



# **AMA Guides® Editorial Panel**

## **Public Meeting**

**Virtual Panel Meeting**  
**April 23, 2020 (9:30 AM – 11:45 AM Central Time)**

# Welcome

Today's Facilitators:



**Doug Martin, M.D.**  
Co-Chair  
Occupational Medicine



**Mark Melhorn, M.D.**  
Co-Chair  
Orthopaedic Surgery

# Agenda

- Welcome
- Meeting Mechanics
- Confidentiality/COI Reminders
- AMA Update
- Editorial Change Proposals
- Closing

# Establishment of Quorum

- Attendance will be taken to establish Panel quorum.

## Panel Members

Marie Acierno, MD  
Helene Fearon, PT  
Steven Feinberg, MD  
David Gloss, MD  
Robert Goldberg, DO

Rita Livingston, MD, MPH  
Doug Martin, MD  
Kano Mayer, MD  
Mark Melhorn, MD  
Marilyn Price, MD

Noah Raizman, MD  
Michael Saffir, MD  
Jan Towers, PhD

## Panel Advisors

Chris Brigham, MD  
Hon. Shannon Bruno Bishop, JD  
Barry Gelinas, MD, DC

Abbie Hudgens, MPA  
Hon. David Langham, JD

# Meeting Mechanics

- Panel members and advisors may speak at any time throughout the duration of the event.
- All other attendees are on **listen-only** mode. Attendees on listen-only mode may press \*1 to indicate to an operator that they would like to speak.
  - **Attendees must be dialed in to speak**
  - The operator will temporarily unmute your line to allow you to speak.
  - Oral disclosure of interests that are directly related to the application is required before addressing the Panel.
  - Public may ask questions and make concise comments about the editorial change proposal when solicited. If needed, a time limitation may be enforced.

# Confidentiality/COI Reminders

- Confidentiality
  - It is at the discretion of the AMA, the publisher and convener, which topics, news items, or policy decisions resulting from this or any Editorial Panel meeting will be announced publicly at the appropriate time. Until and unless the AMA makes such a public announcement, all discussion and decisions made during AMA Guides® Editorial Panel Meetings are confidential.
  - Please refrain from tweeting or participating in podcasts, interviews, or news articles about Panel meetings, discussions, or deliberations. Recording devices by Panel members and co-chairs is strictly prohibited. The AMA will record all Panel meetings for reference materials and will be the only recording of Panel meetings allowed.
- Conflict of Interest (COI)
  - You are here because of your interest and/or experience with the AMA Guides®, but your affiliations could pose a potential conflict of interest. Please mention all of your disclosures if they are relevant to the topic being discussed or the opinions you hold and express.
  - While you were nominated by a society, remember that your Editorial Panel duty is to the AMA Guides®. You are not here to represent the interests of any society, profession, or employer.

# Professional.

# Ethical.

# Welcoming.

# Safe.

- Updated policy in early 2019.
- This is what we expect of our members and guests at AMA-sponsored events.
- We take harassment and conflicts of interest seriously. Read our policy or file a claim at **[ama-assn.org/codeofconduct](https://ama-assn.org/codeofconduct)** or call **(800) 398-1496**.



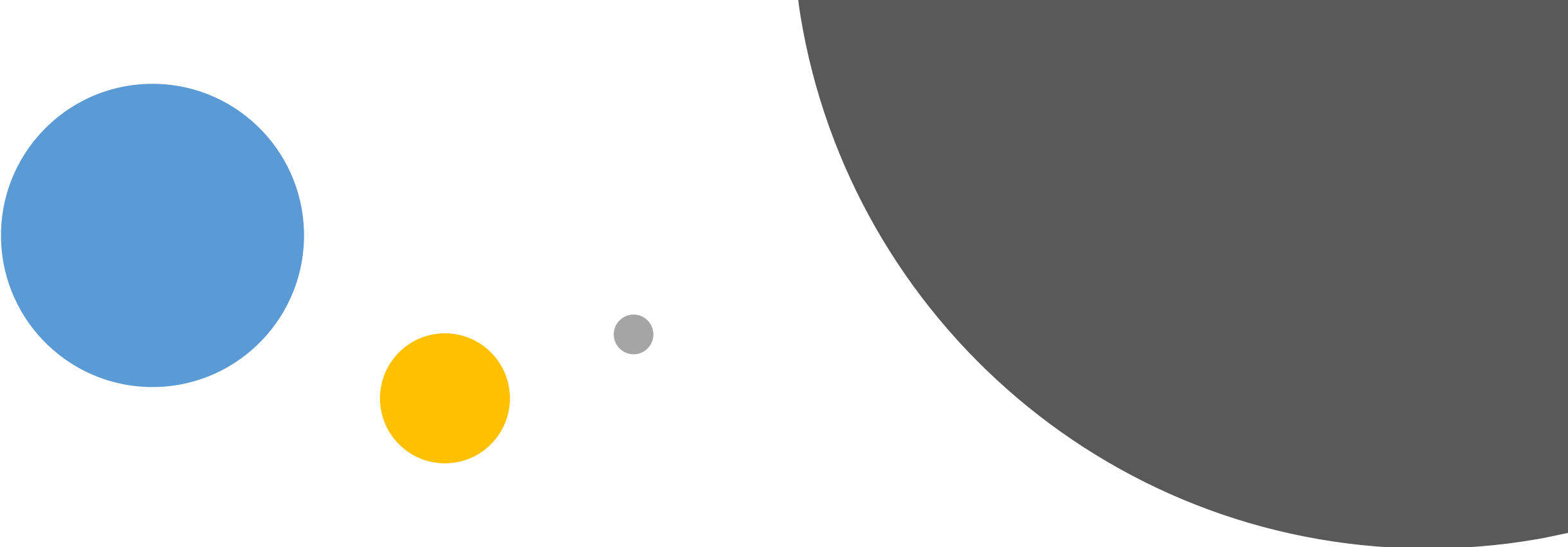
## **AMA Update: Laurie McGraw SVP, Health Solutions Group**



# Timing

	Time allotted
Presentations	30 minutes
Primary Reviewer	5 minutes
Secondary Reviewer	3 minutes
Panel Members	10 minutes (~2 minute each)
Public Comments*	10 minutes (~1 minute each)

*\*Public may pose questions and comments through the Q&A Box*



# PROMS & the 6<sup>th</sup> Edition

American College of Occupational and  
Environmental Medicine & American  
Psychological Association

Kathryn Mueller, MD, MPH, FACOEM  
Stephen Gillaspay, PhD  
Daniel Bruns, PsyD

# Action Requested in the Editorial Change Proposal

- *Approve the approach to evaluate the validity and reliability of the functional tools used in the AMA Guides and approve the team from the APA and ACOEM to apply the approach and suggest reliable tools for the Guides. This approach includes identifying PROMs that are commonly used in practice and are reliable for use in the Guides. The chapters where these tools apply are the spine, lower extremity and upper extremity chapters, but would like the panel's recommendation on other chapters where these tools should be applied/evaluated.*

