The Guides To The Evaluation of Permanent Impairment and Workers' Compensation in Indiana

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Introduction

Workers' compensation systems across the country are under severe strain.[1] The cost of medical care under workers' compensation has skyrocketed. From 1985 through 1989, general health care expenditures increased by 43.8% while health care expenditures for workers' compensation increased by 79.2%, almost twice as fast.[2] Fraud has infected many systems. Experts believe that as many as twenty percent of all claims are fraudulent.[3] Increased litigation is having a disastrous impact on costs and is diverting an alarming proportion of benefit dollars away from injured workers in some systems.[4] Further, employee advocates and other groups have continued to push for expansion of workers' compensation laws to cover a continuously growing list of injuries and illnesses connected to workplace activity.[5]

State legislatures have reacted to these pressures by repeatedly amending workers' compensation laws. Indiana recently amended its Workers' Compensation Act[6] ("Act") when Governor Evan Bayh signed House Enrolled Act 1517 into law on May 20, 1991.[7] The new law introduced many significant changes to the Act, especially with respect to the permanent partial

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1. Ira Magaziner, President Clinton's Chief Policy Development Adviser, said at a recent meeting of the National Association of Manufacturers that "[t]he only thing worse than health insurance is workers' compensation. It's a mess. It's full of fraud and abuse and has huge adjudication costs." Mary Jane Fisher, *Auto, WC Figuring Into Clinton Plan*, Nat'l Underwriter, May 17, 1993, at 54.

2. Ruth Gastel, *Workers Compensation*, Ins. Info. Inst. Rep., Oct. 1992, at *2, *available in* LEXIS, COMPANY Library, IIABS File.

3. Peter Kerr, *Vast Amount of Fraud Discovered In Workers' Compensation System*, N.Y. Times, Dec. 29, 1991, at A1.

4. Gastel, *supra* note 2, at *3.

> In California, for example, despite recent reforms, many cases, particularly stress-related claims, still are litigated. Statewide, the overall litigation rate reached a record 13.8 percent of total new claims reported during the second quarter of 1991, up 17 percent from 1989. . . . A study of more than 1,000 claims settled in Kansas found that lawyers were involved in more than 70 percent of the cases. . . . Massachusetts is yet another state where costs have been driven up by litigation. Lawyers representing claimants made $86.6 million in fees in 1990, according to the state's Industrial Accident Board.

5. Gastel, *supra* note 2, at *7.

6. Ind. Code § 22-3-1-1 to -12-5 (1988 & Supp. 1992).

7. Act of May 12, 1991, Pub. L. No. 170-1991, 1991 Ind. Acts 2426.

benefit scheme,[8] which is one of the most complex and controversial aspects of any workers' compensation system.[9]

This Note examines Indiana's permanent partial benefit scheme and, specifically, the role played by the *American Medical Association Guides to the Evaluation of Permanent Impairment* ("*Guides*")[10] in determining an injured workers' level of permanent partial impairment. Part I begins the examination by briefly describing the origins of workers' compensation laws and the basic forms of compensation available to an injured worker in Indiana. Part II provides a brief general history and analysis of the permanent partial benefit and the theories which underlie its payment. Part III describes the permanent partial benefit in Indiana and how it was modified by House Enrolled Act 1517. Part IV then describes the role of the *Guides* in the rating process, addresses criticisms of its use as a tool to rate permanent partial impairment, and concludes that the use of the *Guides* should be mandated in Indiana.

I. Origins And Forms Of Compensation

A. The Origins of Workers' Compensation Laws

At common law, the only way employees could recover for workplace injuries was to sue their employers for negligence.[11] Employers, however, had many powerful defenses at their disposal, including fellow servant fault, employee assumption of risk, and contributory negligence by the employee, which often precluded the employee from recovering damages.[12]

During the 19th century, the industrial base in the United States increased dramatically. This expansion was accompanied by a significant increase in workplace accidents and injuries. Common law recovery was time consuming, costly, and often resulted in employees and their families being denied compensation.[13] The "grossest deficiencies and inequities of the common law led to employers' liability laws, which restricted the employer's legal

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8. Permanent partial benefits are those benefits which are paid to an injured worker when he sustains an injury that reduces his mental or physical capabilities. *See infra* note 41 and accompanying text.

9. Nat'l Comm'n on State Workmen's Compensation Laws, Report of the Nat'l Comm'n on State Workmen's Compensation Laws 66 (1972).

10. American Medical Association, Guides to the Evaluation of Permanent Impairment (4th ed. 1993) [hereinafter Guides].

11. Gastel, *supra* note 2, at *7.

12. Eliza K. Pavalko, *State Timing of Policy Adoption: Workmen's Compensation in the United States, 1909-1929*, 95 Am. J. of Soc. 592, 593 (1989).

13. *See* Nat'l Comm'n on State Workmen's Compensation Laws, *supra* note 9, at 34.

defenses."[14] Under these laws, however, employees were still required to prove employer negligence.[15]

As an alternative to employer liability laws, workers' compensation statutes began to emerge in the United States in the early 1900's. The first workers' compensation law was enacted in New York in 1910, but was held unconstitutional the following year.[16] As a result of New York's efforts, ten states, led by Wisconsin, enacted workers' compensation laws in 1911.[17] By 1949, every state had enacted some form of workers' compensation legislation.[18]

Indiana's workers' compensation law can be traced to July 7, 1909 when Mr. Addison C. Harris presented a paper to the Indiana State Bar Association entitled, "Modern Views of Compensation for Personal Injuries."[19] The paper described the plight of injured workers and urged Indiana lawyers to consider reform of the law dealing with workplace injuries.[20] The State Bar Association subsequently began drafting a workers' compensation plan to present to the Indiana General Assembly.[21] From 1909 through 1912 the Association wrestled with this issue, and later joined with the General Assembly to produce Indiana's first workers' compensation legislation, entitled the 1915 Workmen's Compensation Act.[22]

The current Indiana Worker's Compensation Act, as well as all other workers' compensation laws, reflects a compromise struck by employers and injured workers. An employer is obligated to provide limited compensation to workers whose injuries and illnesses arise out of and in the course of his employment, regardless of fault.[23] Workers who were previously precluded from recovery under common law theories are thus guaranteed compensation. In exchange, an injured worker relinquishes the right to sue his employer for negligence,[24] and an employer's liability is thereby reduced. The scheme is

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14. *Id.*
15. *Id.*
16. BEN F. SMALL, WORKMEN'S COMPENSATION LAW OF INDIANA § 1.2, at 5 (1950) (citing Ives v. S. Buffalo R. Co., 94 N.E. 431 (N.Y. 1911) (rejecting the idea of liability without fault)).
17. *Id.*
18. *Id.*
19. *Id.* at 6.
20. *Id.*
21. *Id.* at 7.
22. *Id.*
23. Collins v. Day, 604 N.E.2d 647, 648 (Ind. Ct. App. 1992).
24. Gastel, *supra* note 2, at *6. The exclusiveness of workers' compensation as the injured workers' sole remedy is often provided by statute. The Indiana Act provides:

> The rights and remedies granted to an employee subject to IC 22-3-2 through IC 22-3-6 on account of personal injury or death by accident shall exclude all other rights and remedies of such employee, the employee's personal representatives, dependents, or next of kin, at common law or otherwise, on account of such injury or death, except for

not based on notions of tort or contract law, but is instead social legislation designed to aid workers and their dependents[25] and "shift the economic burden for employment related injuries from the employee to the employer and consumers of its products."[26]

B. The Basic Forms of Compensation in Indiana

Most workers' compensation claims involve the payment of wage replacement and medical benefits for injuries or illnesses arising out of, and in the course of employment.[27] The balance of claims involve either the payment of a permanent total disability benefit or a permanent partial impairment benefit.

