

**THE TEXAS WORKERS' COMPENSATION
IMPAIRMENT RATING SYSTEM:
VARIATIONS AND FEATURES**

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Executive Summary

A primary goal of the Texas Workers' Compensation Act of 1989 (Senate Bill 1) was to deliver fair compensation to injured workers while minimizing lengthy and costly litigation. An important component of that goal is the impairment rating process, which determines the duration of income benefits paid to injured workers with physical impairments. In 1999, the Research and Oversight Council on Workers' Compensation (ROC) published the findings of a preliminary study of the impairment rating process in Texas. This study examined the prevalence of multiple impairment ratings for the same injury, disparities in multiple impairment ratings, and the length of time between the first and last rating given to injured workers. Findings concluded that most workers (80.5 percent) received one impairment rating and the number of multiple ratings has been declining during recent years. This follow up study expands the scope of the previous study by examining other aspects of inconsistencies in impairment ratings and their impact on disputes; by conducting a multi-state study of impairment evaluations and relevant system features; and by proposing options for improving the system in Texas. The objective of this study is to answer four questions as they relate to the goals of the 1989 Act:

1. To what extent do variations and inconsistencies characterize impairment rating outcomes in Texas?
2. What is the impact of inconsistent impairment ratings on the rate of disputes in the Texas workers' compensation system?
3. What are the costs of inconsistencies in impairment ratings and disputes that result?
4. How do other states, similar and dissimilar to Texas, manage their impairment rating processes, and how adaptable to Texas are the successful system features?

Key findings on physicians, diagnoses, and treatments:

- Medical Doctors (M.D.s) performed 81 percent of all impairment ratings.
- Chiropractors (D.C.s) performed 8.5 percent of all impairment ratings.

- The top three most common diagnoses made of injured workers issued impairment ratings are:
 1. Lumbar Disc Displacement
 2. Lumbago (i.e., back pain)
 3. Carpal Tunnel Syndrome

Key findings on variations in impairment ratings:

- 17 percent of workers with Carpal Tunnel Syndrome, who received impairment ratings from Medical Doctors (M.D.) in the Fort Worth area, were assigned an average rating of 10 percent or higher. Twice this percentage (34 percent) of workers with the same diagnosis received an average rating of 10 percent or higher when the rating was assigned by an M.D. in the Houston area.
- A larger percentage of workers (65 percent) diagnosed with Lumbago (i.e., back pain) received an average rating of 10 percent or higher in the Beaumont area than injured workers with the same diagnosis in the Houston area (45 percent).
- M.D.s in El Paso assigned an average impairment rating of 10 percent or higher for almost half (47 percent) of the workers diagnosed in 1995 with a tear of medial cartilage. While in 1996, only 21 percent of workers diagnosed with the same injury in El Paso received an average impairment rating of over 10 percent.
- Doctors assigning impairment ratings in Texas tend to cluster their calculations, especially around intervals of 5s and 10s

Key findings on disputes over impairment ratings:

- Dallas leads the state in impairment-related disputes, with its share of these disputes increasing from 13 percent in 1995 to 16 percent in 1997.

- If a Chiropractor assigns the first impairment rating for an injured worker, there is a 54 percent chance it will be disputed; however, if an M.D. assigns the first rating, there is a 34 percent chance of a dispute.
- The higher the impairment rating, the higher the percentage of disputes associated with those ratings.
- Impairment rating examinations performed by designated doctors for disputed ratings averaged \$7 million per year between 1995 and 1997.
- Injured workers initiated 64 percent of the impairment rating disputes, while 26 percent were initiated by insurance carriers and 10 percent by “other” (primarily doctors and employers).
- Most workers (53 percent) involved in disputes over an impairment rating or maximum medical improvement (MMI) date at the Benefit Review Conference level in 1999 were assisted by an ombudsman from the Texas Workers’ Compensation Commission (TWCC).

Key findings on multiple impairment ratings:

- The Waco area had the lowest percentage of workers with multiple impairment ratings at 13 percent for the 1995 – 1997 period, while the El Paso area had the highest percentage of workers with multiple ratings (23 percent).
- The higher the initial impairment rating, the higher the percentage of multiple impairment ratings assigned to the worker. For 1995 injuries, the occurrence of workers with multiple impairment ratings ranged from 28 percent (for initial ratings of 1-5 percent), to 80 percent for initial ratings in the 21-30 percent range.
- In 1995 the Austin-San Antonio area had the lowest rate of multiple impairment ratings per injured worker and the lowest average medical and indemnity cost per claim at \$3,319. El

Paso had the highest percentage of impairment ratings per injured worker in the state in 1995, and the highest average cost per claim at \$4,968.

Key findings on impairment ratings and requests to change treating doctors:

- Almost half of the workers who were injured in 1998 and submitted change of treating doctor requests (47.6 percent) did so within the first two months after receiving their first MMI date.

Key findings on training for impairment rating evaluations:

- Treating doctors in Texas perform 85 percent of the state's impairment ratings, but are not required to attend impairment rating evaluation training.
- Designated doctors in Texas perform less than 10 percent of the impairment rating evaluations in Texas, and are the only doctors in the workers' compensation system required to attend training before evaluating the injured worker.
- Colorado's training requirements resulted in a 39 percent improvement in the accuracy of evaluation scores among doctors performing impairment ratings.

Section I: Introduction

Injured workers generally receive two types of benefits: medical and income benefits. Medical benefits are paid on behalf of an injured worker for as long as the worker needs medical care (*Texas Labor Code* Section 408.021), while income benefits are paid to workers who are either off work due to their injury or as a compensation for permanent impairment.

Income benefits for workers with permanent impairments (Impairment Income Benefits and Supplemental Income Benefits)¹ are based on an injured worker's degree of physical impairment measured by the worker's impairment rating and pre-injury weekly wages. The impairment rating is a calculation based primarily on objective medical observation using the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (third edition, second printing, 1989) (*AMA Guides*).² Under the old workers' compensation system (prior to the 1989 reform), income benefits for injured workers with permanent partial disability were determined by either an established benefits schedule for specific types of injuries or a calculation of the worker's loss of wage earning capacity (i.e., an injured worker's ability to work taking into account factors such as the worker's age and occupation). However, the subjective nature of determining an injured worker's loss of wage earning capacity was thought by many to increase system costs through higher levels of litigation and variation in benefits.³ In

¹ Impairment Income Benefits (IIBs) are based on the percentage point of impairment and 70 percent of the injured worker's average weekly wage. For each point of impairment, the injured worker would receive three weeks of income calculated at 70 percent of his/her weekly wage, not to exceed 70 percent of the state average weekly wage. For example, an injured worker with an 8 percent impairment is entitled to 24 weeks of IIBs. Supplemental Income Benefits (SIBs) are paid to the injured worker with an impairment rating of at least 15 percent who has not returned to work or has returned earning less than 80 percent of his/her pre-injury average weekly wage.

² During the last legislative session in Texas, HB 2510 passed, allowing the Texas Workers' Compensation Commission (TWCC) to update the *AMA Guides* from the 3rd edition, 2nd printing to the 4th edition, effective September 1, 1999. In response, TWCC passed Rule 130.1 requiring that the 4th edition be used for the calculation of impairment ratings starting October 15, 2001.

³ Under the old law, workers could have been determined to have a large or total loss of earning capacity even though they had gone back to work. Difficulty in returning to work at the same pay and/or enhanced

comparison, the application of the *AMA Guides* under the new law was thought to be the most feasible method to improve consistency and objectivity when evaluating physical impairments and assigning impairment ratings to injured workers.

However, a recent study indicated that impairment ratings in Texas are being assigned with some degree of inconsistency. The 1999 study by the Research and Oversight Council on Workers' Compensation (ROC) showed that in cases where injured workers received multiple impairment ratings (which most often results when the initial rating is disputed), 43 percent had a five or more percentage point difference between the first and last rating.⁴ A five percentage point difference could have a significant impact on the level of income benefits received by an injured worker or the amount of income benefits paid by the insurance carrier.⁵ While absolute precision in impairment ratings is unrealistic, the presence of inconsistencies undermines the equity of income benefits in the system and contributes to increased disputes. Reducing significant rating variations should therefore improve overall system effectiveness by reducing administrative costs associated with impairment rating disputes and additional impairment rating examinations while ensuring both the adequacy and equity of benefits.