# Kathryn L Mueller, MD, MPH, FACOEM

- Professor, University of Colorado, School of Public Health and School of Medicine – Department of Physical Medicine and Rehabilitation
- Prior Medical Director, Colorado Division of Workers Compensation – Currently a consultant
- Past President American College of Occupational Medicine
- Serves on Academic and International Advisory Boards for MedRisk and Workers Compensation Research Institute
- No relevant disclosures





# Stephen R. Gillaspy, PhD

- Senior Director, Health Care Financing and the Center for Psychology & Health, American Psychological Association
- Licensed clinical psychologist, clinical scientist and senior administrator with extensive experience integrating psychological services into larger healthcare systems.
- Serves as the APA advisor to the American Medical Association's Relative Value Update Committee (RUC).
- Former professor and director of pediatric psychology in the department of pediatrics at the University of Oklahoma, College of Medicine
- Former President of the Oklahoma Psychological Association (OPA) in 2013 and chaired OPA's Division for Research, Academics, and Training from 2009 to 2011.
- No relevant disclosure



# Daniel Bruns, PsyD FAPA

- **American Psychological Association**
  - Executive Board of Society For Health Psychology
  - Member of Interdivisional Healthcare Committee (IHC)
- **American College of Occupational and Environmental Medicine**
  - Current chair of mental health treatment guidelines
- **State of Colorado**
  - Past chair of chronic pain treatment guidelines
  - Senior clinical instructor at University of Colorado Medical School
- **Principle investigator in 15-year longitudinal study of 29 million patients assessing the impact of biopsychosocial treatment guidelines**
- **Standardized psychometric test development**
  - 33 years experience
- **Independent Pain Psychology Group Practice**
- **Disclosure**
  - Co-author of two standardized psychological tests designed for the assessment of patient risk for poor response to medical treatment



# 6<sup>th</sup> Edition – Functional Component

- **1.7b Self-Assessment Tools**
  - **Need to better reflect individual patient's functional response to injury**
  - **Requires empirical validation through office examination**
  - **Extremes can exist through under or over reporting**
- **1.7c General Definitions for Categories Stated**
- **Acknowledgement that the New York Heart Association classification for cardiac disease and the American Thoracic Society's dyspnea were models for valid tools reflecting function**
- **No separate specific analysis was done of the tools suggested in this edition**
- **Unclear how familiar most doctors were with the tools chosen**

# Functional History Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; +/- medication to control symptoms	Pain/symptoms with normal activity; +/- medications to control symptoms	Pain/symptoms with less than normal activity (minimal); +/- medications to control symptoms	Pain/symptoms at rest; +/- medications to control symptoms
		Able to perform self-care activities independently	Able to perform self-care activities with modification but unassisted	Requires assistance to perform self-care activities	Unable to perform self-care activities
QuickDASH Score	0-2	21-40	41-60	61-80	81-100



# Functional History:

## Musculoskeletal

Functional History	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; Able to perform self-care activities independently	Pain/symptoms with normal activity; Able to perform self-care activities with modification but unassisted	Pain/symptoms with less than normal activity (minimal); Requires assistance to perform self-care activities	Pain/symptoms at rest; Unable to perform self-care activities

\* Based on self-report or scores from the PDQ, *QuickDash*, Lower Limb Outcomes Questionnaire, or other self-report too

# Ultimate purpose of the Guides

---

**Provide medically correct % of functional impairment for individuals**

---

**How that medically correct % , to the best of our ability using current evidence, is used is not the purview of the Guides**

---

**Multiple high-quality studies using Patient Reported Outcome Measures (PROMS) available for the most common procedures and conditions in the Guides**

---

**These studies generally use the most common PROMs available and would be more familiar to doctors**

---

**In order to reflect current practice we must review and update the recommendations for PROMs**

---

**Only functional PROMS – fPROMS – should be used**

# Advantages and Disadvantages of using fPROMs

- Reflects the patient's opinion of their function
- Can be weighed against high quality studies on the same condition to compare with population results
- A few physicians already track patient's progress with these and that would provide an excellent record for impairment evaluators
- Not available in most EHRs
- Many PROMs available – which are most commonly used?
- Numbers needed for both whole person and specific body parts

**What do we  
need to do  
to assure  
that we can  
trust the  
results of  
patient  
reported  
measures?**

---

Psychometrically sound?

---

Measures the aspects of function  
relevant to our assessment?

---

Commonly in usage?

---

Relatively short?

# **How Do You Evaluate a Medication?**

**Is it Safe and Effective?**

# How Do You Evaluate a Psychometric Measure?

## Has It Been “Standardized”?

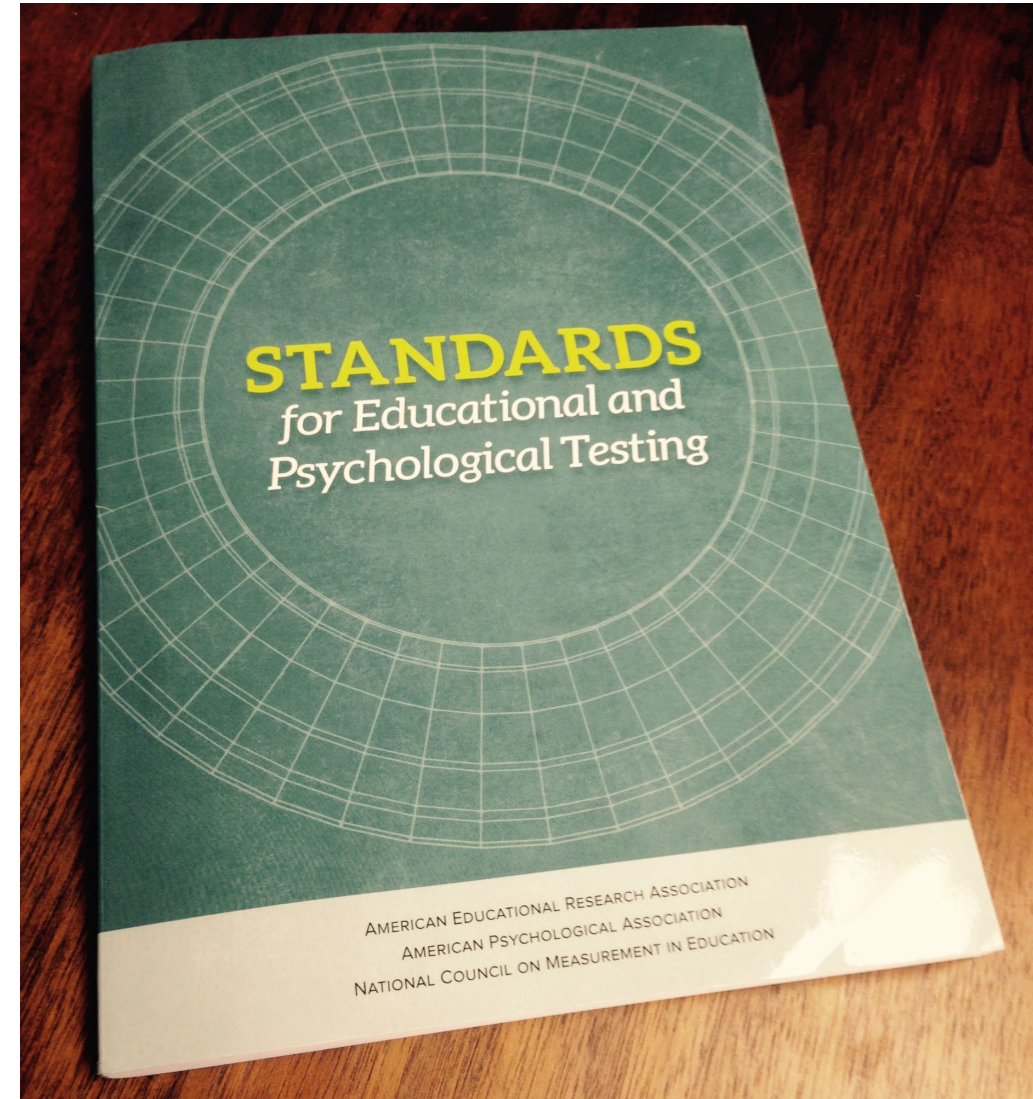
**Standardization Involves Making Determinations About A Measure’s Reliability, Validity, Fairness, and Norm-Based “Standardized” Scores**