1. Wage Replacement.—Indiana law requires employers to pay wage replacement benefits and provides in part: "Compensation shall be allowed on account of injuries producing only temporary total disability to work or temporary partial disability to work."[28] The wage replacement benefit is payable to an injured worker for up to 500 weeks of disability or until the worker's medical condition becomes permanent and quiescent,[29] whichever occurs sooner.[30] The amount of the benefit depends on the worker's average weekly wage over the year preceding the date of the accident,[31] subject to maximum wage levels set forth in the Act.[32]

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remedies available under IC 12-8-6."

IND. CODE § 22-3-2-6 (Supp. 1992).

25. SMALL, *supra* note 16, § 1.2, at 2-3.

26. *Collins*, 604 N.E.2d at 648.

27. The phrases "arising out of" and "in the course of" are often the source of much controversy under the Act. These phrases emanate from the Act, which provides that employers and employees are "to pay and accept compensation for personal injury or death by accident *arising out of and in the course of* the employment." IND. CODE § 22-3-2-2 (Supp. 1992). "Arising out of" refers to the origin or cause of the accident and "in the course of" pertains to the time, place, and circumstances surrounding the accident. *See, e.g.*, Tom Joyce 7 Up Co. v. Layman, 44 N.E.2d 998, 999-1000 (Ind. Ct. App. 1942).

28. IND. CODE § 22-3-3-7(a) (Supp. 1992). Subsection (a) reads in its entirety as follows:

> Compensation shall be allowed on account of injuries producing only temporary total disability to work or temporary partial disability to work beginning with the eighth (8th) day of such disability except for medical benefits provided in section 4 [22-3-3-4] of the chapter. Compensation shall be allowed for the first seven [7] calendar days only if the disability continues for longer than twenty-one [21] days.

29. *See* Vantine v. Elkhart Brass Mfg. Co., 572 F. Supp. 636, 644-45 (N.D. Ind. 1983), *aff'd*, 762 F.2d 511 (7th Cir. 1985). If it is determined a worker's injury has become permanent and quiescent, and the employee has not fully recovered from his or her injury, the employee may be entitled to a permanent partial impairment benefit or a permanent total disability benefit. White v. Woolery Stone Co., 396 N.E.2d 137, 139 (Ind. Ct. App. 1979); *see also infra* Part III.B.

30. IND. CODE § 22-3-3-8 (1988).

31. *Id.*

32. IND. CODE § 22-3-3-22 (Supp. 1992).

The purpose of the wage replacement benefit is to provide injured workers with income during their disability from work.[33] The untoward circumstance of a disabling injury and the resulting discontinuance of income catches many workers without adequate means of support. Absent the immediate financial assistance provided by a wage replacement benefit, many workers would be in financial jeopardy during their recovery.

2. Medical Benefits.—The employer must also pay medical benefits to the injured worker. Indiana Code section 22-3-3-22 provides in pertinent part:

> After an injury and prior to an adjudication of permanent impairment, the employer shall furnish or cause to be furnished, free of charge to the employee, an attending physician for the treatment of his injuries, and in addition thereto such surgical, hospital and nursing services and supplies as the attending physician or the worker's compensation board may deem necessary.[34]

The liability of the employer for medical benefits is limited "to such charges as prevail in the same community for similar service to injured persons of like standard of living when such service is paid for by the injured person."[35] Neither the employee nor the employee's estate have any liability to a health care provider for payment for services obtained under the Act.[36] Claims for such services must be made against the employer and the employer's insurance carrier.[37]

Medical benefits are provided to ensure that injured workers are restored as nearly as possible to their pre-injury medical status, and also to assist in returning the injured worker to gainful employment as soon as possible.[38]

3. Permanent Total Disability.—A third basic form of compensation available to certain injured workers is the permanent total disability benefit. Indiana Code section 22-3-3-10(b)(3) provides that an employee shall receive 500 weeks of benefits at the employee's temporary total disability rate for

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33. NAT'L COMM'N ON STATE WORKMAN'S COMPENSATION LAWS, COMPENDIUM ON WORKMEN'S COMPENSATION 24 (1972).

34. IND. CODE § 22-3-3-4(a) (Supp. 1992).

35. IND. CODE § 22-3-3-5 (Supp. 1992).

36. *Id.*

37. *Id.* Prior to amendment by House Enrolled Act 1517 in 1991, *see supra* note 7, medical providers were allowed to "balance bill" employees for the portion of medical services not paid by the insurance carrier or employer. Thus, medical charges were infrequently challenged and there was suspicion that charges under workers' compensation were inflated and the result of cost shifting. With the amendment, several insurance carriers and employers are now challenging the reasonableness of medical charges in an attempt to control their medical costs. Telephone Interview with Douglas Meagher, Executive Director, Indiana Worker's Compensation Board of Indiana (Sept. 14, 1993).

38. JOHN H. LEWIS, REPORT TO THE GOVERNOR, MAJOR ISSUES IN THE INDIANA WORKER'S COMPENSATION SYSTEM 27 (Dec. 1990).

injuries resulting in permanent total disability.[39] "To establish a 'permanent total disability', the workman is required to prove he or she 'cannot carry on reasonable types of employment.' The 'reasonableness' of the workman's opportunities are to be assessed 'by his physical and mental fitness for them and by their availability.'"[40]

4. Permanent Partial Benefit.—The fourth type of compensation available to an injured worker is the permanent partial impairment benefit. Simply put, this benefit is payable to any worker who sustains an injury that reduces his overall physical or mental capabilities.[41] The benefit is paid when the worker's physical condition is permanent and quiescent.[42] At the point of permanence and quiescence, temporary total disability benefits and medical benefits terminate.[43]

II. History and Underlying Theories of the Permanent Partial Benefit

Permanent partial benefit claims account for the majority of workers' compensation costs in most systems.[44] In Indiana, only 2.5% of all cases involve a permanent impairment, yet the cost of permanent partial impairment claims represent more than 50% of total system costs.[45] Permanent partial benefits are also the most controversial and complex aspect of workers' compensation.[46] No other class of benefits has produced more variation among states or more divergence between statutes and practices.[47]

An injured worker who returns to work may be entitled to a permanent partial benefit based on physical impairment alone, disability caused by the impairment, or some combination of the two concepts depending on the state's statutory scheme. Impairment and disability are not synonymous in workers' compensation systems, and it is important to distinguish between the two concepts. Impairment refers to an "anatomical, physiological, intellectual or emotional abnormality or loss."[48] Disability refers to "inability or limitations in performing social roles and activities such as in relation to work, family, or

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39. Ind. Code § 22-3-3-10(b)(3) (Supp. 1992).

40. Rork v. Szabo Foods, 439 N.E.2d 1338, 1342 (Ind. 1982) (citations omitted).

41. Lewis, *supra* note 38, at 53.

42. *See infra* notes 102-03 and accompanying text.