This study seeks to expand understanding of impairment rating variation that exists in the Texas workers' compensation system, its impact on disputes, and to explore opportunities for system improvements. In addition, the study includes an examination of mechanisms used in other states to ensure quality and consistency of impairment ratings given to injured workers. This project supplements a clinical case review of impairment ratings

possibility of future job loss could be considered when determining loss of wage earning capacity. See Peter S. Barth, Richard B. Victor and Stacey M. Eccleston, *Workers' Compensation in Texas: Administrative Inventory*, Workers' Compensation Research Institute (1989) and Peter S. Barth and Stacey M. Eccleston, *Revisiting Workers' Compensation in Texas*, Workers' Compensation Research Institute (1995).

⁴ Research and Oversight Council on Workers' Compensation, *Impairment Rating Trends in the Texas Workers' Compensation System*, August 1999.

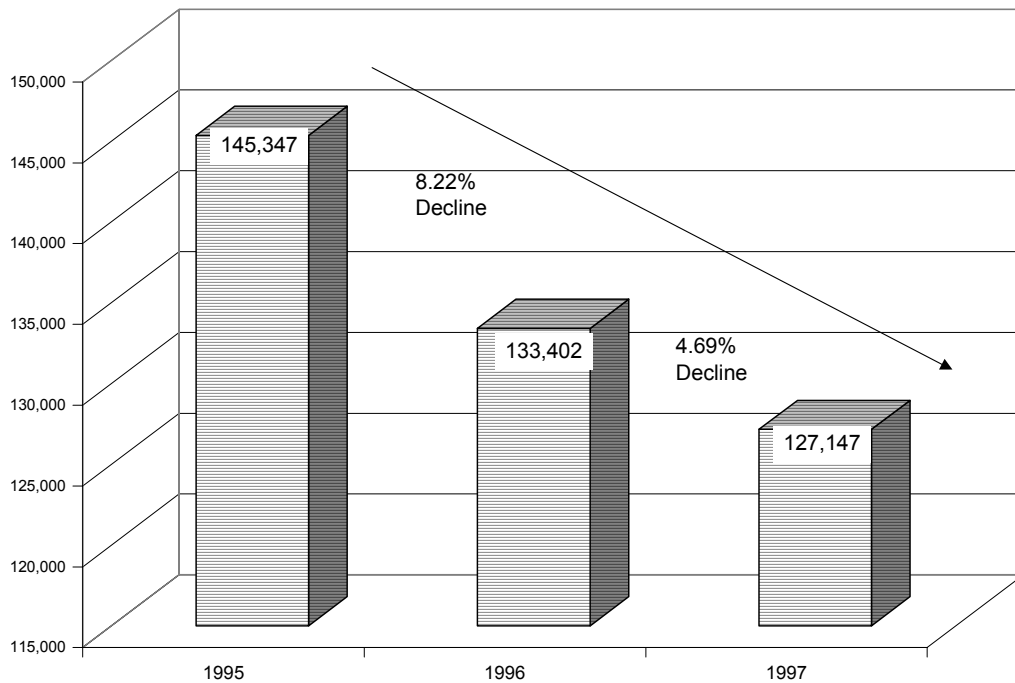
⁵ The average wage of weekly wage of injured workers in Texas was \$421 in 1999. An injured worker earning the average weekly wage in 1999 would therefore receive an additional \$4,420 in income benefits with a 5 percentage increase in impairment rating, or lose \$4,420 with a 5 percent drop in impairment rating ($\$421 \times 70\%$, for 3 weeks times 5). To insurance carriers, increased income benefits mean additional costs and decreased income benefits mean lower costs. These cost differences may impact premium rates for Texas employers.

currently being conducted by Dr. Bill Nemeth on behalf of the Texas Workers' Compensation Commission (TWCC).

Data and Methodology

The primary data source used for this study was the TWCC's impairment rating database covering injury years 1995 to 1997. The 1997 cutoff year was selected to allow injuries to reach statutory Maximum Medical Improvement (MMI)—104 weeks.⁶ The impairment rating database was merged with other files from TWCC to allow the cross-referencing of impairment ratings with geographic location, diagnoses, health care provider specialties, and dispute data.

Figure 1
Total Number of Impairment Ratings Assigned for Injury Years 1995-1997



Source: Texas Workers' Compensation Commission, Impairment Database (TWCC69) and the Research and Oversight Council on Workers' Compensation, 2000.

The lower number of impairment ratings for injury years 1996 and 1997 is the result of less time since the injury to allow for multiple ratings, as well as a moderate decline in

⁶ *Texas Labor Code*, Section 401.011 (30).

the number of impairment ratings. The totals for those injury years may increase as claims mature.

In addition to the analyses performed on the Texas data, the ROC also conducted a survey of nine states to identify their impairment rating regulations, training, and statutory features.⁷ Colorado and California proved to be the most useful to this study. Attempts to acquire impairment rating data compatible to that collected in Texas proved less successful as most states did not have data collection mechanisms comparable to that in Texas.

Discussions with TWCC's staff provided critical insight on administrative procedures and training, as well as valuable input on recommendations for improving the current impairment rating system.

⁷ The nine states surveyed include Florida, California, Colorado, Oregon, Minnesota, Iowa, Arkansas, Kentucky, and New York.

Section II: Variations and Inconsistencies in Impairment Ratings

The vast majority of impairment ratings (81 percent) are performed by medical doctors (M.D.s), while 8.5 percent are performed by chiropractors (D.C.s). The top three most common diagnoses made of injured workers who receive impairment ratings are Lumbar Disc Displacement, Lumbago (i.e., back pain), and Carpal Tunnel Syndrome. In this section we examine variation in impairment ratings performed by M.D.s on the most prevalent diagnoses given to injured workers.

Variations

There are several indications that some treating doctors, insurance carrier Required Medical Examiners (RMEs), and TWCC Designated Doctors are not uniformly applying the *AMA Guides* and following the TWCC rules when assigning impairment ratings.⁸ These inconsistencies appear across geographic locations as well as medical specialties. For example, 17 percent of workers with Carpal Tunnel Syndrome, who received impairment ratings from M.D.s in the Fort Worth area, were assigned an average rating of 10 percent or higher. Twice this percentage (34 percent) of workers with the same diagnosis received an average rating of 10 percent or higher when the rating was assigned by an M.D. in the Houston area.

Further, a larger percentage of workers (65 percent) diagnosed with Lumbago (i.e., back pain) received an average rating of 10 percent or higher in the Beaumont area than injured workers with the same diagnosis in the Houston area (45 percent). While these findings do not take into account the severity of each case, they raise questions about the consistency, reliability, and accuracy of impairment ratings in Texas.

Variations in impairment ratings were also found in injuries with typically narrow ranges of severity. For example, an injured worker with a tear of the medial cartilage (meniscus

⁸ The treating doctor is the primary healthcare provider responsible for managing the injured worker's medical care. The Required Medical Examiner is selected either by TWCC or the insurance carrier to resolve healthcare issues, and the Designated Doctor is a TWCC-assigned doctor, agreed to by the carrier

of the knee) should not experience impairment rating variation compared with another injured worker diagnosed with the same injury.⁹ Yet, this diagnosis is characterized with variations that are unexpected for such an injury. For example, M.D.s in El Paso assigned an average impairment rating of 10 percent or higher for almost half (47 percent) of the workers diagnosed in 1995 with a tear of medial cartilage. While in 1996, only 21 percent of workers diagnosed with the same injury in El Paso received an average impairment rating of over 10 percent.

