How Has The New Law Changed The AME & QME Landscape ?

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The recently published RAND study of permanent disability highlighted the historical problem with having adversary medico-legal evaluations. Physicians evaluating as AME's or IME's were used as a "control" group for the "correct" permanent disability ratings. Those ratings were compared with applicant's QME's and defendants' QME's in the same cases. What they found was not surprising to most of us in the system. The biggest discrepancies between the AME/IME reports and the QME reports exist in Southern California and Coastal California, where the AME/IME reports were much more likely to be closer to the defendant's QME than the applicant's QME.

Why is this true? Because defendants and their representatives have historically gravitated toward physicians who are more likely to rely on consistently reproducible, anatomically valid, objectively verifiable mainstream medical analysis, while applicants and their representatives have historically gravitated toward physicians who are more likely to accept the patient's subjective complaints regardless of the absence objective findings. The difference is the physicians who said "Prove it to me" vs. the physicians who said "I believe you."

The old medico-legal system relied upon the primary treating physician's presumption of correctness. Since applicants gravitated to the "I believe you" doctors who were presumed correct and who would rate subjectives irrespective of objectives, treatment utilization and disability ratings soared. The presumption of correctness made it virtually impossible to rebut the treating physician, who was often chosen by the applicant's attorney based on philosophical acceptance of the "I believe you" and "subjectives are enough" approach, rather than for acumen as a treater. Also, applicant's attorneys don't make any money if their client is cured, and the applicant doesn't get paid

if he is cured. So there was a clear built-in financial disincentive to get better. Further, there were no constraints on treatment, so medical care costs skyrocketed, while disability evaluations produced large ratings based on prophylactic work restrictions premised upon subjective complaints. Employees were awarded prophylactic disabilities even of they continued to do work activities clearly inconsistent with the described disability.

How did this come to pass? Because there was no uniform standard setting out the criteria for medical necessity of treatment, and no uniform standard for assessing permanent disability ratings. Subjectivity of the patient and subjectivity by the physician became the rule. When a dispute arose, the employee designated primary treating physician, or the applicant's QME, generally prevailed in litigation, as WCAB Judges routinely followed their conclusions as the basis for awarding both treatment and disabilities. Although there was some use of AME's, they were often limited to cases where the advocacy reports by the primary treating physician or applicant's QME were clearly defective. Otherwise, the applicant's attorney had no reason to use an AME … he was better off with an adversarial report with a presumption of correctness.

The AME landscape has changed with laws which have come into effect in 2004. We'll be going into the details of what this means in subsequent panels. Forget everything you thought you knew about workers compensation as it existed prior to 1/1/04. Keep in mind that the system has changed and refocused itself to having physicians making medical decisions based on mandatory medically based criteria which is contained within treatment guidelines (ACOEM) and disability evaluation guidelines (AMA). For now, let me tell you the "down and dirty" about what has changed.

1. The ACOEM guidelines are presumptively correct on treatment issues. For those things not covered by ACOEM, or in rebuttal to ACOEM, other evidence based peer reviewed nationally recognized treatment guidelines are admissible into evidence. Once the AD adopts treatment guidelines, those will become presumptively correct. At the moment, because of a RAND critique of guidelines, it looks like ACOEM guidelines may be adopted by the AD, and for orthopedic surgery AAOS surgery guidelines may be adopted. "In my experience" no longer passes muster. Treatments with a scientifically proven efficacy will prevail.
2. Where treatment is provided by an employer/insurer medical provider network established as of 1/1/05, and the patent disagrees with the treating physician's recommendations, there is an in-network second-opinion process, an in-network third-opinion process, and if the patient still disagrees, then the AD has an Independent Medical Review by a single physician whose opinions are supposed to be based on the mandatory treatment guidelines. **The IMR evaluation is in essence a form of AME** whose responsibility is to safeguard the integrity of the system by enforcing its rules … not slanting the opinions based personal philosophical bias or on who made the referral.
3. Where utilization review denies or disputes a primary treating physician's recommendations regarding spinal surgery, there is an expedited "Second Opinion Spinal Surgery" process using the AD's designated list of Board Certified orthopedic surgeons and neurosurgeons. That **second opinion spinal surgery evaluaton is in essence another form of AME** whose responsibility is to

safeguard the integrity of the system by enforcing its rules … not slanting the opinions based personal philosophical bias or on who made the referral.