43. *Id.*

44. Nat'l Comm'n on State Workmen's Compensation Laws, *supra* note 9, at 66.

45. Lewis, *supra* note 38, at 53. Permanent partial impairment benefits represent 27.3% of total system costs in Indiana. Individuals who receive permanent partial benefits however, also usually receive temporary disability and medical benefits, bringing the total cost of permanent partial cases to more than 50% of total system costs. *Id.*

46. Nat'l Comm'n on State Workmen's Compensation Laws, *supra* note 9, at 66.

47. *Id.*

48. Monroe Berkowitz & John F. Burton, Jr., Permanent Disability Benefits in Worker's Compensation 6 (1987) (citation omitted).

to independent community living."[49] Workers' compensation systems that award benefits on the basis of disability involve determinations of the economic consequences of the injury.[50] Alternatively, systems that award benefits on the basis of physical impairment do not consider the economic consequences of the injury and focus only on medical issues regarding the extent of the injury.[51] Disability and impairment represent the basic underpinnings of three theories for paying permanent partial benefits: (1) actual wage-loss; (2) permanent impairment; and (3) earning capacity loss.[52]

A. Actual Wage-Loss

The earliest workers' compensation statutes paid permanent partial benefits based on the actual wage-loss theory.[53] An actual wage-loss statute compares post-injury and pre-injury earnings and pays compensation for weeks in which actual post-injury earnings are less than pre-injury earnings.[54] Such a system has no scheduled losses.[55] Although the earliest workers' compensation laws employed an actual wage-loss rationale, no such system exists today in its pure form.[56]

Actual wage-loss systems were gradually eroded by certain changes in workers' compensation laws and practices, such as the introduction and expansion of scheduled losses.[57] The first statutes incorporating loss schedules appeared in 1912.[58] A schedule is a list of body members with a number of weeks of benefits assigned to each member for its loss or loss of use.[59] The early schedules were justified on two grounds: (1) "the gravity of the impairment supported a conclusive presumption that actual wage loss would sooner or later result; and (2) the conspicuousness of the loss guaranteed that awards could be made with no controversy whatever."[60] Initially, schedules were restricted to the loss or severance of major body members and did not cover partial loss or even total loss of use.[61] The schedules were gradually extended beyond major body members to cover smaller and smaller

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49. *Id.* at 8 (citation omitted).
50. LEWIS, *supra* note 38, at 54.
51. ARTHUR LARSON, WORKMEN'S COMPENSATION § 57.14(a), at 10-69 to 10-70 (1986).
52. *Id.* While the theories for payment of permanent partial benefits are analytically discrete, most systems are comprised of some combination of the theories. LEWIS, *supra* note 38, at 57.
53. LARSON, *supra* note 51, § 57.14(a), at 10-70.
54. *Id.*
55. Scheduled losses are discussed *infra* at notes 59-63 and accompanying text.
56. LARSON, *supra* note 51, § 57.14(a), at 10-70.
57. *Id.* § 57.14(d), at 10-81 to 10-82.
58. *Id.*
59. *See, e.g.*, IND. CODE § 22-3-3-10 (Supp. 1992).
60. LARSON, *supra* note 51, § 57.14(c), at 10-78.
61. *Id.* § 57.14(d), at 10-82.

members, the back, internal organs, the voice mechanism, and the body as a whole.[62] In addition, schedules were extended to cover the partial loss of use of certain body members.[63]

Workers' compensation systems also began to pay scheduled benefits in a lump sum rather than over a period of weeks, months, or years as originally intended.[64] This practice further obfuscated the underlying presumption of scheduled benefits, which was that the benefit represented future wage loss.[65] Workers came to view the lump sum permanent partial benefit as payment for a lost member,[66] and worse, often spent the benefit as quickly as they received it thereby retaining no means to cover lost earning capacity.[67]

Actual wage loss systems also faded from existence because they failed to address non-economic injuries. Under an actual wage-loss system, workers who return to their prior employment at the same level of pay, and who nevertheless experience tremendous difficulties in their personal life, receive no compensation for the non-economic loss they have suffered.[68] In addition, the administrative cost of tracking an employee's future wages and accounting for changes in wage levels that are not caused by an injury also contributed to

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62. *Id.* at 10-82 to 10-83.

63. *Id.* at 10-83.

64. *Id.*

65. *Id.* § 57.14(c), at 10-78.

66. Arthur Larson, *Basic Concepts & Objectives of Workmen's Compensation*, *in* 1 SUPPLEMENTAL STUDIES FOR THE NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS 31, 33-34 (1973). Larson refutes any notion that an injured worker is entitled to permanent partial benefits due to his physical loss of function alone. This "school of thought," says Larson, came about as a "result of a combination of mistaken notions about the nature of schedule benefits." *Id.* at 33. Further, Larson states:

> This controversy is of prime importance in analyzing what is wrong with workmen's compensation today. The trend toward indiscriminate awards of small lump sums for small permanent partial injuries, the "give-the-poor-guy-something" attitude, and the perversion of lump-sum commutations from their original purpose to a facile way of getting a quick short-term disposition of a case satisfying to the immediate parties and their attorneys, adds up to a significant reason why the system is under criticism and in some instances is not doing the job it was intended to do.

Id. at 34.

67. *Id.*

68. LEWIS, *supra* note 38, at 56. Larson, however, rejects the inequity of this situation and asserts that "any argument based on genuine unfairness would have to assume that the injury was attributable to the fault of the employer, using fault in a genuine moral sense, rather than in some constructive legal sense." LARSON, *supra* note 66, at 34. In this regard, Larson further states, "It would be certainly morally unfair to force the employer to pay the employee for a purely physical loss that the employee has brought upon himself by his own negligence or other misconduct." *Id.*

Note, however, that failure to address non-economic losses attributable to an injury led the National Commission on State Workmen's Compensation Laws to recommend in its report that permanent partial benefits should include limited payments for permanent impairments. NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, *supra* note 9, at 69.

the system's demise.[69] In other words, compensable changes in wage levels had to be distinguished from non-compensable influences like inflation, the employee's motivation to work, and intentional under-employment.[70]

B. Pure Impairment

The second theory for paying permanent partial benefits is pure impairment. The focus of this theory is the medical consequences of an injury. The impairment benefit is thought of as a proxy for lost earning capacity or actual wage loss,[71] or a method of compensating injured workers for losses they experience in their personal life unrelated to work.[72] Pure impairment theory requires an injured worker's condition to be evaluated and rated for loss of physical function or ability to function. The rating is then converted into a benefit payable to the employee.

The attractiveness of this system is its simplicity. The only two questions to answer are: (1) Is there a permanent impairment?; and (2) What is the level of that impairment?[73] The opportunity for dispute is minimal, and as a result there is generally less litigation than in other systems.[74]

The major criticism of a pure impairment system is its failure to directly address the economic impact of an injury.[75] For example, a stenographer whose hand is amputated sustains a greater economic loss than a lawyer with the same injury because the stenographer is unlikely to return to his vocation, yet both are equally compensated under a pure impairment theory. In addition, there is no guarantee that the method of rating permanent impairment will be uniform in a pure impairment system. The rating criteria may differ from doctor to doctor, or even if the same criteria are used, there is an element of subjectivity in the methods in which the criteria are applied to the rating process.[76]

C. Earning Capacity Loss

Earning capacity loss, the third basic theory for payment of permanent partial benefits, attempts to combine actual physical impairment with its economic effects to determine the employee's potential loss of earning capacity.[77] Such considerations as the individual's age and education, the

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69. LEWIS, *supra* note 38, at 56.
70. *Id.*
71. *See* John H. Lewis, *Indiana's Workers' Compensation Program: The Inexpensive Model?*, *in* JOHN BURTON'S WORKERS' COMPENSATION MONITOR, Sept.-Oct. 1991, at 5, 13.
72. NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, *supra* note 9, at 69.
73. LEWIS, *supra* note 38, at 54.
74. *Id.* at 55.
75. *Id.*
76. *Id. See also* notes 236-67 and accompanying text.
77. LEWIS, *supra* note 38, at 57.

impact of an injury on the employee's daily work activities, and the individual's work experience are considered in determining the permanent partial benefit.[78] In the previous example of the stenographer and the lawyer, an earning capacity loss system is more likely to provide the stenographer with a greater benefit because of his inability to return to his vocation.