Clustering

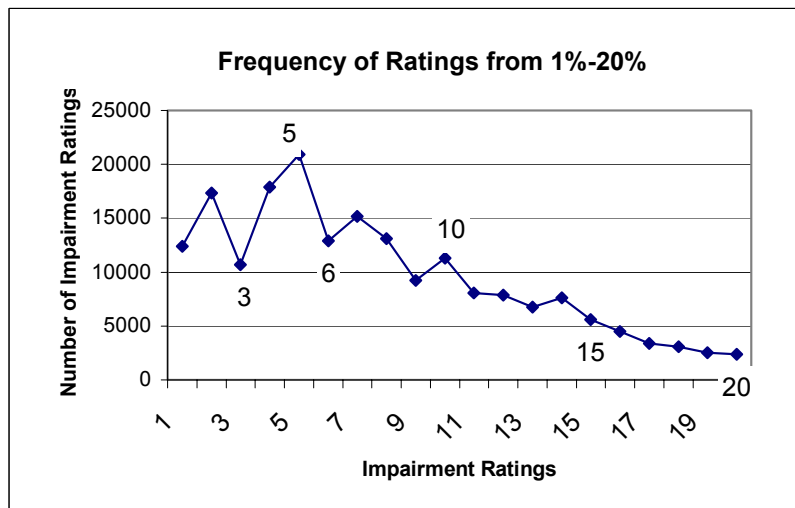
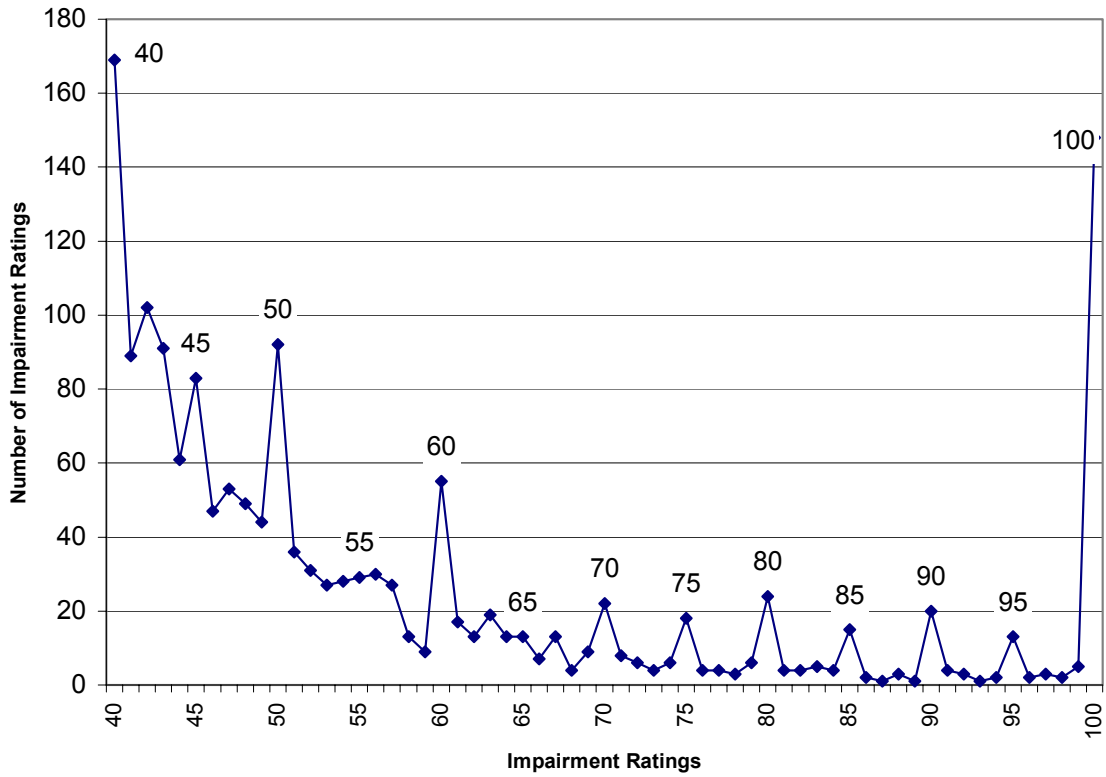
After close examination of impairment ratings assigned to workers injured between 1995 and 1997, it appears that doctors assigning impairment ratings in Texas tend to cluster their calculations, especially around intervals of 5s and 10s (see Figure 2). The clustering is less pronounced in the 20-40 impairment rating range (not included in Figure 2).

For the injury period 1995 to 1997, the number of impairment ratings assigned at 5 percent was 114 percent higher than ratings of 4 percent and 162 percent higher than ratings of 6 percent. Similar trends existed for ratings of 10, 40, 50, 60, and at intervals of 5 from 70 to 95 percent. One notable departure from that trend was at the 15 percent impairment rating, which is the percentage of impairment an injured worker must have to qualify for Supplemental Income Benefits (SIBS). While many of the ratings found in the *AMA Guides* fall into ranges of fives and tens, it is unclear the degree to which these clusters are due to the recommendations in the *Guides* or are evidence of unscientific impairment evaluations.

and the injured worker or selected by TWCC, to resolve disputes. The Designated Doctor is the only doctor required to complete training in the use of the *AMA Guides*.

⁹ Dr. Jeff Harris, a noted occupational health researcher on assignment with the ROC and editor of the American College of Occupational and Environmental Medicine (ACOEM) guidelines, confirms that while there are degrees of severity of meniscus tears, the degrees are minimal compared to most work related injuries, such as musculoskeletal pain. Dr. Harris states that the treatment of meniscus tears is fairly well agreed upon and straightforward.

Figure 2
Frequency of Assigned Impairment Ratings from 1-20% and 40%-100%
Injury Years 1995-1997



Source: Texas Workers' Compensation Commission, Impairment Database (TWCC69) and the Research and Oversight Council on Workers' Compensation, 2000.

Section III: Results of Impairment Rating Inconsistencies

Disputes

When examined geographically, Dallas leads the state in impairment related disputes, with its share of these disputes increasing from 13 percent in 1995 to 16 percent in 1997. Although disputes over Designated Doctors' certified MMI dates and impairment ratings make up approximately 50 percent of all impairment related disputes, the prevalence of these disputes is simply a function of the Designated Doctor process.

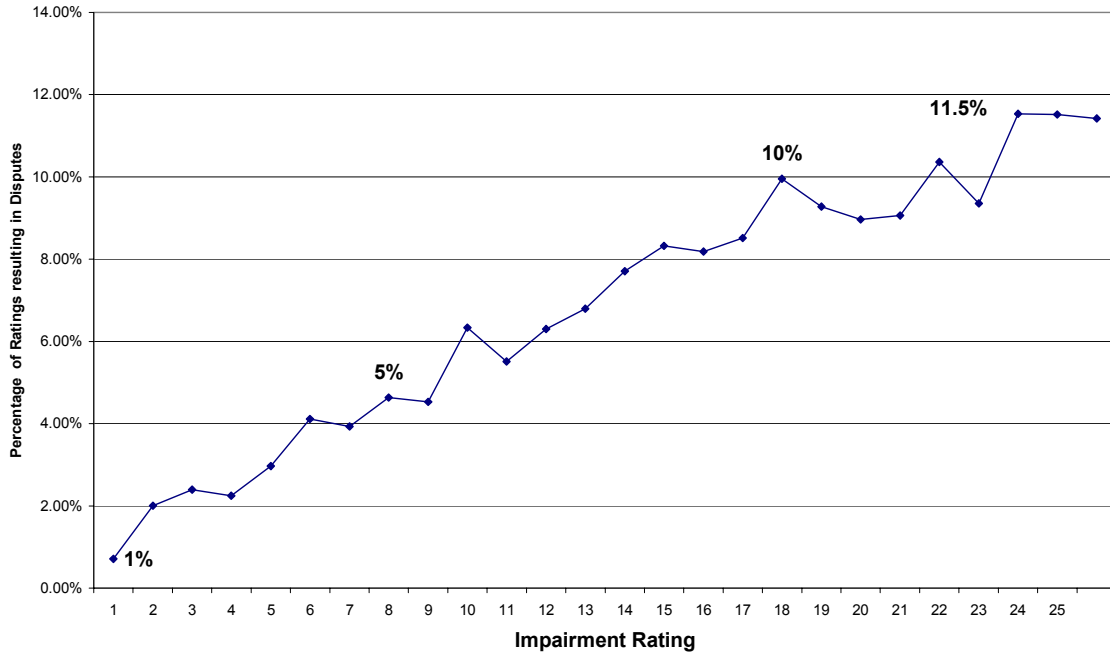
If a dispute arises over an injured worker's impairment rating or MMI date, a Designated Doctor may be called in to resolve the dispute.¹⁰ They are chosen either through a mutual agreement between the worker and insurance carrier, or by TWCC. Designated Doctor evaluations carry presumptive weight in an impairment rating dispute. As a result, these doctors evaluate contentious impairment rating cases rather than routine ones. Although like treating doctors and RMEs, there are some indications that Designated Doctors have similar difficulties in applying the *AMA Guides* uniformly, the rate of disputes over Designated Doctors' impairment ratings does not account for the disputes that they help resolve.

Variations were discovered in the dispute rates among health care provider types. For example, if a Chiropractor assigned the first impairment rating for an injured worker, there was a 54 percent chance it will be disputed; however, if an M.D. assigned the first rating, there was a 34 percent chance of a dispute.

There is also a close correlation between the percentage of the rating assigned and the likelihood of an impairment-related dispute. As Figure 3 illustrates, the higher the impairment rating, the higher the percentage of disputes associated with those ratings.

