

CAN YOU GO HOME AGAIN?**Almaraz/Guzman II: The Appeals Board's Return to Objective-Based Medical Evidence.**

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On 9/3/09 the Appeals Board issued the highly anticipated *Almaraz/Guzman II* decision. While the new decision did affirm the Appeals Board's prior holding that application of the strict AMA Guides rating may be rebutted, the new opinion has arguably reined in the more capricious and arbitrary powers delegated to medical-legal evaluators by the original decision. Furthermore, the Appeals Board also upheld its prior conclusion that the strict methodology espoused in the AMA Guides remains the presumptive method for rating impairment and that the burden of rebutting a permanent disability rating continues to rest with the party disputing the rating.

Under *Almaraz/Guzman II*, physicians may no longer deviate from the strict AMA Guides rating where they determine that an impairment finding will result in an inequitable, disproportionate, or unfair permanent disability rating. Now, physicians may only deviate from the strict AMA Guides impairment methodology where another "chapter, table, or method in the AMA Guides most accurately reflects the injured worker's impairment." Further, physicians may not rely on any other resources besides the AMA Guides in determining an alternative impairment rating.

At first glance, the removal of the "fairness" question does not appear to substantially limit the impact of the first *Almaraz/Guzman* decision as physicians still have license to "rate by analogy" or to apply various Tables or chapters designed for entirely different bodily regions. However, upon closer inspection, the decision does impose a higher evidentiary standard, that of substantial evidence, therein curtailing a physicians' prior ability to arbitrarily assign an impairment rating.

While each medical-legal report will require an independent review on a case-by case basis, the following points of analysis will assist in development of potential defenses to the application of *Almaraz/Guzman II*.

Physicians May Not Justify their Deviation from the Strict AMA Guides Rating by Relying on Non-Medical Evidence.

After issuance of the original *Almaraz/Guzman I* decision, physicians often deviated from the strict AMA Guides rating method because the "employee has not returned to work," because "the employee will have a loss of future earnings" or because "the rating is unfair." This type of medical reporting highlighted the folly of the first *Almaraz/Guzman* decision as it allowed physicians to consider non-medical factors, such as fairness concerns, in determining impairment while simultaneously hiding their bias for "a more desired result" behind a façade of "clinical judgment."

Now, rebuttal is established only where an alternative rating is more medically accurate than the strict AMA Guides rating. This new test suggests the Appeals Board's return to reliance on objective based evidence. This is so especially because the Appeals Board specifically omitted reference to subjective factors such as "fairness" and "equity." As a result, a physician's reliance

on non-medical concerns and justifications will no longer meet the evidentiary standard espoused in *AlmarazGuzman II*.

The Appeals Board should now find that the above-described reports lack evidentiary weight and fail to rebut the strict AMA Guides rating. Arguably, by relying on non-medical factors, such as a loss of earnings capacity, an uncertain economic future, or the inability to compete in the labor market, the physician has undoubtedly utilized an alternative rating to “simply achieve a desired result,” and to compensate the injured worker for what the physician views to be an unfair or disproportionate permanent disability Award.

Given the new test based on “accuracy,” we recommend reviewing medical-legal reports for *non-medical justifications*. Where a report *completely* lacks a basis in medical reasoning, a supplemental report or deposition is not recommended, as it will only offer physicians the opportunity to “fix” their impairment analysis. Instead, Defendants should proceed to the Appeals Board and argue against the evidentiary weight of the report. This tactic may result in the Appeals Board finding that a particular report lacks the necessary substantial evidence to support a permanent disability Award.

Physicians Must Prove by Substantial Evidence that an Alternative Rating Is More Accurate than the Strict AMA Guides Rating.

Almaraz/Guzman II has substituted its prior test based on fairness, equity and proportionality for a test relying on accuracy. The Appeals Board now disallows a physician to “arbitrarily assess an injured employee’s impairment.” Instead, the Appeals Board specifically requires that a physician explain the “how and why” of its impairment conclusions. In short, *Almaraz/Guzman II* requires that a WPI opinion must constitute substantial evidence.

The term “accuracy,” whose dictionary meaning is “precision and correctness,” connotes a level of objective scrutiny not present in the original decision. This test, followed by the Appeals Board’s insistence that an impairment rating constitute substantial evidence, foreshadows the evidentiary battles to be fought over physician’s findings and conclusions.

First, a high level of scrutiny and understanding of the AMA Guides will now be required to disqualify a report based on substantial evidence. Defendants should now more than ever become familiar with the application of the AMA Guides and the basis for its recommended impairment findings.

Second, Defendants should as a matter of course, scrutinize the reliability of the objective findings contained in a report. Defendants should always attempt to determine if the physician alone performed diagnostic testing or measurements or if an assistant or computer was employed. Defendants should also determine if the evidence relied upon by the physician was open to subjective embellishment or exaggeration. The more Defendants learn about the level of precision used during a physical evaluation, the more likely it is that Defendants can establish a lack of substantial evidence.

Indeed, many physicians base their decision to apply an alternative rating method based on a loss of “functional capacity.” This determination of functional loss is almost always based on the findings from a patient questionnaire, a Functional Capacity Evaluation, or ROM measurements, whose reliability is questionable. Surveillance film or evidence of an injured worker’s lack of credibility represents the best strategies for disproving the reliability of the injured worker’s subjective presentation.

Third, if the evidence relied upon by the physician is entirely objective and verifiable, Defendants must then look to whether the physician adequately explained “how or why” the alternative rating is more accurate than the strict AMA Guides rating. Does the physician explain why the DRE method is inaccurate or why a certain Chapter does not adequately describe an injured worker’s bodily impairment? If the physician immediately applies the alternative rating, he has missed a critical step in his analysis. The physician now has the burden of explaining why another chapter, Table, or method is more accurate.