Earning capacity loss systems also suffer from significant difficulties. Sorting out the multitude of factors that affect the benefit level is a cumbersome process, which typically produces prolonged settlement negotiations and, often, litigation.[79] Although experts claim that there is a movement to restore the centrality of the earning capacity loss theory,[80] the practical ability of this system to deliver benefits to those with the greatest economic loss has yet to be demonstrated.[81] Increased litigation tends to consume benefit dollars to the detriment of injured workers, and prolonged settlement negotiations keep needed benefits from injured workers.

III. Indiana's Permanent Partial Benefit

A. History

Generally speaking, Indiana's permanent partial benefit is based on pure impairment.[82] This has not always been the case. The 1915 Indiana Workmen's Compensation Act provided for permanent partial benefits based on disability, rather than impairment.[83] Recovery of the benefit was not based on "loss of a member, such as the loss of a limb, but . . . [on] the loss of earning capacity actually caused by the loss of the limb."[84] Scheduled losses were based on a presumption of diminished earning power extending through life.[85] Recovery for non-scheduled losses required proof of diminished earning capacity because the section of the 1915 Act dealing with such losses referred only to disability.[86]

In 1919 the Indiana General Assembly amended the section of the Act dealing with permanent partial benefits and replaced the word "disability" with

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78. *Id.*

79. *See id.*

80. Larson, *supra* note 51, § 57.14, at 10-69.

81. *See* Lewis, *supra* note 38, at 57.

82. One important exception to this proposition is disfigurement. Disfigurement is compensable "[i]n all cases . . . which may impair the future usefulness or opportunities of the employee." Ind. Code § 22-3-3-10(b)(7) (Supp. 1992). "Usefulness" and "opportunities" have been construed to require proof that the disfigurement interfered with the claimant's ability to earn a living. *See* Campbell v. Kiser Corp. & Diecast, Inc., 208 N.E.2d 727, 729 (Ind. Ct. App. 1965).

83. Centlivre Beverage Co. v. Ross, 125 N.E. 220, 221 (Ind. Ct. App. 1919).

84. *Id.*

85. *Id.* (quoting *In re* Denton, 117 N.E. 520, 523 (1917)).

86. *Id.*

the word "impairment" in every instance where the resulting condition was permanent.[87] Shortly thereafter, the amended Act was construed to allow permanent partial benefits for "physical impairment" and not just diminution of earning power for both scheduled and non-scheduled losses.[88]

Arguably, after the amendment to the Act in 1919 replacing the word "disability" with the word "impairment" Indiana's permanent partial impairment benefits were considered a proxy for lost earning power. For example, in his treatise, *Workmen's Compensation Law of Indiana*, Dean Ben F. Small defined impairment as "either a partial or a total loss of the function of some part or parts of the body, or of the body as a whole, with the result that work opportunities are limited."[89] It is not clear, after the 1991 amendments to the Act by House Enrolled Act 1517,[90] that this statement remains an accurate description of Indiana's permanent partial benefit as it exists today.[91]

B. Indiana's Current Permanent Partial Benefit

Today, the payment of permanent partial benefits is governed by Indiana Code section 22-3-3-10.[92] Paragraph (a) covers complete losses, including amputations, blindness, enucleation of an eye, hearing, and the loss of testicles.[93] Paragraph (b) covers total loss of use, partial loss of use, permanent total disability, whole body impairment, and disfigurement.[94] Paragraph (c) covers the same losses as paragraphs (a) and (b), but provides a different method of computing the permanent partial benefit for accidents occurring on and after July 1, 1991.[95]

Indiana's impairment scheme under the Act can be roughly divided into scheduled and non-scheduled losses. Scheduled losses under the Act include total or partial impairment by amputation or otherwise to a finger, hand, arm,

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87. *See* Edward Iron Works v. Thompson, 141 N.E. 530, 531-32 (Ind. Ct. App. 1923).

88. *Id.*

89. SMALL, *supra* note 16, § 9.5, at 247 (citations omitted).

90. *See supra* note 7.

91. The Report of the National Commission on State Workmen's Compensation Laws stated in its recommendation for reform of permanent partial benefits that impairment benefits might be appropriate in a worker's compensation system. NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, *supra* note 9, at 69. The Commission stated such benefits are justified because of loss incurred by a worker that is unrelated to lost remuneration. *Id.* Because the loss would have no relationship to wage loss, "there would be no necessity to link the value of the weekly benefits to the worker's own weekly wage." *Id.* Interestingly enough, one of the changes made to the Indiana Act in 1991 involved removing the connection between the average weekly wage and impairment benefit levels. *See infra* note 142 and accompanying text. Therefore, the benefit now more closely represents compensation for impairment rather than lost earning capacity.

92. IND. CODE § 22-3-3-10 (Supp. 1992).

93. *Id.* § 22-3-3-10(a).

94. *Id.* § 22-3-3-10(b).

95. *Id.* § 22-3-3-10(c).

toe, foot, leg, eye, hearing, and the complete loss of one or both testicles.[96] Also included under scheduled losses are double amputations (both hands or feet) or the total loss of sight of both eyes.[97] Non-scheduled losses covered by the Act involve impairment to the whole body including injuries to the back, pelvis, internal organs, psychological impairment, as well as any other impairment to the person not covered by the scheduled losses.[98]

Permanent partial benefits are paid to employees for impairment attributable to injuries arising out of and in the course of their employment.[99] The determination of impairment is completely distinct from the question of disability, and an employee may receive impairment benefits whether he is able to return to work or not. "'Impairment', as the word is utilized in the [Indiana] Workmen's Compensation Act, . . . connotes the injured employee's loss of physical function."[100] Disability on the other hand, refers to the injured employee's inability to work.[101]

An injury must be permanent and quiescent before permanent partial benefits are paid.[102] A finding of permanence and quiescence ensures that further medical benefits will not be required and prevents premature settlement or adjudication of claims. The permanence and quiescence of an injury are medical questions that must be established by expert testimony.[103] Consequently, the employee is not allowed to testify regarding this issue.[104] The assessment of impairment must be based on the functional loss present at the point when the employee's injury has become permanent and quiescent, and not based on a concern for future functional loss.[105]

The degree of impairment, in contrast to the permanence of the impairment, is a mixed question of lay and expert medical opinion. Thus, the employee may testify based on his experience and knowledge.[106] Evidence of lost earning capacity and disability is admissible to prove or disprove impairment of body function.[107] As a practical matter however, employee testimony is rarely relevant to the issue of impairment. Although statistics are not available, experience indicates that only a small percentage of claims

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96. *Id.*

97. IND. CODE § 22-3-3-10(c)(2).

98. Andrew C. Charnstrom, *Words for Permanent Partial Impairment and Death in* WORKER'S COMPENSATION LAW 1988 12 (1988).

99. IND. CODE § 22-3-2-2 (Supp. 1992); *see supra* note 27.

100. Rork v. Szabo Foods, 439 N.E.2d 1338, 1342 (Ind. 1982) (citations omitted).

101. *Id.* at 1343 (citations omitted).