¹⁰ See Texas Workers' Compensation Commission Rule 126.10

Figure 3
Percentage of Each Impairment Rating (1-25%)
That Results in an Impairment Dispute
Injury Years 1995-1998



Source: Texas Workers' Compensation Commission, Impairment File (TWCC69), the Dispute Resolution Information System (DRIS), and the Research and Oversight Council on Workers' Compensation, 2000.

Disputes over impairment ratings and MMI dates pose a considerable financial and administrative burden on the system. TWCC estimates that the average administrative cost per disputed case considered at the CCH level (Contested Case Hearing) increased from \$480 in 1998 to \$538 in 1999, and the average administrative cost per case considered at the BRC level (Benefit Review Conference) increased from \$192 to \$224 during the same period.¹¹ If the 1995-1997 trends in the number of impairment-related disputes continue, disputes resolved at BRC and CCH levels would cost TWCC approximately \$620,000 per year.¹² The good news is that about 61 percent of disputed cases are resolved prior to entering the BRC level, and the average administrative cost of

¹¹ Texas Workers' Compensation Commission Strategic Plan Measures, 1998-1999. It is important to note that these cost estimates do not include costs to injured workers or insurance carriers for their participation in these disputes.

¹² An average of 1,690 cases were heard in BRC and 455 cases in CCH over the 1995-1997 injury period. Approximately 3,965 were resolved prior to BRC.

those cases has fallen, from \$122 in 1998 to \$82 in 1999. These impairment-related disputes resolved prior to the BRC cost TWCC approximately \$325,000 per year.

In addition, impairment rating examinations performed by designated doctors totaled approximately \$7 million per year between 1995 and 1997.¹³ An important step in understanding impairment rating disputes is to examine the group responsible for initiating the majority these disputes: injured workers.

Injured Workers' Reasons for Disputing Impairment ratings

In a 1996 study by the ROC, injured workers were asked about their experience in the impairment rating process in Texas.¹⁴ The results show that injured workers initiated 64 percent of the impairment rating disputes, while 26 percent were initiated by insurance carriers and 10 percent by “other” (primarily doctors but also including employers). When asked for their reasons for disputing their impairment ratings, most either disagreed with how their impairment rating was calculated (65 percent), or they thought the ratings were too low (53 percent) (see Table 1). This 1996 study also noted that “the data suggest a generally high degree of distrust of impairment calculations, the objectivity of insurance doctors, and the ways maximum medical improvement is determined.”

¹³ Texas Workers' Compensation Commission Medical Forms database, November 1999.

¹⁴ Research and Oversight Council on Workers' Compensation, *An Analysis of Texas Workers With Permanent Impairments*, August 1996.

Table 1
Reasons Given by Injured Workers for Disputing Impairment Ratings

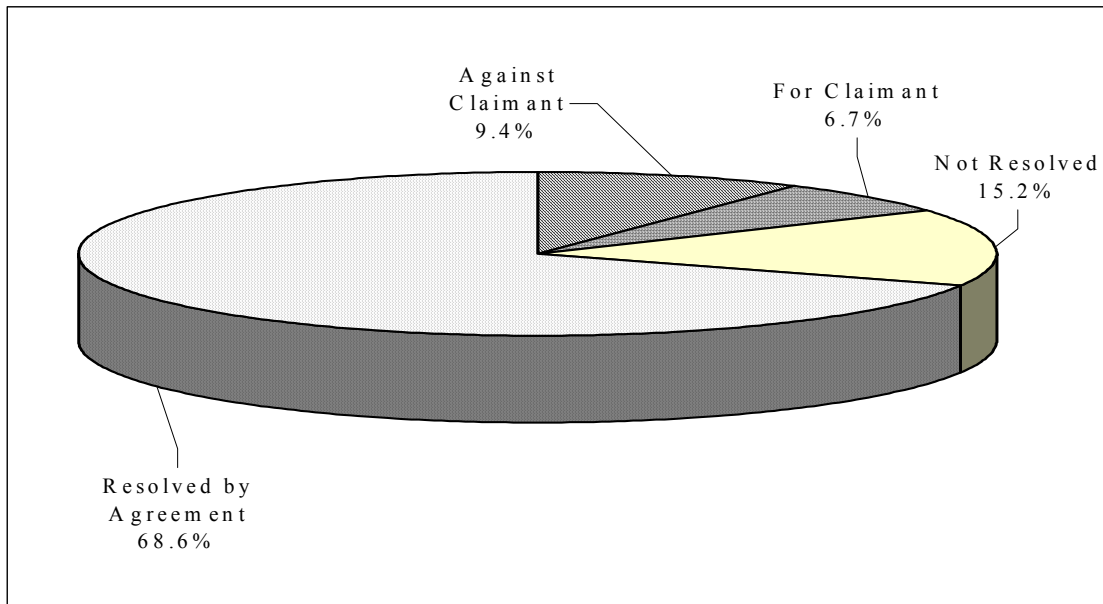
Why did you dispute your impairment rating?	Percent
Didn't agree with how your impairment rating was calculated	65
It was too low	53
You didn't feel like you had reached maximum medical improvement (MMI)	50
You felt that the insurance doctor was biased	46
Didn't feel like you got a thorough exam by insurance doctor	42
Didn't feel like you got a thorough exam by treating doctor	39
Didn't feel like you got a thorough exam by designated doctor	38
You felt that the designated doctor was biased	30
You felt that the treating doctor was biased	20

Source: Survey of Permanently Impaired Workers, Texas Workers' Compensation Commission and Research and Oversight Council on Workers' Compensation, 1996.

Note: The percentages do not total 100 because more than one answer was allowed.

In an attempt to determine the consequences of these disputed issues, ROC examined the outcomes of impairment rating and MMI date disputes raised at the BRC level in 1999. The outcomes of the 1999 disputes indicate that 69 percent of all of impairment rating and MMI disputes are resolved by a mutual agreement between the injured worker and the insurance carrier at the BRC level. In comparison, only 9.4 percent of the impairment rating and MMI disputes resulted in a decision against the worker. An additional 15.2 percent of these cases were not resolved (See Figure 4).

Figure 4
Outcomes of Impairment Rating and Date of MMI Disputes
BRC Level – 1999



Source: Texas Workers' Compensation Commission, Impairment File (TWCC69), the Dispute Resolution Information System (DRIS), and the Research and Oversight Council on Workers' Compensation, 2000.

Most workers (53 percent) involved in an impairment rating or MMI date dispute at the BRC level in 1999 were assisted by a TWCC Ombudsman. Workers utilizing TWCC Ombudsmen assistance or attorney representation had similar dispute outcomes (see Table 2).

Table 2
Impairment Rating and Date of MMI Dispute Outcomes
by Type of Claimant Assistance Utilized
BRC Level -- 1999

	Against Claimant	For Claimant	Not Resolved	Resolved by Agreement
Ombudsman Assistance	9.4%	6.7%	15.2%	68.6%
Attorney Representation	9.8%	7.8%	13.4%	69.1%
Other Representation	8.6%	7.0%	10.9%	73.4%
No Representation	3.3%	1.1%	27.3%	68.3%

Source: Texas Workers' Compensation Commission, Dispute Resolution Information System (DRIS) database, and the Research and Oversight Council on Workers' Compensation, 2000.

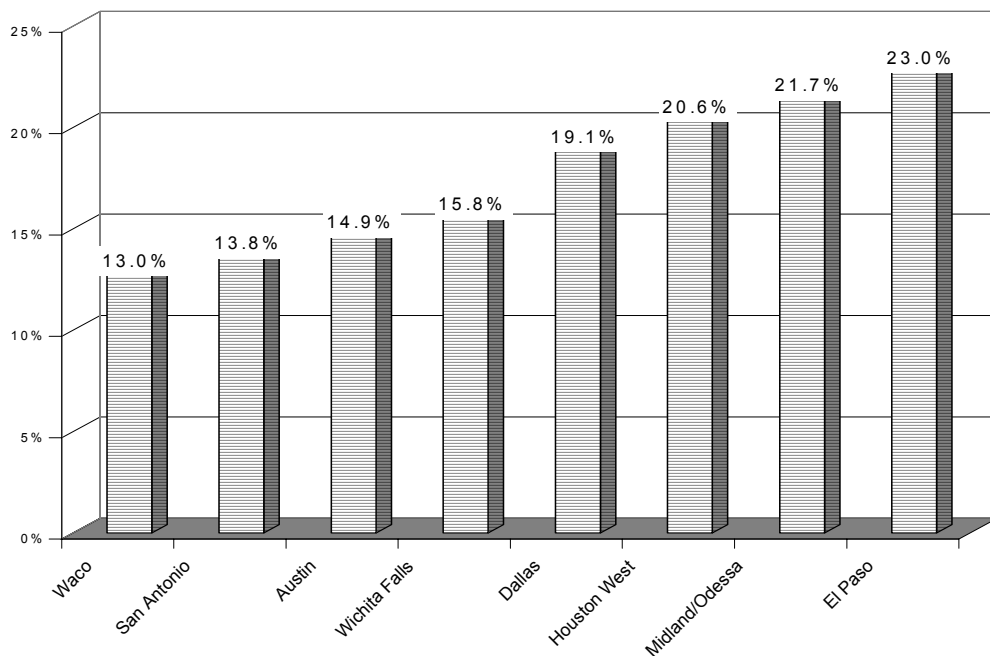
Note: "Other Representation" includes health care providers, union representatives, and family or friends, among others.