# What is a *Standardized Test*?

A psychometric measure is regarded as “standardized” to the extent it was developed in accordance with the principles in this book.

**The *Standards*** is one of the most extensively peer-reviewed method documents in science. It is a standard, not a guideline.


In contrast, the term “validated” does not have a specified definition.



**For over 50 years,  
the *Standards for Educational  
and Psychological Testing* has been  
the accepted conceptual framework  
for determining how trustworthy a  
questionnaire's scores are.**

**We should apply those principles here.**





# Current Initiatives in the AMA and Elsewhere

## **fPROMS are:**

- Foundational for Evidence-based research
- Required for opioid therapy
- Used in Clinical Registries
- Advocated for use in determining justification for treatment continuation or change
- Aligned with Medicare value standards

# Functional Outcomes Used in Practice

- Many valid tools for functional patient reported outcomes measurements – fPROMs - are available
- Using these along with
  - the physical exam
  - physical therapy notes
  - knowledge of likely job duties
- Usually results in appropriate recommendations for activities and work duties
- Recommendations for safe and therapeutic activities should be part of any medical exam



# Opioid Treatment Requirements

- Limited use in acute situations
- Screening for risk
- Continual functional assessment to determine if the patient is improving or doing worse on opioids if they are continued
- Screening for mental health issue and treatment when identified.



**Multi-  
specialty  
Meeting  
sponsored by  
ACOEM  
NIOSH, and  
APA – June  
2019**

- American College of Occupational and Environmental Medicine
- American Psychological Association
- National Institute of Occupational Safety and Health
- Purpose: To development multi-specialty interest in incorporating fPROMS into everyday practice
- Some specialties routinely or frequently use these

# Participating Organizations

- **American College of Occupational and Environmental Medicine**
- **American Psychological Association**
- **National Institute for Occupational Safety and Health**
- American College of Physicians
- American Physical Medicine & Rehabilitation
- American Academy of Orthopaedic Surgeons
- California Academy of Family Physicians
- American Medical Association – Integrated Health Model Initiative
- American Occupational Therapy Association
- American Physical Therapy Association
- American Association of Occupational Health Nurses
- American Society of Addiction Medicine
- The Joint Commission
- Enterprise Health
- Liberty Mutual Insurance Co.
- Albertsons Companies
- Rising Medical Services\*

\*Unable to join meeting that day

# Why use patient – reported outcome tools for Impairment Evaluation?

- ***Facilitates conversation with patient.***
- ***Enhances communication with all parties.***
- ***Identifies functional deficits.***
- ***Objective and measurable to support decision making and treatment plan.***
- ***Assists in management of patient expectations.***
- ***Assists in determination of end of treatment***





# Why use patient – reported outcome tools for Impairment Evaluation?

- *Provides insight regarding the patient's impression of the condition*
- *Can help identify when various parties disagree regarding the functional deficit*
- *If there are other functional assessments available in the medical record, can assist in explaining the treatment results*



# Specialties Currently Using Function Assessments as Part of Routine Care

- **Occupational Medicine**
- **Physical and rehabilitation medicine**
- **Pediatrics**
- **Geriatrics – maintaining function**
- **Sports Medicine**
- **To some extent**
  - **Cardiology**
  - **Pulmonary medicine**
  - **Oncology**
- **Psychology in many areas**





# Current Efforts

- **Integrated Care Resource Center – Medicare**  
<http://www.integratedcareresourcecenter.com/>
- **Coordinates Medicare and Medicaid offering medical, behavioral health and long-term services – state by state**
- **Value-based Health care: population-based patient outcomes**
  - Patient-centered medical home
  - Improved provider satisfaction
  - Improved health outcomes
- **Colorado's QPOP**
  - Quality Performance and Outcome Payments

# What steps are necessary to accomplish this?

**APA and  
ACOEM**

**We have experience in this area**

We have connections with multiple societies and parties to assess acceptance and cooperation

We have already piloted an assessment of PROMs tools using a treatment framework

# Improving the Functional Tools - Patient Reported Outcome Measures - Used in the Guides

## Step 1

- **Develop suggested criteria for the tools** that would be accepted. Participants from the ACOEM, APA, and IHC (APA's Interdivisional Healthcare Committee) should be able to do this via e-mail and conference call.
- **Have the Guides Panel or its designees review and approve exactly what criteria is to be used** by the experts who will be reviewing the PROMs identified by the plan below.
  - Psychometric experts from the APA and IHC will be assessing reliability and other criteria identified for the tools identified in steps 3-6.
  - A preliminary review of this type was already performed, using slightly different criteria, as we were looking for tools to use during medical practice.