102. White v. Woolery Stone Co., 396 N.E.2d 137, 139 (Ind. Ct. App. 1979).

103. Kenwood Erection Co. v. Cowsert, 115 N.E.2d 507, 508 (Ind. Ct. App. 1953)

104. *Id.*

105. Sears Roebuck & Co. v. Murphy, 508 N.E.2d 825, 831 (Ind. Ct. App.), *reh'g denied*, 511 N.E.2d 515 (1987); *see infra* note 259.

106. *Kenwood Erection Co.*, 115 N.E.2d at 509.

107. SMALL, *supra* note 16, § 9.5, at 246 (citing Miers v. Standard Forgings Co., 69 N.E.2d 180 (Ind. Ct. App. 1946)).

proceed to a formal hearing on the issue of impairment where the employee's testimony would be heard.[108] Most permanent partial impairment benefits are paid by agreement between the employee and employer, or their lawyers,[109] subject to approval by the Worker's Compensation Board of Indiana (Board).[110] Thus, there is usually no opportunity for an injured worker to testify about the degree of impairment.

The Board, as trier of fact, is given broad discretion to determine the level of impairment.[111] The findings of the Board will not be disturbed on review unless, based upon substantial evidence in the record, reasonable men would reach a contrary conclusion.[112] The Board may choose from the impairment ratings presented to it or compromise the values.[113]

The calculation of the permanent partial impairment benefit is simple but differs slightly depending on the date of accident. For accidents occurring prior to July 1, 1991, the benefit is calculated by converting the impairment rating into a number of weeks of benefits derived from either the schedule in the statute for scheduled losses or as a percentage of 500 weeks for non-scheduled losses.[114] The value of each week of benefits is based on a percentage of the employee's average weekly wage.[115] The number of weeks of benefits is multiplied by the weekly benefit, credit for wage replacement benefits is taken if appropriate,[116] and the portion accrued as of the date of the accident is paid in a lump sum with the remaining portion paid weekly until exhausted.[117] For example: Suppose an employee sustains an injury that results in a ten percent permanent partial impairment to the left hand. Total loss of use of a hand is valued at 200 weeks, and ten percent of 200 weeks is twenty weeks. Assume that the employee was subject to the maximum compensation rate of $120 each week.[118] The permanent partial impairment benefit would be $120 multiplied by 20 weeks, or $2,400.

Until July 1, 1991, the maximum weekly wage for permanent partial benefits was $120.[119] This positioned Indiana at the low end of a nationwide scale for payment of permanent partial benefits.[120] Observers complained

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108. Telephone Interview with Douglas Meagher, *supra* note 37.

109. According to a telephone and income replacement survey conducted by John Lewis, 22% of all permanent partial claims have attorney involvement. *See* Lewis, *supra* note 71, at 12.

110. Telephone Interview with Rita Bradley, Claims & Statistics Director, Worker's Compensation Board of Indiana (Sept. 14, 1993); *see* IND. CODE § 22-3-4-4 (Supp. 1992).

111. *See* Huffman v. United States Steel Corp., 268 N.E.2d 112, 113 (Ind. Ct. App. 1971).

112. Rork v. Szabo Foods, 439 N.E.2d 1338, 1341 (Ind. 1982) (citations omitted).

113. Wilson v. Betz Corp., 146 N.E.2d 570, 572 (Ind. Ct. App. 1957).

114. IND. CODE § 22-3-3-10(b)(6) (Supp. 1992).

115. IND. CODE § 22-3-3-10 (Supp. 1992).

116. *Id.*

117. *Id.*

118. *See* IND. CODE § 22-3-3-22 (Supp. 1992).

119. *Id.*

120. LEWIS, *supra* note 71, at 12.

that a low maximum benefit, coupled with impairment ratings determined by physicians, rendered Indiana's system deeply flawed and incapable of delivering appropriate benefits.[121] Throughout the late 1980s employee representatives pursued major changes in Indiana's workers' compensation system because of these and other perceived inequities.[122] These factors provided the impetus for Indiana to reform its workers' compensation system.

In 1990 Governor Evan Bayh appointed a Worker's Compensation Task Force (Task Force) to review the Indiana system and generate a comprehensive reform package to be introduced to the 1991 session of the Indiana General Assembly.[123] Governor Bayh's administration sought reform based on the belief that numerous amendments had caused the Act to stray from its original intent, which was "to provide an injured worker a certain source of compensation by eliminating the need to prove the employer's fault, while also providing the employer a relatively predictable level of financial exposure upon which it could seek insurance."[124] Bayh's administration sought to simplify the law thereby making it more accessible and understandable to the persons it was intended to serve.[125]

The Task Force was comprised of seven individuals from management, labor, and government.[126] Five committees were formed with appointees from business, labor, the legal and medical professions, and academia.[127] These committees included Agency Infrastructure and Data Management, Cost, Self-Insurance, Medical Care and Physical Rehabilitation, and Compliance and Safety Initiatives.[128]

Each committee was charged with analyzing specific workers' compensation issues and reporting their findings to the Task Force.[129] Governor Bayh also retained John H. Lewis to conduct an independent evaluation of the Indiana system and to provide information and assistance to the Task Force and the committees.[130] Permanent partial benefits were analyzed by the Task Force, which adopted, by a 6-0 vote, recommendations proposed by Lewis.[131]

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121. *Id.*

122. *Id.* at 5 ("Most of their concerns centered around the need for additional benefit increases, but they also included other issues such as the choice-of-physician mechanism, occupational disease coverage, and the ability of the employer or insurance carrier to terminate temporary total disability benefits at will.").

123. Release from Governor Evan Bayh, Governor of Indiana, *New Governor's Task Force Announced* (June 22, 1990) (copy on file with the *Indiana Law Review*).

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

129. LEWIS, *supra* note 71, at 5.

130. *Id.*

131. GOVERNOR'S TASK FORCE ON WORKER'S COMPENSATION AND OCCUPATIONAL DISEASE LAWS REFORM, TASK FORCE RECOMMENDATIONS, 28 (Dec. 17, 1990).

These findings were presented to Governor Bayh in the December 17, 1990 *Task Force Recommendations Report* and later became law with some modification, by the Task Force, of the benefit levels which were suggested by Lewis.[132]

As part of his analysis of the Indiana workers' compensation system, Lewis conducted telephone and income replacement surveys[133] and conclud-

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132. *See* IND. CODE § 22-3-3-10(c) (Supp. 1992). Although increasing benefit levels for the most severely injured, the benefit schedule passed by the Indiana General Assembly actually reduced benefits for persons with low impairment ratings as compared to the previous schedule.

> [A]s a result of the manner in which the phase-in [of increased benefits] is structured, those injured during the period July 1, 1991 through June 30, 1992 who have an average weekly wage of $200 or more and an impairment of thirty-five percent or less of the body will receive less than they would have received under the old law. The level of impairment affected by this benefit reduction will decrease during the phase-in, until it reaches ten percent on July 1, 1994.

LEWIS, *supra* note 71, at 16. The phase-in structure referred to by Lewis is provided below:

	Degrees	Dollars per Degree *of Impairment*
Current	1-100	$ 600
7/1/91	1-35	500
	36-50	900
	51-100	1,500
7/1/92	1-20	500
	21-35	800
	36-50	1,300
	51-100	1,700
7/1/93	1-10	500
	11-20	700
	21-35	1,000
	36-50	1,400
	51-100	1,700

Robert A. Fanning, *Worker's Compensation—Changes in Defense Practice in* WORKERS' COMPENSATION 1991 24 (1991).