A physician can most readily prove the inaccuracy or inadequacy of a Chapter or method when a particular chapter does not provide a rating method for a particular condition, or where there is 0% WPI finding, but the injured worker’s condition has a significant impact on Activities of Daily Living (ADLs).

However, where a Chapter does deal specifically with a particular condition and its disabling effects, what reasons does the physician justify “rating by analogy” other than a desire for a higher rating? Again, in proving accuracy, a physician will most likely refer to non-medical factors, and not objective medical evidence, to justify the higher rating. The physician’s fall-back on subjective reasoning and non-medical factors needs to be highlighted by Defendants.

Gaps in evidence and lack of objective findings as well as a lack of familiarity with the Guides or expertise is best exemplified by conducting the physician’s deposition, which allows Defendants to highlight and tease-out the various inconsistencies and fallacies contained in a physician’s reasoning. The deposition can be Defendants’ most effective weapon in attacking the evidentiary weight of a report.

Physicians May Only Deviate From the Strict AMA Guides Impairment Methodology by Relying on a “Chapter, Table or Method” Found in the AMA Guides.

What did the Appeals Board mean to say when it held that a physician may determine an alternative whole person impairment by utilizing “any chapter, table, or method in the AMA Guides?” Does this mean that a physician is strictly confined to a methodology adopted by the AMA Guides, or is their room for some creative manipulation of the AMA Guides’ language and basic definitions?

Sadly, the ambiguity found in the above statement of the rule has led the applicant’s bar to suggest to physicians that they may only loosely base their finding of WPI on the AMA Guides, rather than asking physicians to expressly refer to a specific table, chapter, or method in the Guides. This interpretation arose out of dicta in the *Almaraz/Guzman II* decision, where the

Appeals Board stated that while the “WPI component of a scheduled rating *must be founded* on the AMA Guides, *a physician is not inescapably locked into a specific paradigm for evaluating WPI under the Guides.*”

This loose interpretation of *Almaraz/Guzman II* has led to a new “methodology” amongst physicians in determining whole person impairment. Now many physicians will determine whole person impairment by first approximating a body part’s “functional loss” and then multiplying the percentage of functional loss by the body part’s total level of whole person impairment. This has led to significant increases in whole person impairment findings especially in cases involving spinal injuries.

Using the above method in a knee case, for example, a physician might find that an injured worker has lost 75% of their functional use of the lower extremity. Because the lower extremity equates to a total of 40% WPI according to the AMA Guides, they will find that the injured worker has 30% WPI, which is 75% of 40.

However, Defendants must vigorously attempt to convince physicians and trial judges that the above method is not proscribed or recommended by the AMA Guides, nor does the AMA Guides even outline such a method as an option for rating impairment. As such, it cannot be said that this method is “founded” on the AMA Guides.

Indeed, the AMA Guides does not even consider the term “functional loss” or provide a method for determining such a percentage. This is most likely due to the fact that “functional loss” is based on subjective complaints or data that cannot be objectively measured without some estimation or approximation. In fact, many physicians who have used the above method do not explain how they determined “functional loss” besides simply stating that the conclusion is based on their years of experience and/or clinical judgment.

The above method is also inadequate in terms of its scientific reliability as it appears to be a simple mathematical short-cut, cleverly guised as a methodology “based on the AMA Guides.” Yet, unlike the other methods outlined in the Guides, the medical community has not tested this method for several years or subjected the method to peer review or publication. Instead, this fictional method may only be summed up as a “creative” manipulation of the Guides’ percentage data that wholly lacks scientific validity.

In keeping with the Appeal Board’s holding that an alternative finding of impairment must be based on substantial evidence, Defendants should argue that any report relying on the above method is inadequate to support a finding of permanent disability.

Physicians May Not Determine Impairment Through Duplication or Overlap.

Unfortunately, some physicians have mistakenly understood *Almaraz/Guzman* to allow for duplication of impairment. For instance, rather than choose between both the DRE and ROM methods, a physician might combine the two impairment findings into one WPI, citing *Almaraz/Guzman* as a justification. However, the AMA Guides explains in introducing the

spinal chapter that both rating methods assign impairment levels, which address anatomic impairment as well as loss of spinal function and impact on ADLs. Thus, the combination of both the DRE and ROM methods would result in direct overlap and duplication of impairment for the spine.

It would also be inaccurate to provide impairment findings for both grip loss due to a hand injury and then also provide a ROM impairment finding for the digits and thumbs as both assess the employee's loss of functionality in his or her hand. Indeed, the lack of ROM leads to the grip loss and is representative of the same disability or impairment.

While the above examples highlight some instances of duplication, there are multiple opportunities for overlap in the AMA Guides. As such, Defendants must be able to identify duplication or when a physician is attempting to camouflage pyramiding or overlap of impairments by relying on "rating by analogy." Is the physician truly analogizing or simply identifying every possible applicable chapter or table and adding overlapping impairments? Again, Defendants can address this abuse of the AMA Guides and *Almaraz/Guzman* decision through a careful deposition of the doctor or through a supplemental report.

Conclusion

In sum, the use of *Almaraz/Guzman II* by physicians can and should be adjudicated as these reports are often hastily written with a large potential for error or over-reliance on non-medical factors or subjective evidence. Doctor depositions and requests for supplemental reports are essential to building a strong defense to the application of *Almaraz/Guzman II*. Until the Court of Appeals has weighed in on the legality of the *Almaraz/Guzman* decision, the issue of substantial evidence should be raised at every stage, and kept alive for appeal. While it is not certain that this decision will be ultimately overturned, it is clear that the evidentiary burden is a weapon Defendants can and must rely on to ensure that an injured worker does not receive an arbitrarily assigned permanent disability Award.