# Improving the Functional Tools - Patient Reported Outcome Measures - Used in the Guides

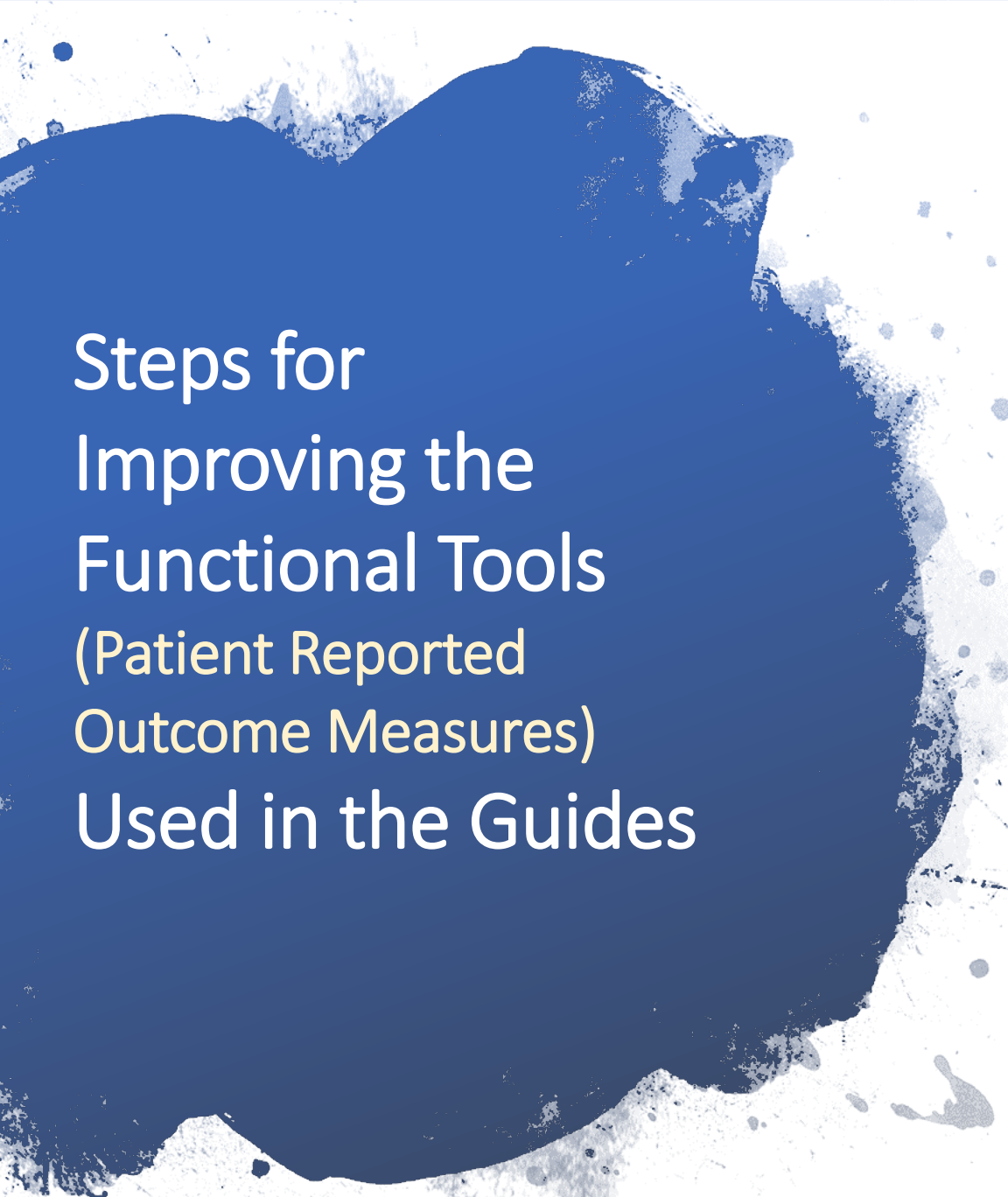
## Step 2

- **List areas that the group wants to address.**
  - For example, the panel choose to focus on shoulder, low back, neck, wrist, elbow, knee, hip, foot, etc.
- **Survey existing clinical registries** and list the measurement tools they use
- **Consider how to structure a librarian led search** to find all related articles
  - There are beginning to be more on the tools themselves and how they interact with each other, but it is unlikely we will find articles that directly address our problem

# Improving the Functional Tools - Patient Reported Outcome Measures - Used in the Guides

## Step 3

- **Collect the highest-level evidence for common procedures** (discectomy, carpal tunnel, ACL repair, hip and knee replacement, etc.) and see **what tools** were used to assess patient- reported outcomes.
  - This can easily be accessed from high quality guidelines that are already published. We would only be reviewing studies that meet the highest grade for quality.
- **Rate the tools identified** using steps 3-6 based on the required criteria specified by the Guides Panel in step 1 & 2



## Steps for Improving the Functional Tools (Patient Reported Outcome Measures) Used in the Guides

Our findings would then be summarized and returned to the Guides group for decision making or resolutions of other issues.

Naturally throughout the process we would be communicating with AMA staff, Mark and Doug about where we were and what they think is needed.

It is more important to know  
what sort of person has a  
disease, than to know what sort  
of disease a person has.

*Hippocrates*







# Suggested Characteristics of an Ideal Function Survey

- **Measures should be focused on the adult population** – approximately 18 and above
  - Some scales may not have been trialed on older individuals if so please just note that in the review.
- **Measures should be short** – preferably 12 questions or less for a one-dimensional scale.
  - IME examiners to use more than a single one-dimensional scale,
  - Alternately examiners could use one longer multidimensional scale such as the Rand/SF 36
- **The survey should have acceptable psychometrics** with regard to:
  - Internal consistency (Cronbach's alpha)
  - Test-retest stability
  - Validity
  - Fairness/absence of bias
  - Patient and community norms

# Suggested Characteristics of an Ideal Function Survey

- **Ceiling and floor effects** (What range of functioning can the measure assess?)
  - “Floor effects” (Items too hard, most get the lowest possible score) or “ceiling effects” (Items too easy, most get the highest possible score) will need to be identified for meaningful assessments
  - Most patients can perform basic ADLs (e.g. feed and dress oneself), measures should assess the midrange of work/home activities that are likely to change with treatment, as these would be most helpful for tracking progress.
- **Instrumental ADLs** (e.g. participation at work or in social settings) would likely to be areas affected in our patients with diagnoses of low back pain, carpal tunnel or other peripheral neuropathies, shoulder and knee injuries, chronic pain etc.
- **Assessment of Impairment vs Functional Ability**
  - On some measures, a high score reflects a high level of ability. On other measures, a high score reflect a high level of disability. To avoid confusion, we should score all measures one way or the other

# Suggested Characteristics of an Ideal Function Survey

- **Activities/conditions to be covered by survey**
  - Measures should be sensitive to important psychological conditions (e.g. depression)
  - Consideration should also be given to how the survey works with chronic pain.
  - Measures should also assess the degree to which a medical condition interferes with:
    - **social and recreational activities,**
    - **other basic activities of daily living**
    - **ability to work and attitude toward work (Many of the surveys we have seen do not treat work as a separate entity but include it in other social activities categories. We may need to accept this combination of factors.)**
    - **instrumental ADLs**
- The tool should be patient reported and preferably have a 4<sup>th</sup> grade reading level but not above a 6<sup>th</sup> grade level. Preferably with a Spanish version
- Survey must be used routinely currently in evidence based literature and ,if possible, reflect current use in other areas such as clinical registries. This should assure some acquaintanceship by examiners with the instrument itself.