133. *Lewis*, *supra* note 71, at 12. The findings of these studies included among other things: (1) "Ninety-seven percent of those in the telephone survey returned to work"; (2) 843 workers who were permanently injured in the first quarter of 1986 were doing better economically than a control group of workers randomly selected from the unemployment compensation program data base; (3) attorney involvement was substantially lower than most jurisdictions at only 22%; (4) two percent of those who were employed were not making as much as they were at the time of the injury; (5) "Sixty four percent felt that they had no work restrictions as a result of their injuries"; (6) "Eighty-three percent returned to the same employer, and approximately fifty percent of those were still with that employer four years later." (7) Thirteen percent were not working and 8.3% consider themselves disabled and unable to work; (8) "the only factor that could be identified as providing any correlation between injury factors and post-injury income loss was the level of

ed that the Indiana system, although simplistic and low cost, had begun to accomplish several meritorious goals.[134] A significant percentage of permanent partial benefits provided by the statute went to employees rather than attorney's fees and litigation costs.[135] Lewis also concluded that Indiana "returns a very high proportion of permanently injured workers to substantial employment."[136] To the extent that impairment benefits are intended to provide for future lost earning capacity or income, Lewis said:

> [I]t appears that there are relatively few permanent partial cases in Indiana that require income replacement assistance, or claimants who believe that their job abilities are any way affected by their injuries. For those who are suffering such losses, the impairment approach appears to be a reasonable way to predict who is likely to have the greatest [economic] need.[137]

The Indiana permanent partial benefit suffered from one major shortcoming according to Lewis. In his report to Governor Bayh, Lewis stressed that the benefit was one of the lowest in the nation.[138] To correct this situation, Lewis rejected solutions such as replacement of the pure impairment system with a pure wage-loss or loss of earning-capacity system because benefit levels would need to be increased significantly to enable such systems to deal with economic losses.[139] He also noted that there was little evidence to suggest that such an increase would go to the injured worker because litigation would most likely consume much of the increase.[140] Lewis concluded that if there was an interest in trying to more closely tie permanent disability benefits to economic loss, the existing permanent partial benefit system should be retained, but restructured, so that those who suffer the greatest impairment and who are most likely to suffer the greatest economic losses receive greater benefits.[141]

To accomplish the goal of directing more benefit dollars to those who are most likely to suffer economic loss, Lewis recommended two modifications of the then-existing system which were eventually adopted by the Indiana General Assembly. First, the connection was severed between benefit levels and average weekly wages.[142] Second, benefits were increased for higher

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impairment, and the only predictor (but not a guarantee) of eventual income loss was a relatively high level of impairment." *Id.*

134. *Id.*
135. *Id.*
136. *Id.* at 17.
137. *Id.* at 13.
138. LEWIS, *supra* note 38, at 59.
139. *Id.* at 60.
140. *Id.*
141. *Id.*
142. *See* IND. CODE § 22-3-3-10(c). Lewis justified elimination of the average weekly

impairment ratings.[143] The new scheme of computing permanent partial impairment benefits retained the scheduled losses contained in the statute.[144] Rather than each scheduled loss representing a number of weeks of benefits, each loss was converted to degrees of impairment.[145] The degree-based schedule retained the relative weight assigned to each scheduled loss in the week-based schedule.[146] Whole body impairment, previously expressed as 500 weeks of loss, was expressed as 100 degrees of loss.[147] Each degree of impairment was assigned a dollar value with the greater values at the higher levels of impairment[148] and the benefit was calculated in a cumulative fashion.[149] Payment of the benefit under the new system, as amended by the Indiana General Assembly, is still made on the basis of the employee's average weekly wage, but is now paid at the employee's temporary total disability rate.[150]

In his report to Governor Bayh, Lewis also briefly addressed how impairment is evaluated and rated by physicians in Indiana. He touched upon various issues raised by the present practice, but made no specific recommendation for legislative action.[151] As a result, House Enrolled Act 1517 left the method of evaluating impairment unchanged. Part IV of this Note undertakes an examination of this issue and concludes that the Indiana General Assembly may have some additional work to do to fulfill Governor Bayh's mandate.[152]

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wage as a basis for paying permanent partial benefits on his finding that 80% of permanent partial benefit recipients were receiving the maximum benefit under the old system. LEWIS, *supra* note 38, at 62. Thus, according to Lewis, Indiana might consider simply recognizing the fact that most workers are compensated irrespective of their average weekly wage and build the new system around this premise. One should note, however, that severing the connection between average weekly wages and benefit levels lessens the likelihood that economic loss is being compensated. If economic loss is the basis for the permanent partial benefit, it is illogical to compensate workers irrespective of their wages. *See supra* note 91.

Perhaps the average weekly wage scheme could have been retained with the maximum average weekly wage gradually increased for higher levels of impairment. This would have allowed only those with higher wages to collect higher benefits. Thus, the benefit would more closely compensate for economic loss.

143. *See* IND. CODE § 22-3-3-10(c).
144. *See id.*
145. *See id.*
146. *See id.*
147. *See id.* § 22-3-3-10(c)(11).
148. *See id.* § 22-3-3-10(d).
149. *See id.* § 22-3-3-10.
150. *See id.*
151. LEWIS, *supra* note 38, at 63-64.
152. *See supra* notes 123-25 and accompanying text.

IV. Evaluation of Permanent Partial Impairment in Indiana

A. The Role of the Guides to the Evaluation of Permanent Impairment

Generally speaking, Indiana does not prescribe under the Act, or by Board rule, a method for rating impairment.[153] Physicians, claims adjusters, and lawyers are given no legislative guidance regarding the content or extent of impairment evaluations. This is not to say that the practice of rating impairment is chaotic in Indiana.[154] In fact, most persons involved with workers' compensation claims in Indiana agree that the lion's share of permanent partial benefits are paid on the basis of an evaluation that relies in some measure on the *American Medical Association Guides to the Evaluation of Permanent Impairment.*[155]

The *Guides'* role in the Indiana workers' compensation system is to provide a physician, or other expert, with one method of evaluating and rating impairment. It is not the only impairment rating tool available to physicians[156] nor are its reporting and evaluation requirements always followed.[157] To a significant degree, the *Guides* plays only a supporting role in the system. Impairment ratings derived from the *Guides* are usually applied to the schedule in the Act,[158] or to other impairment rating tools developed by the Board, in order to derive a permanent partial impairment benefit.

The *Guides* originated from thirteen separate articles published from 1958 through 1970 in *The Journal of the American Medical Association.*[159] The first edition of the *Guides* was published in 1971 with the fourth and latest edition released in 1993.[160]

The fourth edition of the *Guides* consists of fifteen chapters, eleven of which relate to the evaluation of impairment for specific bodily systems. The first two chapters provide an overview of impairment evaluation and methods

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153. Two exceptions include the Board's "bone loss" rule and "multiple digital loss" schedule. *See infra* notes 300-09 and accompanying text.

154. Lewis, *supra* note 38, at 63.

155. Guides, *supra* note 10. Interview with Douglas Meagher, *supra* note 37 (stating the *Guides* are the major source of impairment ratings in Indiana). *See also infra* note 210 (without exception, every health care professional interviewed for this Note used the *Guides* to some degree in evaluating impairment).

156. There are several alternative sources available to rate impairment. *See* Richard E. Johns, *Compensation and Impairment Rating Systems in the United States*, Journal of Disability, Oct. 1990, at 198-99.

157. *See infra* notes 197-233 and accompanying text.

158. The permanent partial impairment benefit for a non-scheduled loss is derived directly from the impairment rating. *See supra* note 98 and accompanying text.

159. American Medical Association, Guides to the Evaluation of Permanent Impairment xix (3rd ed. rev. 1991) [hereinafter Guides - 3rd ed.].

