

# MEMORANDUM

September 24, 2013

To: Management-Labor Advisory Committee

From: Cara Filsinger, Medical Advisory Committee Administrator

Subject: Input from Medical Advisory Committee (MAC) on Impairment rating

At the MAC meeting on September 20, the committee discussed the questions provided by MLAC regarding possible improvements to the methods used to rate impairment. The committee provided the following input.

Question 1 (regarding problematic areas for range of motion measurement);

- The committee still supports its prior advice (attached) regarding the AMA 6<sup>th</sup> edition and the challenges and possible benefits to changing methodology.

Question 2 (regarding alternatives to measure impairment):

- Other than the diagnosis based model offered by the AMA 6<sup>th</sup> edition, the committee could not identify viable alternatives. The committee indicated the diagnosis based model may be difficult to insert piecemeal in the existing standards.

Question 3 (regarding areas that are not adequately covered):

- They agreed strength measurement may be subjective, but the alternative measures are difficult and cumbersome for providers.
- Cold intolerance.
- Pain. For example, one worker may have restricted range of motion but no pain and be released to work; but another with good range of motion but a lot of pain may not be able to work.
- They pointed to the examples cited in the Sept. 18, 2009 presentation by Dr. Rischitelli (posted on Impairment Subcommittee website).

Question 4 (regarding incongruous outcomes):

- The committee had no specific comment on this issue.

**Date:** 12/4/2009

**To:** Lou Savage, Administrator, Management Labor Advisory Committee

**From:** Jacqueline Sewart, Asst. Manager Medical Section, WCD

**RE:** MLAC questions on AMA 6th Edition

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Below are the MAC (Medical Advisory Committee) responses to the questions asked by MLAC (Management Labor Advisory Committee) regarding the AMA 6<sup>th</sup> Edition.

**Assist MLAC and the department to determine whether to proceed with a more extensive study of the AMA Guides 6<sup>th</sup> Edition by answering the following questions from a medical perspective:**

**1a. Does the 6<sup>th</sup> Edition represent an evolution in medical knowledge?**

Yes. The 6th ed represents a fundamental shift in the assessment of impairment. It adopts a modern model of function, disability and health (WHO, 2001). It adopts evidence-based principles and incorporates advances in diagnosis, treatment and the functional outcomes of treatment.

**1b. Would use of the 6<sup>th</sup> Edition result in improved validity, clarity and inter-rater consistency as compared with Oregon's current method for rating impairment?**

Yes. Moving away from ROM (Range of Motion) as the primary determinant of musculoskeletal impairment to the use of diagnosis and clinical data will likely improve validity, clarity and inter-rater reliability.

**1c. Currently, ratings of impairment are calculated by insurers, based on medical findings and measurements. Would this structure need to change with the adoption of the 6<sup>th</sup> Edition?**

This structure would not necessarily need to change. The attending physician or another examiner could still perform the closing examination and report the findings to the insurer who would then calculate the impairment. This system prevents the large proportion of incorrect ratings seen in other jurisdictions by limiting impairment rating to experienced individuals who understand the rating system and apply it without personal bias. In some ways, the closing evaluation would be easier for physicians since it would rely on clinical data already collected in the medical record, and would eliminate the need for complex and time-consuming range of motion measurements (e.g., using inclinometers) that serves as a major barrier to performing closing exams for many physicians.

**1d. Could attending physicians readily interpret and apply the 6<sup>th</sup> Edition? If not, what would enable them to do so?**

Correct application of any edition of the AMA Guides requires a significant level of understanding and familiarity. This is usually achieved by training and frequent use of the Guides, two attributes that most physicians do not have. Physicians could, however, readily report the data necessary for rating by the use of simplified worksheets and very basic education and training.

**1e. Who else could rate impairment using the 6<sup>th</sup> Edition?**

Ratings can be performed by non-physicians as they are under the current system. Delegating the application of the Guides to all attending physicians would probably result in greater variability, greater potential for errors, and possibly more disputes. Alternatives could include identifying a subset of qualified physicians, or using a system similar to the present medical arbiter panel.

**2. Would Oregon's "major contributing cause" law be a deterrent to adoption of the 6<sup>th</sup> Edition? If so, what changes would be necessary?**

No. The key factor in assigning impairment in the 6E is assigning the correct diagnosis. It is assumed that the impairment rating would be based on the "accepted condition(s)." Therefore, the application of MCC would occur during "acceptance" (compensability) before the 6E is applied and would not create a conflict.

**3. What medical policy questions would need to be addressed prior to adopting the 6<sup>th</sup> Edition?**

Identification of roles & responsibilities.

Stakeholder acceptance.

Accepted condition nomenclature.

Use of functional modifiers.

Impact of adoption of 6E Guides "in toto" vs. local modification of 6E Guides vs. revision of current system using 6E methods.

**4. Could a comparison of impairment ratings using current calculation v. the 6<sup>th</sup> Edition be undertaken using information that is typically in a patient's medical record? If not, what would be missing? If so, who would need to rate the subjects' impairment using the 6<sup>th</sup> Edition?**

This could be achieved for many but not all conditions. Some conditions require the use of functional assessment tools or data that may not be included in the medical record currently.

**5. Are there other roles, requirements, processes or issues that Oregon's policy-makers need to understand?**

MCC is primarily a factor in pre-existing and degenerative conditions. The 6th eliminates many of those conditions. It would be important that the "accepted condition" be among one of the diagnoses listed in the 6E.

**6. Overall, what would be the advantages and drawbacks of adopting the 6<sup>th</sup> Edition?**

**ADVANTAGES**

Eliminate the use of ROM as a major determinant of PPD.

Reduces inter-rater variability.

Adopts evidence-based principles.

Reflects clinical reality.

Incorporates advances in diagnosis, treatment and the functional outcomes of treatment.

**DISADVANTAGES**

Shifting the paradigm.

Expensive to train users, particularly physicians.

Please let me know if you have additional questions you would like MAC to Answer.