## Scale Comparison ODI and SF 36

### Lumbar Disk Herniation and SPORT: A review of the literature Ilyas & Savage, 2019

	2 Year	4 Year	8 Year
Rand SF-36 Physical Function	12.0	14.9	10.6
Rand SF-36 Bodily Pain	10.2	15.0	10.9
Oswestry Disability Index	-13.4	-13.2	-11.3

# ***A Proposed Supplement to the AMA Guides to the Evaluation of Permanent Impairment***

**A Presentation to the AMA Guides Editorial Panel**

**John F. Burton Jr.**

**April 23, 2020**

---

# Action Requested in the Editorial Change Proposal

---

- *Approve change in text as outlined in the proposal and*
- *Approve the proposed supplement in principle, with the understanding that the initial approval to proceed with the proposal does not obligate the Panel to accept the complete Supplement for publication by the American Medical Association.*

*The goals of the proposed Supplement are to*

- *(1) conduct a new wage loss study of injured workers who received PPD benefits in the California workers' compensation program and*
- *(2) use the results of the wage loss study to demonstrate how to convert AMA Guides Whole Person Permanent Impairment (WPI) ratings into Work Disability (WD) ratings.*

# John F. Burton Jr, PhD, LLB

---



- **Professor Emeritus, Rutgers University and Cornell University**
- **Fellow, The American Bar Association College of Workers' Compensation Lawyers**
- **Member, Study Panel on National Data on Workers' Compensation, National Academy of Social Insurance**
- **Former Chairman, National Commission on State Workmen's Compensation Laws, 1971-1972**
- **Author of numerous publications on Workers' Compensation and Employment Policy**



# Conflict of Interest Disclosure

---

- John Burton's professional interests are indicated in his resume (Appendix C of the proposed Supplement to the AMA Guides).
- Dr. Burton has held preliminary discussions with the RAND Institute about the preparation of the proposed Supplement.
- He plans to work with the National Academy of Social Insurance to establish relations with organizations involved in workers' compensation if the proposal is endorsed by the AMA Guides Editorial Panel.

# What Will the Proposed *Supplement* Not Do?

---

- Physicians would use the existing methodology in the *AMA Guides* to produce Permanent Impairment (PI) ratings for damage to the arm or to other body systems.
  - **The proposed *Supplement* does not advocate any changes to that methodology or to the PI ratings that are the outcome of the current methodology.**
- After AMA Guides PI ratings are determined, the procedure in the proposed Supplement still does not begin. The Sixth Edition of the *AMA Guides* has approximately 75 Equivalent Values for converting PI ratings for body systems into Whole Person Impairment (WPI) ratings. For example, a PI rating of 100 percent for the upper extremity is equivalent to 40 percent of a whole person. This conversion of PI ratings into WPI ratings means an arm has an Equivalent Value of 40 percent in the *AMA Guides*.
  - **The proposed *Supplement* does not suggest any changes in the Equivalent Values of the 75 body systems for which PI ratings are converted into WPI ratings by the *AMA Guides*.**

# What Will the Proposed *Supplement* Do?

---

- The proposed *Supplement* will review the history and theory of workers' compensation cash benefits and assert that the primary (and arguably the sole) purpose of the benefits is to compensate for Work Disability (WD), which is measured by actual loss of wages or by loss of earning capacity.
- The WPI ratings as determined by the *AMA Guides* will not be altered by the proposed *Supplement*.
  - Rather the *Supplement* will explain how WPI ratings can be converted into WD ratings by using evidence from wage loss studies on the actual loss of wages caused by workplace injuries.
- The only content of the *AMA Guides* that needs to be changed to accommodate the proposed *Supplement* is on pages 5-6 of the Sixth Edition. As spelled out in the *Guides Editorial Change Proposal*, one paragraph would be deleted and three paragraphs would be substituted.
  - The new paragraphs briefly summarize the purpose of wage loss studies and the use of the data on actual wage loss to construct adjustment factors that can convert impairment ratings into disability ratings. The final paragraph indicates that some workers' compensation programs may decide to continue to rely on the PI ratings in the *AMA Guides* as the basis for their permanent partial disability (PPD) benefits, while other states may decide on the adjustment factors in the proposed *Supplement* to convert impairment ratings into disability ratings.