4. Where utilization review denies or disputes a primary treating physician's recommendations regarding treatment other than spinal surgery, the employee can both appeal administratively within the UR system and trigger the formal WCAB dispute resolution system. The new law does away with adversarial QME's for *represented* workers, and instead allows the parties to choose an AME. If they can't, then the DWC Medical Unit issues a three-member panel of QME's and the parties can select an AME off the three member panel. If they still can't agree, then each side gets to strike one panel member, and the **remaining physician is the de facto AME** whose responsibility is to safeguard the integrity of the system by enforcing its rules … not slanting the opinions based personal philosophical bias or on who made the referral. The *unrepresented* worker dispute resolution process prohibits the use of an AME, but instead uses a panel QME process. Since no opposing QME can be obtained, that **panel QME physician is a de facto AME** whose responsibility is to safeguard the integrity of the system by enforcing its rules … not slanting the opinions based personal philosophical bias or on who made the referral.

5. For represented claimants with injuries with permanent disability *prior* to adoption of the new PD schedule under the AMA guides (likely 1/1/05), those cases will be rated under the old PD guidelines … not the AMA guides. **The old AME/QME process will apply** and the evaluators nonetheless required to use the AMA guides as well.

6. For all injuries with permanent disability *subsequent* to the adoption of the new PD schedule under the AMA guides (likely 1/1/05), and for all dates of injury on/after 1/1/05, the new AME or Panel QME/AME process will apply. The **physician is a de facto AME** whose responsibility is to safeguard the integrity of the system by enforcing its rules … not slanting the opinions based personal philosophical bias or on who made the referral.

In addition to the increased use of AME's to resolve medically related issues, there is a need to address new and difficult legal issues, most notably the new standard for apportionment as it relates to permanent disability. Prior to the enactment of SB899, the law regarding apportionment of permanent disability required that there be a preexisting ratable permanent disability, ratable permanent disability from the natural progression of an underlying disease process, or ratable disability from a subsequently occurring injury. With the enactment of SB899, and specifically new Labor Code Sections 4663 and 4664, the law has changed.

All of us have been receiving a lot of letters telling us what the new law means and how attorneys and physician should be applying it. Since there is no judicial or regulatory interpretation of the new law, nobody knows for sure what it means or how the appellate courts will interpret it. Even the WCAB hasn't figured it out, as evidenced by last week's written solicitation to the community at large to submit answers and analysis on the new apportionment issue. So, at this stage, it would be disingenuous at best for anyone to tell you they know for sure what the new law

means. *What we can do is ask that physicians address certain questions, and then leave it up to the lawyers and the courts to decide what to do with the answers.*

To acquaint you with the new apportionment law, contained within SB899 which enacted new Labor Code Sections 4663 and 4664, I will quote it verbatim below (my emphasis in bold and underlining):

Labor Code Section 4663. (a) **Apportionment of permanent disability shall be based on causation**. (b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability. (c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. **A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury**, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination. (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code Section 4664. (a) **The employer shall only be liable for the percentage of permanent disability directly caused by the injury** arising out of and occurring in the course of employment. (b) **If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury**. This presumption is a presumption affecting the burden of proof. (c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following: (A) Hearing. (B) Vision. (C) Mental and behavioral disorders. (D) The spine. (E) The upper extremities, including the shoulders. (F) The lower extremities, including the hip joints. (G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive. (2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

From these two statutes, it is apparent that the legislature has compelled us to embrace some new principles as they relate to apportionment of permanent disability:

1. Apportionment of permanent disability shall be based on causation (Perhaps this eliminates the old rule which limited apportionment to cases of preexisting disability. Perhaps not. Whereas a physician formerly could only apportion to preexisting actual disability, the law now requires the physician to address apportionment of disability to causation. It no longer looks to whether the preexisting or subsequently occurring conditions were disabling independently). This brings into consideration the potential contributing causation of underlying preexisting conditions and their potential role in making the injury more severe, treatment more prolonged and difficult, cure less likely, and residual impairment greater than would have existed without the underlying condition. *For years, applicants' doctors have justified the prophylactic work restrictions by referring to the pathology on CT/MRI/films, etc. If that was a valid basis to recommend a higher PD rating before, it should still remain a valid basis to recommend apportionment of the PD now.*
2. A physician is required to make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury (This eliminates the old rule disfavoring apportionment based on percentages). *Physicians who try to circumvent this statute by describing it as "speculation" will soon be stricken from the AME roles. Word travels rapidly within our small community. Do the best you can to answer the questions, and explain your medical decision-making process used to arrive at the*

conclusion. Leave it up to the Judge to decide whether the conclusions pass legal scrutiny.