There are indications that the impairment rating process may lack the level of credibility necessary to encourage acceptability from injured workers and insurance carriers. This distrust in the accuracy of the impairment evaluations may contribute to disputes, which can lead to multiple impairment ratings and increased costs to the system.

Multiple Impairment Ratings

A possible symptom of variations and inconsistencies in the current impairment rating process can be found in the number of multiple impairment ratings assigned to injured workers. The percentage of workers receiving multiple impairment ratings remained stable for the 1995-1998 injury period at around 18 percent per year. However, there is significant regional variation in the percentage of workers with multiple ratings (see Figure 5). The Waco area had the lowest percentage of workers with multiple impairment ratings at 13 percent, while the El Paso area had the highest percentage of workers with multiple ratings (23 percent).

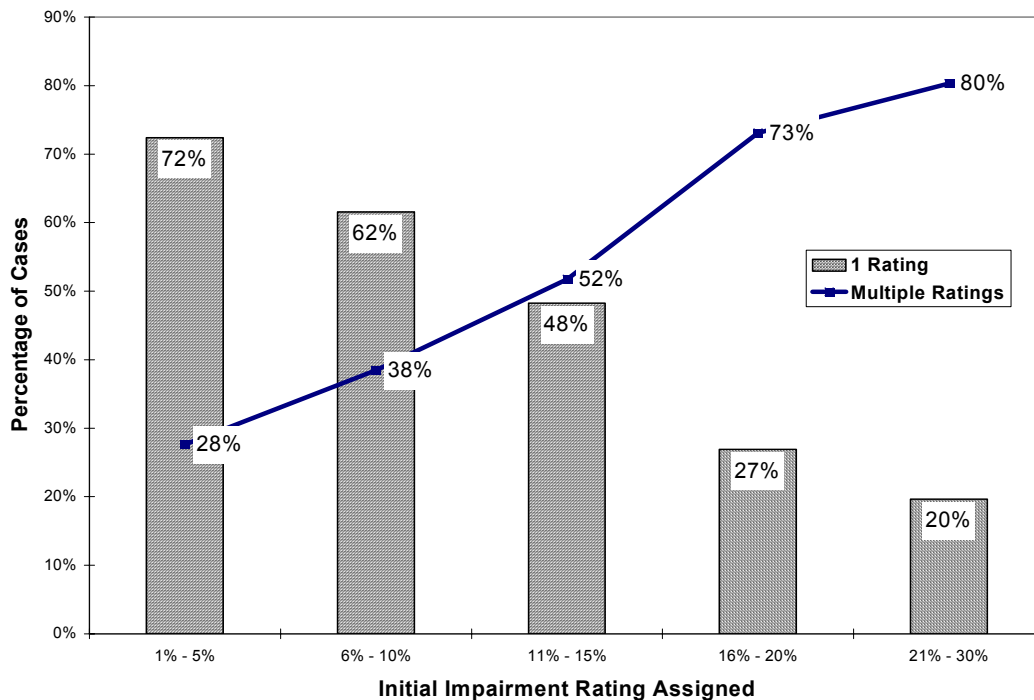
Figure 5
Percentage of Workers with Multiple Impairment Ratings
Selected Field Office Locations - 1995-1997



Source: Texas Workers' Compensation Commission, Impairment File (TWCC69), the Claims Database, and the Research and Oversight Council on Workers' Compensation, 2000.

Two primary factors appear to be driving the number of multiple ratings assigned to injured workers. One is the degree of doubt that injured workers and insurance carriers have regarding the accuracy and consistency of the first impairment rating. The other is the economic incentive for both workers and carriers to challenge ratings in the more serious claims. This is supported by data, which suggest that the higher the initial impairment rating (meaning higher potential income benefits for the injured worker and higher costs for the insurance carrier), the higher the percentage of multiple impairment ratings assigned to the worker (see Figure 6).

Figure 6
Percentage of Cases with One Impairment Rating
Compared to Those with Multiple Ratings, by Initial Impairment Rating Assigned
Injury Year 1995

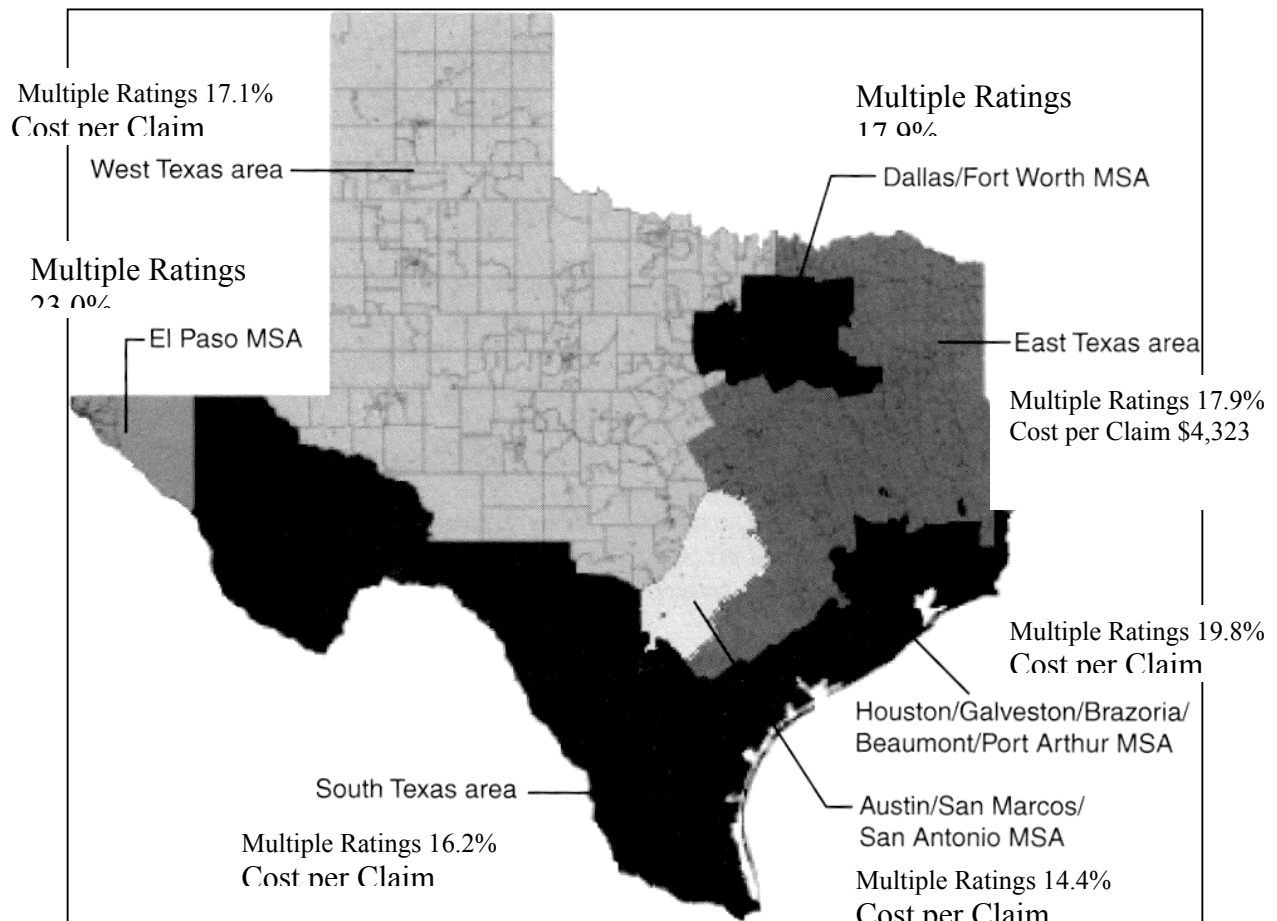


Source: Texas Workers' Compensation Commission, Impairment File (TWCC69) and the Research and Oversight Council on Workers' Compensation, 2000.

