction scores" in calculating physician bonuses, this is particularly true. In my view, this is an abdication of professionalism.

The reason why arm's-length or "third-party" physicians are preferred as the source of opinions is to protect patients from harm from either the "first party" (treating physician) or the "second party" (the payer, which has an obvious business interest in controlling cost). However, a legitimate cause for concern is the way an arm's-length physician has been selected, since it can sometimes be distorted by the interests of either the first or second party.

Fact: Impartial Physicians' Opinions Should Not Find for Both Sides Equally

Second is the belief that "truly" impartial physicians should come down on the side of individuals vs their employers or insurers half of the time. Said another way, impartial physicians should call it 50:50 for plaintiff vs defense. This belief is wrong because cases selected for review or IME have been preselected by claims/case managers. These professionals may not be healthcare professionals but they see thousands of cases and become very familiar with the medical landscape. In fact, they often have much more experience observing the actual process of care than many treating physicians who are focused on their own preferences and practices. Claims/case managers quickly learn to recognize patterns of care that are within the usual range—and those that stick out. Today, they are often expected to use evidence-based guidelines to identify outlier cases. Those who focus on specific geographical areas come to see which doctors "get their patients better" and which ones don't.

It is unusual for cases to be referred for independent review. Most of the time, the treating physician seems to be doing the typical things; their diagnoses, prescribed treatment, and causation determinations (if work related) make sense and appear reasonable and appropriate. If claims/case managers see no problems or have no questions, they do not refer the case for outside review.

Thus, as a rule of thumb, you can assume any case sent to review has some feature that has raised questions in the mind of an experienced observer of the care process. The reason why the case is being referred is because that observer has only a very superficial knowledge of medicine. They need an adviser—an impartial, expert physician who can evaluate the clinical facts and context and then either confirm that the treating physician is doing the right thing or validate the claims/case manager's concerns.

When claims/case managers are doing a good job selecting cases for referral, we should expect that most of their decisions will favor the insurer/defense. The more expert the claims/case managers are, the more likely the independent physicians will agree because the claims/case managers are accurately detecting real problems and concerns.

Consider this: If you are a treating physician who frequently ends up with your care plans rejected by claims managers and utilization review, it's possible that you stick out. Your care patterns may be more unusual than you realize. Your outcomes may be worse than those of your colleagues.

Sadly, some physicians discredit input from independent experts in front of patients. They may think they are advocating for their patients. While on a social justice crusade, they may end up harming their patients instead of helping them by teaching patients they have been wronged, are victims of "the system," and helpless pawns. This message increases distrust, resentment, and anger (which in turn worsens symptoms) and encourages passivity rather than problem-solving, which in turn increases the likelihood of job loss, permanent withdrawal from the workforce, and a future of poverty on disability benefits.

The physicians' care plans should consist of those treatments known to restore function and work ability most rapidly. Physicians should also encourage their patients to tell their employers they want to find a way to stay productive, contribute to the company, and keep their jobs. This gives the employers a reason as well as an opportunity to help. When employers are not supportive, physicians should counsel their patients to try to find a new job quickly, even if it's temporary or they have to make a change to the kind of work they do.

A former president of the Oregon Medical Association said he counsels patients this way: "Your two most important treasures are your health and your job. And I am here to help you protect both of them." Healthcare practitioners should do everything they can to help their patients find a successful way out of these predicaments, instead of allowing them to believe they are trapped. The "system" is not designed to solve their life predicament for them—they have to do it themselves. Adapting to loss is a key part of recovery. When I was treating patients, I could tell they were going to be okay when they said with pride, "I've figured out how to work around it, and life is getting back on track."

References

1. Christian J, Siktberg D. Time to unleash the untapped power of IMEs? *J Workers' Compensation.* 2002; 11(3):3-18.
2. Barth R, Brigham C. Who is in the better position to evaluate: the treating physician or independent examiner? *Guides Newsletter.* September-October 2005, 9-11.