3. The employer shall only be liable for the percentage of permanent disability directly caused by the injury (This eliminates the old rule disallowing apportionment to concurrent contributing causes). *Analyze how conditions not directly caused by the injury contribute to the formulation of the permanent impairment, and explain your medical decisoin-making process used to arrive at the conclusion.*
4. Any prior permanent disability award is conclusively presumed to continue to exist at the time of the later industrial injury. (This produces a mandatory subtraction of prior disability awards.) This isn't a medical issue, but rather a purely legal one. However, if the prior award of permanent disability was made under the old PD system, and the current case is rated under the AMA Guides, the proposed regulations indicate that you should use "apportionment to causation." My own recommendation for physicians would be to rate the current case under BOTH the AMA Guides and the old PD rating system. That makes the apportionment of disability to causation simple.
    a. (old PD rating) – (current injury rated under old system) = apportionment
    b. Result in (a) multiplied by new AMA rating = PD to new injury

With these legislative changes in mind, defendants will have to revisit how we develop the evidence on the issue of apportionment … by way of deposition, investigation, records acquisition and supplemental medical report. Our depositions will now need to inquire more broadly into a host of underlying and concurrent

medical and pathological conditions which could impact the resulting disability factors under the AMA guides; identify prior employers to allow checking of personnel files for medical conditions, work impairments and absenteeism; delve into group health systems to identify potentially relevant medical conditions which could indirectly impact the disability factors by way of overlapping or duplication of factors of ratable impairment under AMA. Investigation will need to be more aggressive in identifying and obtaining this newly relevant documentation. Records acquisition will increase to include group medical records, primary care physician records, laboratory studies, radiology reports, and personal health information, prior industrial and nonindustrial injuries, thus mandating a broader inquiry into nonindustrial factors which may more indirectly impact the resulting disability. Medical reports will be targeted to these other conditions, with epidemilogic data coming into play on the issue of indirect causation, and analyzing concurrent contributing causes impacting the ultimate disability. Increased frequency of medical depositions is also anticipated as we attempt to establish our various contentions through expert medical opinion.

Specifically, we will need the physician's best medical judgment on the new issue regarding the **apportionment to *causation* of permanent residual disability**. Physicians will be asked to discuss apportionment to causation of permanent disability in detail, and address the following questions.

a. What approximate percentage, if any, of his orthopedic **permanent disability** is **directly caused** by the industrial orthopedic injury? . If applicable, please assign a

percentage of causation of the disability to this industrial injury, and discuss in detail your reasons for your conclusions on this issue.

b. What approximate percentage, if any, of the orthopedic **permanent disability** is not directly caused by the industrial injury, but instead is **caused by other factors both before and subsequent to the industrial injury**? If applicable, please assign a percentage of causation of the disability to such factors as

(1) the preexisting lumbar disc herniations,

(2) underlying pathological condition of his spine, upper and lower extremities, and

(3) the role of subsequent "cumulative trauma" in causing further symptom progression and disability, and discuss in detail your reasons for your conclusions on this issue.

(4) Any subsequently developing conditions or injuries

c. What approximate percentage, if any, of his orthopedic **permanent disability** is caused by non-orthopedic factors (i.e., psychiatric issues) ? If applicable, please assign a percentage of causation of the orthopedic disability to this factor, and discuss in detail your reasons for your conclusions on this issue. To the extent that his subjective complaints may be increased or otherwise influenced by psychiatric issues, care should be taken to distinguish orthopedic complaints/disability from psychiatric/chronic pain/depression so that his subjective complaints are not included within both ratings and thus duplicated.

The combination of the causation percentages of (a), (b)(1), (b)(2), (b)3, (b)4 and (c) should equal 100% of causation.

(a) % causation of disability directly by industrial injury ..... ____ %

(b) (1) % causation of disability by preexisting herniations .... ____ %

(b) (2) % causation of disability by other underlying pathology ..... ____ %

(b)(3) % causation of disability by subsequent cumulative trauma ..... ____ %

(b)(4) % causation of disability by subsequent injuries ..... ____ %

(c) % causation of disability by psychiatric factors ..... ____ %

Causation Total 100%

In analyzing apportionment of disability to causation *preexisting* the industrial injury, logic suggests that the physician should consider the underlying well documented preexisting pathology and its potential role in making the initial injury more severe, making treatment more prolonged and difficult, making cure less likely, and thus contributing to the residual impairment (i.e., permanent disability) being greater than would likely have existed without the underlying condition(s).

In analyzing apportionment of disability to causation of events *subsequent* to the industrial injury, logic suggests that the physician similarly should consider the extent to which the subsequent events (i.e., return to work, work duties, increased symptoms, subsequent lost time, subsequent medical treatment, nonindustrial injuries, car/bicycle/motorcycle/pedestrian accidents, etc. etc.) contributed to greater or more

difficult medical treatment, further making the treatment less curative, and thus contributing to the ultimate residual impairment (i.e., permanent disability) being greater than what would likely have existed without the subsequent events.