# Why Should Work Disability Ratings Be Constructed?

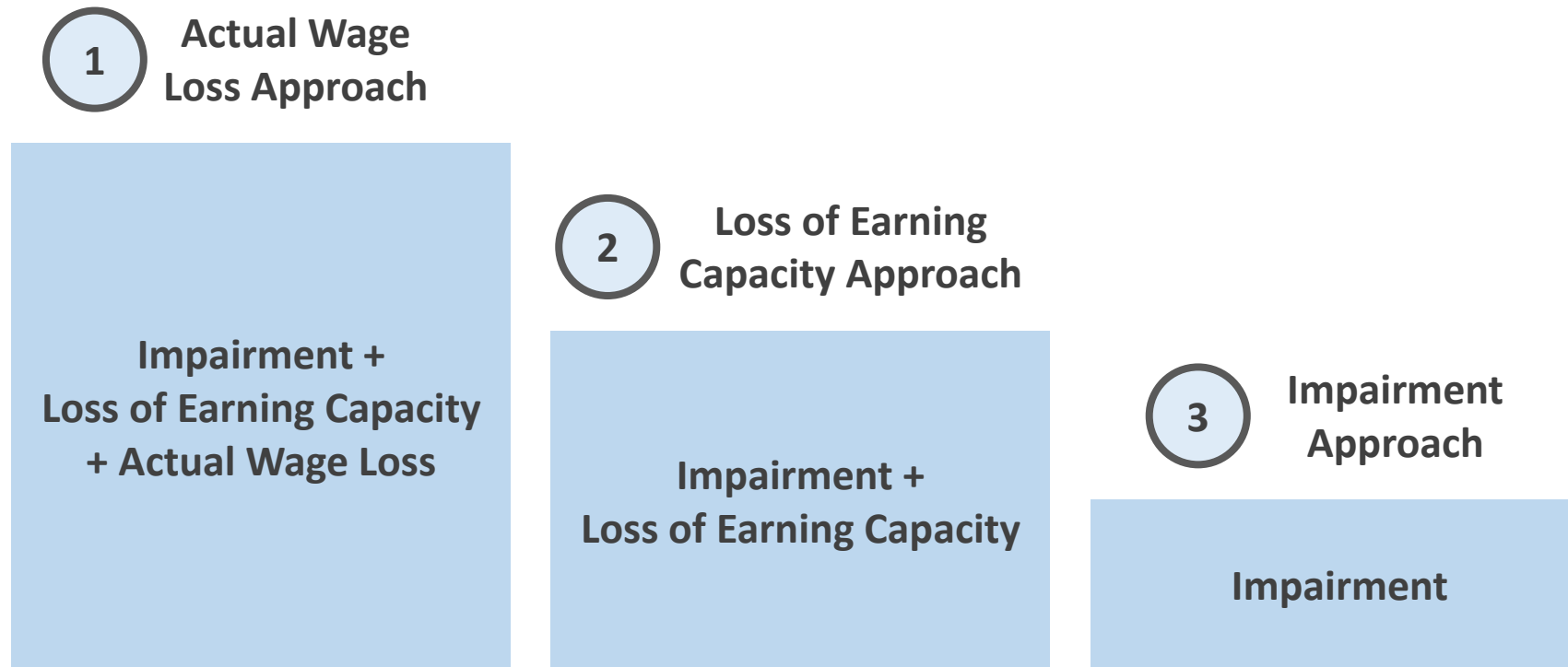
---

- **A conceptual Framework for the analysis is provided in Section I.A. of the proposed *Supplement*. The analysis distinguishes between:**
  - **the purpose of cash benefits in workers' compensation programs.**
    - Why are the benefits being paid?
      - Because of the impairment?
      - Because of work disability (loss of earning capacity or actual loss of earnings)?
  - **the operational approaches to cash benefits in workers' compensation.**
    - For which of the consequences of workplace injuries does the claimant need to provide evidence in order to qualify for benefits?
- **The three operational approaches are shown in Figure 1 on the next slide.**
  1. Actual Wage Loss
  2. Loss of Earning Capacity
  3. Impairment
- **Distinguishing between the purpose and the operational approaches for the various types of cash benefits provided by workers' compensation program is a challenge.**

# Figure 1

---

## Three Basic Operational Approaches to Cash Benefits in Workers' Compensation



# Cash Benefits in the Temporary Disability Period

---

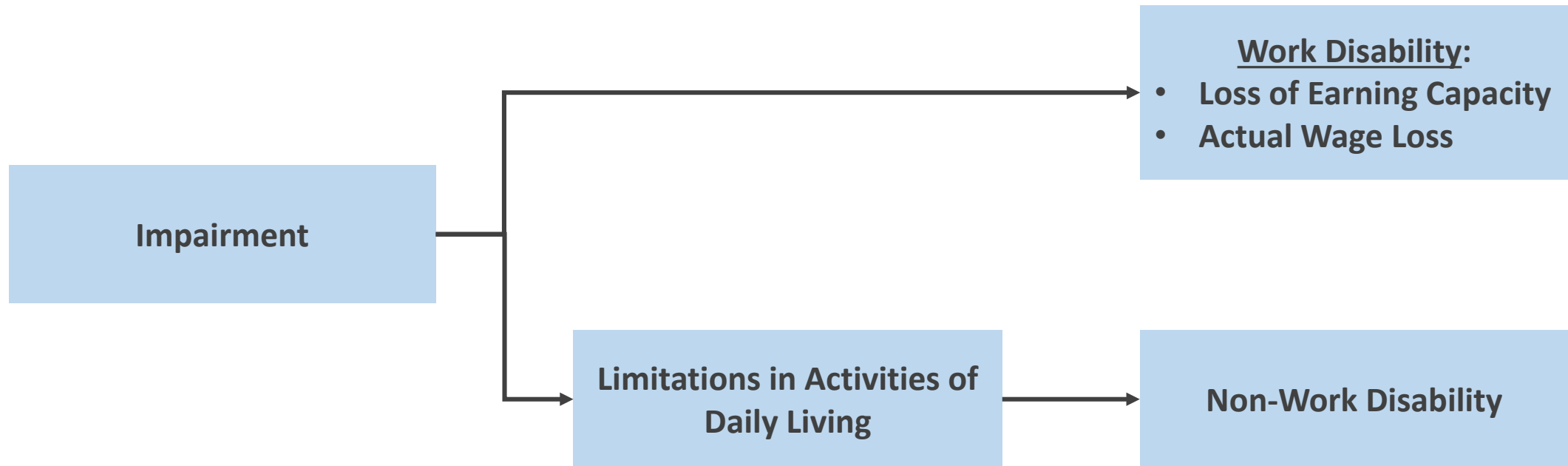
The temporary disability period is the period between the date of injury and the date of maximum medical improvement.

- **Temporary total disability (TTD) benefits**, paid to workers who are unable to work because of their workplace injury during the temporary disability period, are the most frequent type of workers' compensation benefit, accounting for 61.5 percent of all cases with cash benefits.
- TTD benefits are based on the actual wage loss approach since they are only paid for weeks in which the worker has no earnings. The purpose of TTD benefits is "obvious," namely to compensate the worker for actual loss of wages.
- In this case, the operational approach – the actual wage loss approach – and the purpose of the benefits – to replace actual loss of earnings -- coincide.

## Figure 2

---

### The Permanent Consequences of and Injury or Disease





# Cash Benefits in the Permanent Disability Period: Part One

---

The permanent disability period begins on the date of maximum medical improvement for those workers with permanent consequences of their injuries.

- **Permanent Partial Disability (PPD) benefits** are the most expensive type of cash benefits, accounting for 55.4 percent of the dollars spent on cash benefits.
- **The three operational approaches are used in some states for some types of PPD Benefits.**
  - The actual wage loss operational approach is used in a few jurisdictions. In New York, for example, §15.3.v of the workers' compensation law provides additional PPD benefits based on the actual wage loss approach for serious injuries to the arm, leg, hand, or foot if the worker has actual loss of wages after the duration of the PPD benefits specified in the law expires.
    - The congruence between the purpose (compensate for work disability) and the actual wage loss operational approach for the §15.3. v PPD benefits is apparent.

# Cash Benefits in the Permanent Disability Period: Part Two

---

The loss of earning capacity operational approach is used in many states for at least some types of PPD benefits.

- Iowa is an example of a state that bases the duration of PPD benefits for injuries not included in the schedule of injuries included in the statute (unscheduled injuries) on the extent of the worker's loss of earning capacity, as determined by the workers' compensation agency or courts based on the salient facts in the case, such as the worker's age, occupation, and nature and severity of the worker's injury.
- California is the only state that determines the duration of all PPD benefits on a formula, which begins with the WPI ratings from the *AMA Guides* and adjusts the WPI ratings for the worker's age and occupation to produce an estimate of the Loss of Earning Capacity.
- The congruence between the purpose (compensate for work disability) and the loss of earning capacity operational approach is evident.