160. Guides, *supra* note 10, at 1.

for preparing records and reports. The final two chapters address psychological disorders and pain.

The purpose of the *Guides* is to provide "a standard framework and method of analysis through which physicians can evaluate, report on, and communicate information about the *impairments* of any human organ system."[161] Under the *Guides*, impairment and disability are defined in roughly the same manner as under Indiana law.[162] Impairment is defined in the *Guides* as the "deviation from normal in a body part or organ system and its functioning."[163] It is assessed by medical means and is a medical issue.[164] Disability, which the *Guides* is not intended to evaluate, is defined in the *Guides* as "an alteration of an individual's capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements, because of an impairment."[165] Evaluating disability is "a nonmedical assessment of the degree to which an individual does or does not have the capacity to meet personal social, occupational, or other demands, or to meet statutory or regulatory requirements."[166]

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161. *Id.* (emphasis added). The ability of any impairment evaluation system to accomplish this task is problematic. Indeed, the editors of the Guides acknowledge that

> the *Guides* does not and cannot provide answers about every type and degree of impairment, because of . . . [the inability of physicians to identify objective data on the normal functioning of some organ systems] and the infinite variety of human disease, and because the field of medicine and medical practice is characterized by constant change in understanding disease and its manifestations, diagnosis, and treatment.

Id. at 3.

162. *See supra* notes 100-01 and accompanying text.

163. GUIDES, *supra* note 10, at 1.

164. *Id.*

165. *Id.* at 2.

166. *Id.* at 317. The distinction in the *Guides* between impairment and disability appears fairly clear. However, consider the following passages from the *Guides*:

> In the *Guides*, impairments are defined as conditions that interfere with an individual's "activities of daily living," some of which are listed in the Glossary (p. 315). Activities of daily living include, but are not limited to, self-care and personal hygiene; eating and preparing food; communication, speaking, and writing; maintaining one's posture, standing, and sitting; caring for the home and personal finances; walking, traveling, and moving about; recreational and social activities; and *work activities.*

Id. at 1 (emphasis added).

Here, the distinction between disability and impairment is blurred beyond recognition. In fact, the two concepts appear to be intimately connected. Further, the foreword to the *Guides* expressly recognizes this connection and provides that "[p]ermanent impairments are evaluated in terms of how they affect the patient's daily activities, and this edition recognizes that one's occupation constitutes part of his or her daily activities." *Id.* at v-vi.

Interestingly, the *Guides* later disavows any connection between an impairment rating and disability: "The impairment estimate or rating is a simple number. Although it may have been derived from a well structured set of thorough observations, it does not convey any information about the person or the impact of the impairment on the person's capacity to meet personal, social, or occupational demands." *Id.* at 8.

The *Guides* is widely used in workers' compensation systems across the country. Its use is mandated by statute in some states; by policy, directive or regulation in others; and is used, although not mandated, in a few states.[167] The *Guides* is also the most highly regarded impairment rating tool available today.[168] Although widely used and highly regarded, the *Guides* is not without its critics. These criticisms, however, do not seriously detract from the *Guides*' usefulness as an impairment rating tool.

B. Criticisms of the Guides

1. Garcia v. Eagle Pass Auto Electric, Inc..—A recent decision by a Texas trial court in *Garcia v. Eagle Pass Auto Electric, Inc.*[169] incited critics of the *Guides* to challenge the validity of any system linking permanent partial benefits directly to impairment ratings based on the *Guides*.[170] After *Garcia*, one lawyer postulated that hundreds of thousands of injured workers who had been denied benefits in systems that use the *Guides* could have new claims and, that even the American Medical Association could face liability for the *Guides*' misuse.[171]

In *Garcia*, the plaintiffs, Garcia, the Texas AFL-CIO, and the Texas Legal Services Union, Local No. 2, sued Eagle Pass Auto Electric, the Texas Workers' Compensation Commission, and George Chapman in his capacity as executive director of the commission to obtain declaratory and injunctive relief.[172] Plaintiffs argued in part that the 1989 Texas Workers' Compensation Act's mandate that permanent partial benefits be paid to workers with

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167. LARSON, *supra* note 51, § 54.11 at 10-492.80.

> In March, 1988, the U.S. Department of Labor published a table showing that use of the AMA Guide was mandated by statute in these states: Alaska, Florida, Georgia, Kentucky, Louisiana, Maryland, Montana, Nevada, New Hampshire, Oklahoma, Oregon, and Tennessee and by policy directive, or regulation in Arizona, Delaware, District of Columbia, Hawaii, Iowa, North Dakota, South Dakota, Vermont and Washington. In the following states it was used although not mandated: Alabama, Arkansas, Colorado, Idaho, Indiana, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, Rhode Island, South Carolina, Texas, Utah, and Wyoming. In the remaining states it was not used.

Id.

168. *See infra* notes 193-94 and accompanying text.

169. Garcia v. Eagle Pass Auto Elec., Inc., No. 90-11-10301 CV (Dist. Ct. Maverick Cnty., 365th Judicial Dist. of Texas, Dec. 31, 1990).

170. *See* Gary Taylor, *Workers' Comp Under Attack; AMA Guides Criticized*, NAT'L L.J., June 24, 1991, at 3.

171. *Id.*

172. Texas Workers' Compensation Comm'n v. Garcia, No. 04-91-00565-CV, 1993 WL 302683, at *1 (Tex. Ct. App. Aug. 11, 1993), *aff'g*, Garcia v. Eagle Pass Auto Elec., Inc., No. 90-11-10301-CV (Dist. Ct. Maverick Cnty, 365th Judicial Dist. of Texas, Dec. 31, 1990). Two plaintiffs, Fuller and Rivero, lacked standing and were dismissed from the suit. Eagle Pass Auto Electric presented no defense and did not appeal the judgment of the lower court.

permanent impairment as determined by the "'second printing . . . of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association . . .'" violated the open courts, due course of law, and equal protection provisions of the Texas Constitution.[173] The trial court agreed and found in pertinent part that the Act's use of the *Guides* as a basis for awarding compensation was unconstitutional because impairment ratings derived from the *Guides* do not have an "adequate scientific or medical foundation."[174] The court stated that the *Guides* was not a reasonable approach to impairment and was "dreadfully flawed" because it failed to cover illnesses such as chronic pain and mental trauma.[175] The trial court also proclaimed that impairment percentages generated by the *Guides* had no reasonable relationship to "true impairment."[176]

The Texas Court of Appeals affirmed the lower court but did not directly attack the *Guides*' ability to measure impairment as the trial court had done. Instead, the court of appeals criticized the Act's use of the *Guides*.[177]

The court reasoned in part that the Act's use of the *Guides* violated the open courts provision of the Texas Constitution because it constituted an unreasonable and arbitrary restriction of a cognizable common law cause of action when balanced against the purpose and basis of the workers' compensation statute.[178]

To establish the unreasonableness and arbitrariness of the Act's use of the *Guides*, the court of appeals highlighted the testimony of Dr. Smith, an editor

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173. *Id.* at *12 (citation omitted). The constitutionality of the pure impairment system under the Indiana Constitution is beyond the scope of this Note. It should be noted, however, that the Indiana Worker's Compensation Act has employed a pure impairment approach since 1919 and that most constitutional challenges to the Act have failed. *See* Warren v. Indiana Tel. Co., 26 N.E.2d 399 (Ind. 1940) (Workmen's Compensation Act does not violate Indiana Constitutional provisions that courts shall be open, due course of law, right of trial by jury); Buckler v. Hilt, 200 N.E. 219 (Ind. 1936) (limit on attorney's fees under the Act to amount fixed by Board not violative of the Fourteenth Amendment of the United States Constitution); Collins v. Day, 604 N.E.2d 647 (Ind. Ct. App. 1993) (exclusion of agricultural workers from coverage does not violate equal protection or equal privileges and immunities guaranties); Eastham v. Whirlpool Corp., 524 N.E.2d 23 (Ind. Ct. App. 1988) (due process does not require that full board hold trial de novo after hearing before single member); McGinnis v. American Foundry Co., 149 N.E.2d 309 (Ind. Ct. App. 1958) (right to compensation barred by expiration of one year time limit under Occupational Diseases Act is not a violation of rights of due process and equal protection of law under Indiana Constitution). *But see* Portman v. Steveco, Inc., 453 N.E.2d 284 (Ind. Ct. App. 1983) (presumptive dependency statute relating to worker's compensation benefits violates equal protection provisions of Federal and Indiana Constitutions, to the extent that it employs gender-based discrimination).