For 1995 injuries, the occurrence of workers with multiple impairment ratings ranged from 28 percent (for initial ratings of 1-5 percent), to 80 percent for initial ratings in the 21-30 percent range.

Multiple impairment ratings in Texas are also characterized by regional variations (see Figure 7).

Figure 7
Multiple Impairment Ratings and Costs per Claim in Texas, by Geographic Region
Injury Years 1995-1997



Source: Map, Metropolitan Statistical Area (MSA) breakdowns, and average claim costs are taken from Gotz, Glenn A., et al, *Area Variations in Texas: Benefit Payments and Claim Expenses*, Workers' Compensation Research Institute (May 2000). Data were derived from the Texas Workers' Compensation Commission, TWCC69 Database, 2000. Analysis conducted by the Research and Oversight Council on Workers' Compensation, 2000.

Note: Austin/San Marcos/San Antonio MSA consists of Austin and San Antonio TWCC field offices; South Texas Area consists of Corpus Christi, Harlingen, Laredo, and Victoria TWCC field offices; West Texas consists of Abilene, Amarillo, Lubbock, Midland-Odessa, San Angelo, and Wichita Falls TWCC field offices; East Texas consist of Bryan-College Station, Lufkin, Tyler, and Waco TWCC field offices; El Paso MSA consists of El Paso TWCC field office; Dallas/Fort Worth MSA consists of Dallas, Denton, and Fort Worth TWCC field offices; Houston/Galveston/Beaumont/Port Arthur MSA consists of Houston East, Houston West, and Beaumont TWCC field offices.

For the injury years 1995 to 1997, the Austin-San Antonio area had the lowest average rate (14.4 percent), while El Paso had the highest average rate of multiple impairment ratings in the state (23 percent). While it is not clear why these variations exist, it suggests that factors other than objective medical criteria may be influencing impairment rating patterns in the Texas workers' compensation system.

When these regional percentages of multiples are compared with the regional average medical and indemnity cost per claim, as calculated by WCRI for 1995, it appears that the incidence of multiple impairment ratings may have a correlation with the cost of claims.¹⁵ The Austin-San Antonio area has the lowest rate of multiple impairment ratings per injured worker, and the lowest average medical and indemnity cost per claim at \$3,319. El Paso has the highest percentage of impairment ratings per injured worker in the state, and the highest average cost per claim at \$4,968. El Paso's percentage of multiple ratings exceeds the Austin-San Antonio area's rate by 60 percent and its' cost per claim by almost 50 percent.

Requests to Change Treating Doctors

The dissatisfaction with impairment ratings may also contribute to increased requests by injured workers to change treating doctors. An injured worker in Texas is allowed by statute to change treating doctors for reasons other than personal dissatisfaction with their impairment rating.¹⁶ However, a current study by the ROC show that a growing number of injured workers are filing requests to change their treating doctors in the months immediately following their first impairment evaluation.¹⁷

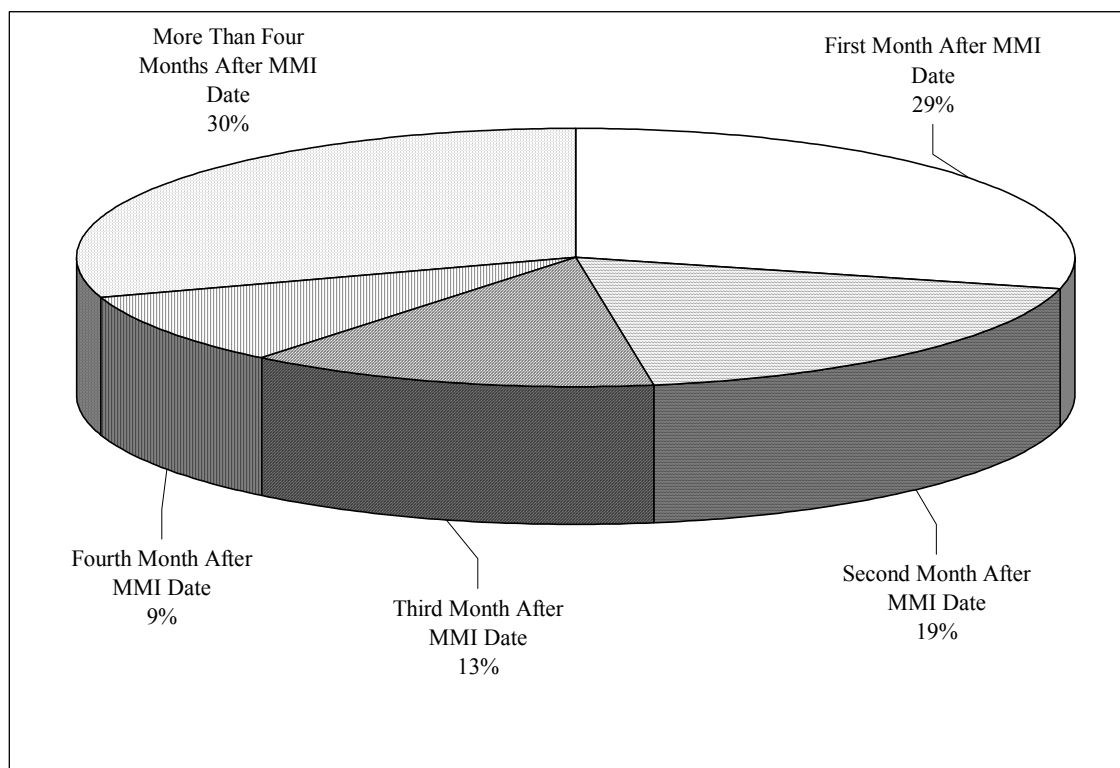
¹⁵ Workers Compensation Research Institute, *Area Variations in Texas benefit payments and Claim Expenses*, May 2000.

¹⁶ An injured worker could request a change of treating doctor for reasons such as if the doctor or worker relocates, if the treating doctor becomes unavailable, or if the worker becomes dissatisfied with the medical treatment. Changing treating doctors to secure a new impairment rating is not allowed under the Texas Workers' Compensation Act of 1989.

¹⁷ Research and Oversight Council on Workers' Compensation, *Analysis of Change of Treating Doctors Issues in the Texas Workers' Compensation System*, 2000

Among injured workers who have reached MMI and submitted a request to change treating doctors, a significant percentage (approximately 30 to 40 percent) requested the change in the first month after receiving their initial MMI date (39.5 percent for workers injured in 1997, 29.1 percent for workers injured in 1998 and 36.3 percent for workers injured in 1999) (see Figure 8).

Figure 8
Percentage of Change of Treating Doctor Requests Made by Injured Workers After Their First MMI Date
Injury Year 1998



Source: Texas Workers' Compensation Commission, Impairment File (TWCC69), Change of Treating Doctor File, and the Research and Oversight Council on Workers' Compensation, 2000.

As Figure 8 indicates, almost half of these workers injured in 1998 (47.6 percent) submitted their change of treating doctor requests within the first two months of receiving their first MMI date. These findings suggest that the impairment rating system has a significant impact on disputes, multiple impairment ratings, and requests to change treating doctors.

Section IV: Impairment Ratings in Colorado and California

How important is training?

Texas law mandates that a doctor use the *AMA Guides* to rate an injured worker's permanent impairment.¹⁸ However, there is some concern that most doctors are not adequately skilled in using the *Guides*. Dr. Christopher Brigham, an internationally recognized expert in impairment and disability assessment, cites a study that showed how 88 percent of the impairment ratings conducted by a sample of doctors using the *Guides* were incorrect.¹⁹ The study found that of 197 cases analyzed for accuracy, the average impairment rating assigned was 18.2 percent, while under the *Guides*, the average should have been 8.9 percent. Dr. Brigham argues that doctors assigning impairment ratings must be qualified both in their medical specialty and in performing impairment evaluations.

Treating doctors in Texas perform 85 percent of the state's impairment ratings, yet are not required to attend impairment rating evaluation training.²⁰ Designated doctors, who perform less than 10 percent of the impairment rating evaluations in Texas, are the only doctors in the workers' compensation system required to attend training prior to evaluating the injured worker. Training and certification has had significant impact on the quality of impairment evaluations in states such as Colorado.