# Cash Benefits in the Permanent Disability Period: Part Three

---

**The permanent impairment operational approach is used in most states to determine the duration of PPD benefits.**

- New Jersey is a typical state. The statute lists fifteen body parts with a corresponding duration of PPD benefits for each entry. For example, total loss of use of the arm is entitled to 330 weeks of PPD benefits. Partial loss of the body part is entitled to a proportion of the total loss of use of the body part. Thus, 30 percent loss of use of the arm is entitled to 99 weeks of PPD benefits.
  - The scheduled injuries in New Jersey and most other states clearly rely on the permanent impairment operational approach to determine the duration of PPD benefits.
- But is the purpose of the New Jersey workers' compensation statute to compensate for the workers' permanent impairment or for the workers' work disability? I argue in the proposed *Supplement* that the purpose of the New Jersey statute is to compensate for work disability. Consider this history:
  - Ten states adopted their first workers' compensation laws in 1911. Eight of these states relied on the actual wage loss operational approach to determine the duration of both temporary and permanent disability benefits. Only New Jersey adopted the permanent impairment operational approach for permanent partial disability (PPD) benefits. However, the evidence indicates that the Garden State adopted this approach not because it disagreed with the purpose of PPD benefits – to compensate for work disability – but because the permanent impairment operational approach was much easier to administer for state agencies, insurance carriers, and self-insuring employers.

# The Significance for the *AMA Guides*

---

## The Significance for the *AMA Guides* of the Distinction Between the Purpose and the Operational Approaches for Permanent Partial Disability (PPD) Benefits

- For all types of PPD benefits, the purpose is to compensate for work disability. However, the operational approaches used to achieve the purpose vary among the types of PPD benefits.
- In the 40 plus states that have adopted the *AMA Guides*, the *Guides* play a major role in determining the durations and amounts of PPD benefits. Since the PI and WPI ratings measure the extent of workers' impairments, there is a potential problem since the purpose of the PPD benefits is to compensation for work disability.
  - This leads to a fundamental question: do the WPPI ratings do a good job in predicting the extent of work disability? Wage loss studies provide evidence that help answer that questions

# The Methodology of Wage Loss Studies

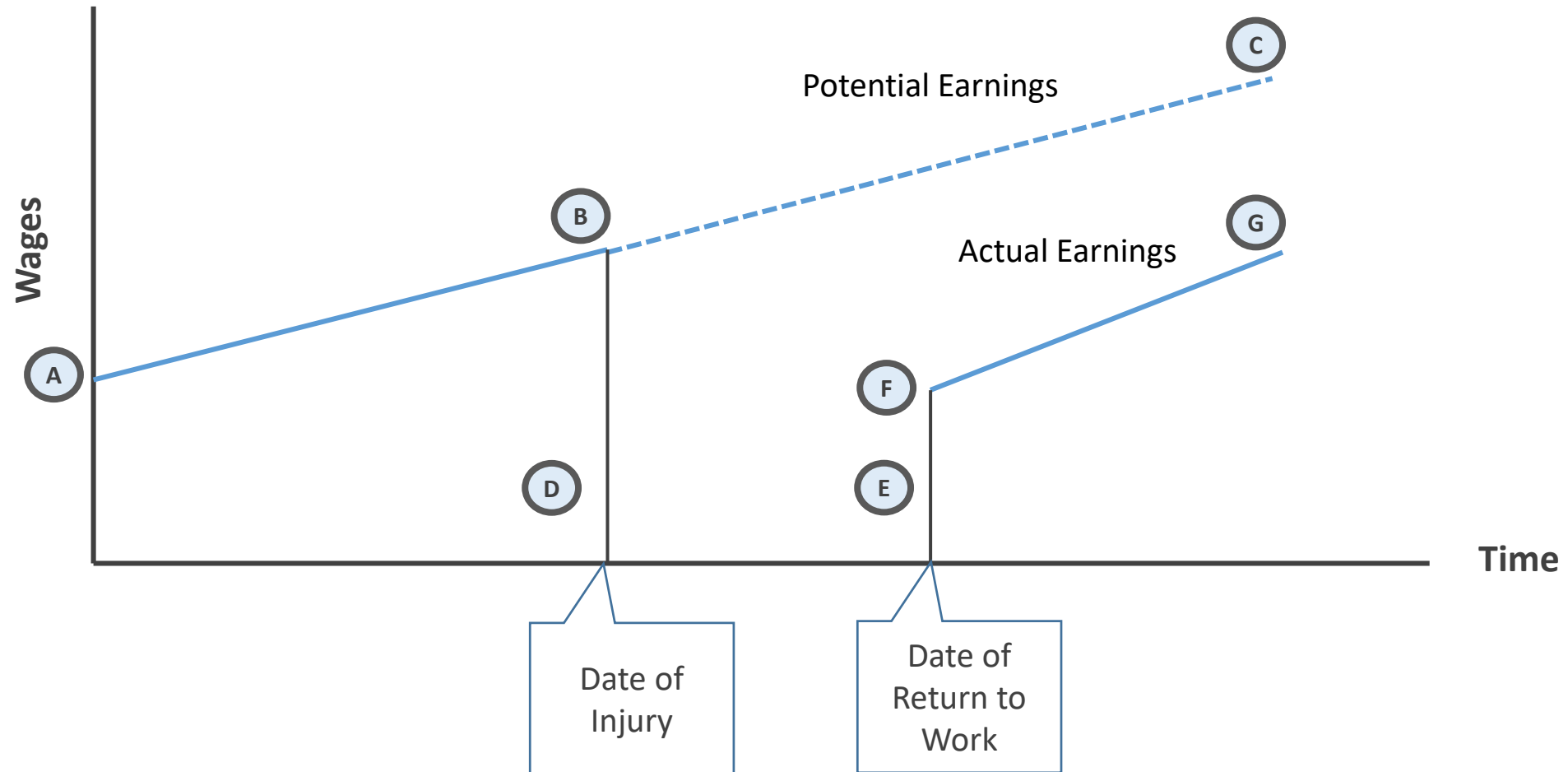
---

The methodology for measuring actual wage losses for workers who received PPD benefits can be explained by referring to Figure 3

- The actual earnings of each worker in the study measured for several years before the worker received a work-related injury are shown as the line **AB**.
- These preinjury actual wages of the injured worker are used to identify a control group of workers who were not injured and who had earnings during **AB** that were similar to the actual earnings of the injured worker.
- After the Date of Injury, the wages of the workers in the control group increase from **B** to **C** and provide an estimate of the Potential Earnings after the date of injury for the worker who was injured.
- The Actual Wages of the injured worker drop at the date of Injury from **B** to **D** and remain at a zero level of earnings until the Date of Return to Work, when the Actual Wages increase from **E** to **F**. Thereafter, the injured actual earnings increase from **F** to **G**, but these post-injury earnings remain below the worker's Potential Earnings.
- The loss of actual wages because of the worker's injury are measured by (1) the worker's Potential Earnings under **BC** (2) minus the worker's Actual Earnings after the injury **EFG**.

# Figure 3

## Actual Losses of Earnings for a Worker with a Permanent Disability



# The Results of Wage Loss Studies

---

The results of two wage loss studies are discussed in Sections I.B. and I.C. of the proposed *Supplement* and the complete results of these studies are included in the Supplemental Literature distributed for the April 23 meeting of the *AMA Guides* Editorial Panel. Here are selected examples of the findings.

- **The Wisconsin Wage Loss Study.** The sample included 1,685 workers who were injured in 1968 and who received PPD benefits from the Wisconsin workers' compensation programs. One important finding involved a variant of horizontal equity:
  - ***Inter-Injury Horizontal equity for Ratings*** requires that the actual wage losses for workers with the same disability (or impairment) ratings but different types of injuries should be the same or similar. However, in Wisconsin there were significant differences among types of injuries in the relationship between disability ratings and lost earnings. For example, for workers with disability ratings of 11 to 15 percent, earnings losses ranged from 31.7 percent for lower extremities to 12.8 percent for upper extremities.
- **The California Wage Loss Study.** The study, published in 2013, was based on a sample of 21,663 workers who received PPD benefits and WPI ratings between 2005 and 2008 using the Fifth Edition of the *AMA Guides*.
  - ***Inter-Injury Horizontal equity for Ratings.*** The authors "found systematic differences across body regions in the associations between impairment ratings and earnings losses. For example, holding the impairment at the average sample average, spine impairments were associated with 22% higher earnings losses than knee impairments."



# A New Wage Loss Study of Injured California Workers

---

The Proposed *Supplement to the AMA Guides to the Evaluation of Permanent Impairments* includes new research consisting of two components, of which the first is:

- Validation and extension of the findings of the 2013 wage loss study of injured California workers based on a new wage loss study.

**Section II.A of the proposed *Supplement* identifies several issues that need to be resolved in designing the new wage loss study:**

- Which State will be included in the study? The obvious answer is California because it is the only state that relies on the WPI ratings based on the *AMA Guides* as part of the rating for all workers who receive PPD benefits
- Which years will be included in the study? The sample will include workers injured for some or all the years between 2007 and 2016 depending on the availability of data and the need for a large enough sample to produce robust statistical results.
- Which body systems will receive special considerations? There are approximately 75 body systems for which the *AMA Guides* provides Equivalent Values for converting PI ratings of 100 for the body system into the equivalent Whole Person Impairment (WPI) ratings. The decision on how many of these 75 body systems will be treated as separate categories for the statistical analysis depends on advice from the medical profession as well as the number of observations for each of the body systems represented in the sample of injured workers.

# Using the Results of the New Wage Loss Study

---

## Using the Results of the New Wage Loss Study of injured California Workers to Prepare Factors to Convert Whole Person Impairment (WPI) Ratings into Work Disability (WD) Ratings

The second component of the new research included in The Proposed *Supplement to the AMA Guides to the Evaluation of Permanent Impairments* is:

- If the new study of injured California workers finds equity problems when WPI ratings are compared to actual wage loss, the *Supplement* will suggest a procedure that can convert the whole person impairment (WPI) ratings into work disability (WD) ratings that are more closely related to the extent of actual wage loss.

## Section II.B of the proposed *Supplement* identifies several issues that need to be resolved in designing a procedure to convert WPI ratings into WD ratings:

- How complicated should the Conversion Factors be for a body system with a significant disparity between the WPI ratings and the extent of actual wage loss? For example, should the conversion factor for a body system be a constant increase (or decrease) for all levels of WPI ratings?
- Can the Conversion Factors based on a wage loss study of California, which relies on the Fifth Edition of the *AMA Guides*, be used for other editions of the *Guides*? One study concluded there was a 36 percent reduction in impairment ratings between the Fifth and Sixth Editions. Another study found that WPI ratings dropped by about 25 percent in Tennessee and by about 32 percent in New Mexico. The sources of the apparent discontinuity between the Fifth and Sixth editions will be examined

# Implementation of the Proposal to Prepare a *Supplement*

---

## Implementation of the Proposal to Prepare a *Supplement to the AMA Guides* that will Convert Whole Person Impairment (WPI) Ratings into Work Disability (WD) Ratings

Part III of the Proposal contains a seven-step implementation plan for the proposed *Supplement to the AMA Guides*

- Step One:** Endorsement of the Proposal by the AMA Guides Editorial Panel. The Panel is asked to endorse the proposed *Supplement* in principle, with the understanding that the initial approval to proceed with the proposal does not obligate the Panel to accept the completed *Supplement* for publication by the AMA.
- Step Two:** Negotiate an Agreement with the RAND Corporation to Prepare the *Supplement*.
- Step Three:** Establish a Research Team at RAND to Prepare the *Supplement*.
- Step Four:** Obtain Financing for the Preparation of the *Supplement*.
- Step Five:** Obtain Support of Organizations Involved in Workers' Compensation for the Preparation of the *Supplement*.
- Step Six:** Conduct Research and Prepare the *Supplement to the AMA Guides to the Evaluation of Permanent Impairment*.
- Step Seven:** Obtain Approval of the *Supplement* from the AMA Guides Editorial Panel.

# A Recapitulation of this Presentation: Part One

---

**The Proposed *Supplement to the AMA Guides to the Evaluation of Permanent Impairments* includes new research consisting of two components:**

- Validation and extension of the findings of the 2013 wage loss study of injured California workers based on a new wage loss study.
- If the new study of injured California workers finds equity problems when WPI ratings are compared to actual wage loss, the Supplement will suggest a procedure that can convert the whole person impairment (WPI) ratings into work disability (WD) ratings that are more closely related to the extent of actual wage loss.

**The Relationship of the Proposed Supplement to the Methodology and Ratings of the *AMA Guides***

- The Supplement does not advocate any changes to the methodology or to the PI ratings that are the outcome of the current methodology.
- The proposed Supplement also does not suggest any changes in the Equivalent Values of the 75 body systems for which PI ratings are converted into WPI ratings by the *AMA Guides*.

# A Recapitulation of this Presentation: Part Two

---

## The Options for States or other Jurisdictions using the *AMA Guides*

- Some states may decide to base their PPD benefits primarily or solely on the extent of the worker's permanent impairment, as measured by the WPI ratings. These states can ignore the *Supplement*.
- Other states may decide to base their PPD benefits primarily or solely on the extent of the worker's work disability, as measured by the WD ratings. These states will need to use the *AMA Guides* to produce WPI ratings and the *Supplement* to convert the WPI ratings into WD ratings. The benefit of this option is that states can more closely relate their PPD benefits to the actual loss of earnings associated with particular types and severities of impairments.

# Thank You

## Q&A

# Public Meeting Closing

- Thank you to today's presenters. This now concludes the public meeting.
- The next public Editorial Panel Meeting will be held virtually on **May 14<sup>th</sup> at 6:00 pm CT.**
- Panel members will reconvene at 12:15 pm CT for the executive session. A new meeting link will be sent momentarily.
- Thank you all for joining us today!





**Physicians' powerful ally in patient care**