The next section of the report highlights the impairment rating process in two key states: Colorado (a state that uses the same version of the *AMA Guides* as Texas, but has a doctor training program) and California (a state that has developed its own impairment rating schedule).

¹⁸ *Texas Labor Code*, Section 408.124

¹⁹ *The Journal of Workers Compensation*, "Understanding the AMA Guides—And Catching an Evaluating Doctor's Mistakes," Winter 2000.

²⁰ Research and Oversight Council on Workers' Compensation, *Impairment Rating Trends in the Texas Workers' Compensation System*, August 1999. The Texas Workers' Compensation Act of 1989 only requires that the doctors be on the Approved Doctor List (ADL). Every board certified doctor in Texas is automatically qualified for the Approved Doctor List, except if dropped from the list by TWCC for violating the statutes and rules governing workers' compensation in Texas.

Colorado

Like Texas, impairment ratings in Colorado are based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (third edition, second printing, 1989) (*AMA Guides*), and treating doctors perform most of the impairment ratings. Compared to Texas, however, there are significant differences in the qualifications and training required of doctors performing impairment rating evaluations. In the early 1990s, Colorado enacted legislation that significantly changed its approach to impairment ratings. In an attempt to minimize the number of impairment rating disputes and subsequent litigation, Colorado developed a program to provide doctors with knowledge of workers' compensation administrative, legal, and ethical issues, as well as train them to accurately assign impairment ratings based on the *AMA Guides*.

In July 1993, two years after implementing the program, Colorado evaluated its doctor accreditation program and found that the training substantially increased the accuracy of impairment ratings. These findings were discovered after testing doctors both prior to training and immediately following the training (See Table 3).

Table 3
Colorado Level II Medical Accreditation
Pre test and Post test Scores by Medical Specialty

Medical Specialty	Scores			
	Objective Portion		Rating Cases Portion	
	Pre Test	Post Test	Pre Test	Post Test
Occupational Medicine	63.7 %	87.5%	42.9%	81.8%
Orthopedics	66.8%	79.9%	39.1%	74.9%
Physical Medicine & Rehabilitation	61.0%	84.9%	39.5%	78.1%
Hand	66.5%	83.7%	45.3%	83.7%
General Practice	70.0%	83.6%	47.9%	77.6%
Psychiatry	65.9%	92.1%	32.7%	91.4%
Neurology	58.7%	85.0%	38.0%	79.2%
Other	-----	84.4%	-----	75.3%

Source: Adele Platter, Ph.D., Colorado Medical Accreditation Program: Level II Accreditation, *Program Evaluation 1991-1993*, July 1993.

As indicated by the pre-test and post-test scores for the category labeled “Rating Cases Portion,” the accuracy of these doctors’ impairment rating scores increased an average of 39 percent following training.²¹ All medical specialties saw significant increases following impairment rating training. The material covered in the category labeled “Objective Portion” deals with the workers’ compensation system and administrative issues. Scores in this category also increased by an average of 20.5 percent, with Psychiatrists and Neurologists experiencing the greatest gains. Generally, training resulted in greater impairment rating proficiency and improved knowledge of the workers’ compensation system.

Rating Inconsistencies in California

²¹ ‘Rating Cases Portion’ refers to the section of the exam testing a doctor’s ability to rate an injured workers’ level of impairment, utilizing the *AMA Guides*.

The California workers' compensation system also reports inconsistency in impairment ratings (referred to as permanent disability ratings), despite differing approaches in determining impairment. California does not utilize the *AMA Guides*, rather a disability schedule prepared within their own system (*The California Permanent Disability Rating Schedule*). Some California administrators within the Workers' Compensation Disability Determination Unit have expressed the opinion that overall ratings would be lower if the *AMA Guides* were utilized (California's rating schedule takes into consideration the worker's age and occupation at the time of injury in addition to the degree of physical impairment).

Additionally, California workers' compensation staff are tasked with assigning impairment ratings, based on the treating physician's written assessment. As in Texas, treating doctors most often determine when an injured worker reaches MMI, and evaluate and develop a written assessment of the worker's injury. However, employees within California's Disability Evaluation Unit (DEU) often determine the actual impairment rating, based on reports received from the treating physician. These DEU employees are not required to have any formal medical education. The DEU evaluator reviews the physician's written report, assesses the workers' age and occupation, and assigns a rating based on the criteria in *The California Permanent Disability Rating Schedule*.

While the system was devised so that ratings are assigned by the DEU, nothing in the state's statute prevents the treating doctor from assigning his or her own rating. If the treating doctor does assign the rating, it is no longer necessary for the DEU to assign a rating.

Because of delays in receiving ratings, it is becoming more commonplace for California treating doctors to forgo the DEU and assign the impairment rating themselves. System participants complain that numerous changes in the California workers' compensation system have resulted in differing statutes based on the worker's injury date. This, in conjunction with the loss of experienced and knowledgeable DEU staff has resulted in

rating delays and inconsistencies between various DEU offices in applying the rating schedule.

The California Commission on Health and Safety and Workers' Compensation (CHSWC) produces an annual report outlining the status of the state's workers' compensation system. In the 1998-99 Annual Report, CHSWC indicated that many of California's Department of Workers' Compensation's (DWC) disability evaluators believe that the poor quality of medical reports leads to inconsistent ratings.²² This prompted CHSWC to initiate a study to evaluate a random sample of DWC medical reports for accuracy. The study results confirmed that treating physician reports are of poorer quality than Agreed Medical Examiners (AME) and Qualified Medical Examiners (QME).²³

²² California Commission on Health and Safety and Workers' Compensation, *Annual Report 1998-99*.

²³ California Commission on Health and Safety and Workers' Compensation, *Report on Quality of Treating Physician Reports and Cost-Benefit of Presumption in Favor of the Treating Physician*, August 1999.

Section V: Monitoring Quality of Doctor Care

In addition to training issues, many states do not have provisions for monitoring the quality of care or sanctioning doctors for improperly assigning impairment ratings. As a result, these states must resort to the use of “dueling doctors” or dispute resolution to arrive at a final rating.²⁴

The Texas workers’ compensation statute does establish TWCC’s authority to monitor and sanction doctors for substantial differences in diagnoses and treatments from those TWCC determines are fair and reasonable. However, TWCC’s resource limitations and interpretation of this statutory authority have restricted its ability to establish an effective medical monitoring process. As a result, medical care quality audits are rare in comparison to the number of doctors on the Approved Doctor and Designated Doctor Lists.

There are currently 68,000 doctors on the TWCC Approved Doctor List and approximately 1,200 doctors on the Designated Doctor List. As of April 2000, 494 doctors had been removed from the Approved Doctor List. The majority of removed doctors (58 percent) had medical practices outside the state of Texas and provided little or no treatment to injured Texas workers.

In a March 2000 response to the governing board of the Research and Oversight Council on Workers’ Compensation (ROC), TWCC reported that the agency was staffed with eleven criminal investigators assigned to five field offices statewide. It also reported being involved in nearly 200 active health care provider criminal fraud cases, as well as the completion of 45 health care provider audits in FY 99. No specific process for identifying inappropriate medical treatment or evaluation practices was provided; however, most audits are the result of complaints or other activities denoting erroneous

²⁴ “Dueling Doctors” is a term often used to describe two or more doctors with differing medical opinions, evaluations, or diagnoses for the same injured worker.

behaviors. TWCC does not routinely engage in health care provider audits to detect improprieties in the impairment rating process.

In the recent past, the purpose of health care provider audits was to verify compliance with the Texas Workers' Compensation Act and Rules, and not necessarily to monitor the quality of care received by injured workers. TWCC's health care auditing concentrated primarily on the doctor's medical billing practices, reporting compliance, benefits delivery, reasonable and necessary health care, and fair reimbursement practices. TWCC commonly utilizes two criteria in establishing overall health care provider compliance levels: (1) the percentage of impairment reports (TWCC-69 forms) filed timely and (2) the average number of days for payment of medical bills correctly submitted by health care providers.²⁵

To date, TWCC has not engaged in impairment rating quality reviews of doctors on the Approved Doctor List; however, TWCC staff indicate that a process to monitor the quality of medical care and impairment ratings will be part of future compliance audits. A research project currently underway at TWCC includes a clinical case review of designated doctor and treating doctor impairment ratings. Given appropriate resources and policy direction, TWCC's staff may be more effective in developing and implementing programs to monitor quality of care practices in the workers' compensation system.

²⁵ Texas Workers' Compensation Commission, *System Data Report 2000*, August 2000.

Section VI: Conclusion and Policy Options

Findings from this study strongly support earlier research findings that there are inconsistencies in the impairment ratings assigned in Texas. There is some evidence that variations exist between doctor types and across geographic locations for injured workers with similar diagnoses. The multiple impairment ratings that result from disagreements over the ratings are symptomatic of a rating system that lacks credibility among the system participants. These variations often lead to disputes over impairment ratings and MMI dates.

Impairment rating disputes and the multiple impairment evaluations that accompany these cases contribute significant financial costs to the system. Further, they create a substantial administrative burden on TWCC's limited resources. Emphasis on dispute prevention rather than dispute resolution may have positive long term impacts on TWCC's resource allocation and system efficiencies. Variations and inconsistencies in impairment ratings tend to undermine their credibility and increase their vulnerability to disputes. Any strategy to prevent impairment rating disputes in Texas should therefore include steps to increase accuracy and consistency in impairment rating evaluations.

Improving the consistency and accuracy of impairment ratings for injured workers may include options such as doctor training and accreditation programs, closer scrutiny of ratings assigned to injured workers, and the ability to sanction doctors whose ratings do not meet quality assurance measures established by TWCC. These options are described in more detail below.

Policy Options for Improving the Quality of Impairment Ratings

One or more of the following policy options may be explored by policymakers and regulators to improve the current impairment rating process.

- 1. Develop a required training program for all doctors conducting impairment rating evaluations and determine whether accreditation by a national**

organization (such as the American Board of Independent Medical Examiners, ABIME) should be required for doctors in Texas. Determine whether more advanced training requirements should be required for Designated Doctors; or whether, in the absence of additional training, a Designated Doctor’s decision should have presumptive or predominant weight in an impairment rating dispute.

- The Colorado experience demonstrates the value of providing doctors with knowledge of the workers’ compensation administrative, legal, and ethical issues, as well as, providing them with the needed skills to accurately assess impairment based on the *AMA Guides*. Texas will need to determine whether additional requirements may include attendance at training sessions and testing.

- Preliminary results from case studies conducted by Dr. William Nemeth from TWCC tend to support the rationale for required training. Impairment ratings by treating doctors (not required to have impairment evaluation training) seem to have significantly wider variations and inconsistencies than ratings conducted by designated doctors (required to have impairment evaluation training). There are early indications that even among designated doctors, more advanced training may further reduce the rates of variations found in their impairment ratings.²⁶

- The most prevalent indications of inadequate impairment training and improper utilization of the *AMA Guides* include:²⁷
 - Failure by the physician to properly differentiate between disability and impairment;
 - Failure to properly reference the *Guides*;
 - Rating subjective complaints that have no corroborating objective findings;
 - Attaching a numeric value to an evaluated psychological disorder; and
 - Qualifying ratings as an approximation.

²⁵ The primary goals of TWCC’s case reviews are to measure these doctors’ skill in the use of the *AMA Guides*, gauge the effectiveness of the designated doctor training program, and determine if need exists for increased credential criteria and testing requirements for doctors who assign impairment ratings in Texas.

- Training prerequisites may reduce by a significant margin the number of treating and RME doctors that TWCC has to monitor for quality impairment rating evaluations. Properly trained doctors may also minimize system costs by reducing disputes and multiple impairment ratings.
- Nationally recognized certification programs that conduct training on the impairment evaluations and the *AMA Guides* are already in existence. This eliminates the need for TWCC to develop its own specialized training program.
- One potential drawback to the option of increased training and testing requirements includes increased costs to doctors, which may impact the availability of these qualified evaluations in medically underserved areas in Texas. Any discussion of increased training requirements must include options to ensure equal access to qualified doctors for all injured workers.

2. Implement a TWCC monitoring program to ensure accurate impairment ratings given by all doctors who perform impairment evaluations on injured workers in Texas.

- This would be an expanded version of the current TWCC designated doctor monitoring program to include all doctors performing impairment evaluations on injured workers in Texas. The emphasis on ensuring quality evaluations would be a compliment to TWCC's current auditing focus on billing patterns.
- This may include random reviews of medical records and impairment rating reports to screen for common errors indicating inaccurate treatments or ratings. Should inaccuracies or 'red-flags' be revealed during a routine review, a thorough review by a medical doctor or peer review panel may be appropriate.

²⁷ *The Journal of Workers Compensation*, "Understanding the AMA Guides and Catching a Physician's Costly Mistakes," Winter 2000.

- Training requirements for treating and RME doctors who perform impairment ratings may facilitate monitoring activities by:
 - Reducing inconsistencies and variations; and
 - Reducing the number of doctors that TWCC has to monitor

- One possible drawback to the implementation of a comprehensive quality assurance monitoring system for impairment ratings is the administrative cost of collecting and analyzing the necessary data to identify possible “red flags” and the cost of individual medical reviews. These costs may be offset by a decrease in disputes. Although other system efficiencies could be achieved with consistent monitoring (e.g., fewer under and overpayment of IIBs to workers and fewer impairment rating exams), the impact of this type of monitoring should be tested through a small scale pilot program.

3. Increase TWCC’s resources dedicated to doctor regulation and enforcement.

- The Compliance and Practices Division at TWCC is charged with monitoring approximately 68,000 doctors on the Approved Doctor List (ADL). Over 1,200 of these are on the Designated Doctor List (DDL). Three auditors are assigned to conduct regulation and enforcement activities for both lists of doctors.

- The primary compliance standard used for monitoring impairment ratings is percent of impairment reports (TWCC-69) filed timely rather than the quality of impairment ratings.

- An effective program to monitor the ADL and DDL for consistent and accurate impairment ratings evaluations may require:
 - Increased staffing;
 - Additional training for staff; and
 - Upgraded database and data-mining technology to accommodate more sophisticated detection profiles.

- Similar to the issues associated with a quality assurance monitoring program at TWCC, the impact of adding additional resources should be tested in a pilot project before large scale resource additions are made.

4. Possibly develop more stringent criteria for admittance on the Approved Doctor List.

- The Approved Doctor List (ADL) includes all doctors licensed in Texas on or after January 1, 1993, and out-of-state doctors who were added after submitting a written request. The total exceeds 68,000 doctors.
- Currently, a doctor may be deleted from the ADL for criminal and ethical improprieties, as well as if the doctor's license is revoked or suspended by the appropriate licensing authority. Efforts have been made by TWCC staff recently to identify doctors for removal based on their workers' compensation medical treatment patterns. These efforts have been difficult, however, since no accepted practice pattern criteria have been established by TWCC.
- The Texas Workers' Compensation Commission is inadequately staffed and equipped to ensure that 68,000 doctors are in compliance with the Commission's rules. A staff of three has been tasked with removing doctors from the list. Since 1999, over 600 doctors have been dropped from the ADL.
- Preliminary findings in the House Bill 3697 Medical Cost studies suggest that approximately 7 percent of medical providers (about 4,000 doctors) may account for over 80 percent of all professional service medical costs in Texas.²⁸
- Developing proficiency, ethical, and practice criteria for admission to the Approved Doctor List could be highly effective in limiting the ADL to a manageable level. This

²⁸ Mandated by House Bill 3697, the ongoing studies are being conducted by Med-Fx LLC and the Research and Oversight Council on Workers' Compensation, 2000.

may include requiring specific training in the use of the *AMA Guides* and/or training in TWCC administrative procedures and requirements.

- This may be accomplished by a phase-out of the existing ADL (including all Texas and out-of-state doctors) on a reasonable timetable that allows reapplying doctors to meet the new requirements without interruptions in their practice. Reapplication to the ADL could be accomplished several different ways, including: the establishment of a probationary period for new doctors; the creation of different tiers of doctors based on their training and experience in the system; the establishment of a medical panel to review sanctions or disciplinary actions of doctors as well as the establishment of accepted practice pattern criteria.
- Periodic reviews could be conducted by TWCC staff to evaluate doctor compliance with the Act and Rules; training adequacy; and requirements for re-admissibility to the ADL.
- One potential drawback to this policy option is the limitation of widely accessible medical care for injured workers, especially in certain medically underserved areas in Texas. The purpose behind the original creation of the ADL was to ensure widespread accessibility for injured workers who exercised their right to choose their initial treating doctor. Many of the doctors on the ADL, however, do not take workers' compensation cases or treat them very infrequently. As a result, their knowledge of reporting requirements and rules is often limited. However, ensuring equal access to high quality medical care for all injured workers is a core component of a successful workers' compensation system. Any discussion of limiting the ADL must also include options to ensure equal access to qualified doctors for all injured workers.