174. Garcia v. Eagle Pass Auto Elec., Inc., No. 90-11-10301 CV at 12.

175. *Id.*

176. *Id.*

177. *Texas Workers' Compensation Comm'n*, 1993 WL 302683 at *24.

178. *Id.* at *16-*24.

of the *Guides*:

> Dr. Smith . . . testified that the Act utilizes the Guides in an arbitrary manner. He testified that the Guides "state very specifically that the impairment rating number is not to be put into a one-to-one correspondence with disability or any other concept under which money is to be paid." The Act uses the impairment rating from the Guides as a percentage factor in computing the amount to be paid, a method specifically disapproved by the Guides.[179]

While dissimilar to the trial court's assault on the *Guides*' ability to measure impairment, Dr. Smith's testimony appears to support an argument that it is inappropriate for any impairment system to directly convert a *Guides*-based impairment percentage into an impairment benefit. Interestingly, this argument finds further support, apart from the *Garcia* decision, in the latest edition of the *Guides* which provides in relevant part that "[i]t must be emphasized and clearly understood that impairment percentages derived according to the Guides criteria should not be used to make direct financial awards or direct estimates of disabilities."[180] Neither the court's basis for reaching this conclusion nor the apparent support for this conclusion in the most recent edition of the *Guides*, however, survives careful examination.

First, a key piece of evidence referred to by the court did not support Dr. Smith's testimony. After referring to Dr. Smith's testimony, the court quoted a passage from the *Guides* as evidence of their misuse. That passage provided:

> Each administrative or legal system that uses permanent impairment as a basis for disability rating needs to define its own process for translating knowledge of a medical condition into an estimate of the degree to which the individual's capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements, is limited by the impairment. We encourage each system not to make a "one-to-one" translation of impairment to disability, in essence creating a use of the Guides which was not intended.[181]

As Dr. Smith testified, this language from the *Guides* does advise against a one-to-one translation of impairment to disability. However, the language from the *Guides* does not specifically disapprove of using an impairment rating as a percentage factor in computing the amount to be paid, as Dr. Smith's testimony indicated and the court concluded.

Further, and quite separate from the *Garcia* court's unpersuasive analysis, there are at least three additional reasons to reject the argument that *Guides*-based impairment ratings should not be directly converted into impairment

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179. *Id.* at *18.

180. GUIDES, *supra* note 10, at 5.

181. *Texas Workers' Compensation Comm'n*, 1993 WL 302683 at *23 (citation omitted).

benefits. First, evaluating impairment by itself provides no benefit to an injured worker. The whole purpose of evaluating impairment is to convert the results of the evaluation into a benefit. For the injured worker, a *Guides*-based impairment rating is worthless unless it is converted into a benefit. A prohibition against using a *Guides*-based impairment rating to directly determine a benefit would render the *Guides* useless in most, if not all, workers' compensation systems based on pure impairment. Surely, the editors did not have this in mind when they drafted the above language.

Second, whether a *Guides*-based impairment rating becomes part of a benefit calculation is within the province of legislators who develop benefit schemes and not the editors of the *Guides*.[182]

Third, the key language, "direct financial awards," from the latest edition of the *Guides* is subject to interpretation. Rather than a proscription against converting an impairment percentage into an impairment benefit in all systems, the language more likely proscribes such activity in those systems that base the impairment benefit on non-medical factors not measured by a *Guides*' based rating.[183] This interpretation is supported by the fact that the language at issue is immediately preceded by a discussion of the importance of distinguishing between medical and non-medical information in workers' compensation systems that compensate employees for impairment to their bodies.[184] Further, this interpretation is a less radical departure from the immediately preceding edition of the Guides which provided:

> Each administrative or legal system using permanent impairment as a basis for disability rating should define its own process for translating knowledge of a medical condition into an estimate of the degree to which the individual's capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements, is limited by the impairment.[185]

From this language, it is impossible to argue that the *Guides* proscribes using an impairment rating as a factor in calculating permanent partial benefits. Instead, this passage only proscribes the use of an impairment rating as the sole basis for a disability rating.

With respect to the purpose and basis for workers' compensation, the Texas Court of Appeals stated that the workers' compensation law is intended "'to provide adequate, equitable and timely benefits to injured workers, at a

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182. "The editors who testified [in Garcia] were making a statement about workers' compensation, not medical information," said Attorney General Delmar Cain of Texas. Taylor, *supra* note 170, at 3. "They say they don't think you should plug [the GUIDES] into a workers' compensation system, but I think that's a legislative function." *Id.*

183. *See supra* notes 162-66 and accompanying text.

184. *See* GUIDES, *supra* note 10.

185. GUIDES-3RD ED., *supra* note 159, at 4.

reasonable cost to employers.'"[186] The historical basis for workers' compensation laws is the workers' relinquishment of the right to sue his employer for negligence in exchange for a system that compensates him at least partially for loss of earning capacity as a result of an industrial injury.[187] The court stated the Act's "pure impairment-based system is not an adequate or reasonable substitute for worker's common law negligence actions,"[188] and "for this reason the Act's use of the *Guides* violates . . . our constitution."[189]

The importance of these conclusions is paramount and they form the crux of what the court really found unacceptable about the Act.[190] The court's unwillingness to accept the legislature's adoption of a pure impairment system over a loss of earning capacity system preordained the Act's use of the *Guides* as unconstitutional. The inescapability of this conclusion derives from the fact that the *Guides* was never intended nor designed to measure lost earning capacity.[191] This apparent attempt to legislate from the bench[192] helps one to understand why the court failed to recognize significant testimony supportive of the *Guides*' use in a pure impairment system. For example, as the dissent noted, the court failed to recognize that three experts who testified at trial referred to the *Guides* as "state of the art" and several experts agreed that there was "no better written study or text for determining impairment."[193] Dr. Smith, cited by the majority to support its conclusions, testified that the *Guides* may be properly used to determine the extent and degree of impairment.[194] Further, The Report of the National Commission on State Workmen's Compensation Laws, referred to by the majority for the proposition that pure impairment is an improper basis for permanent partial benefits,[195] actually recommended incorporation of pure impairment as part of a permanent partial benefit scheme, and sanctioned the use of the *Guides* as a "rational" basis for evaluating an injury or disease.[196]

As is demonstrated above, and as the dissent concluded; Garcia was "the work of a court hell-bent on striking down the Act, not a court dispassionately reviewing a statute from a coordinate branch of government to see if it is

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186. Texas Workers' Compensation Comm'n v. Garcia, No. 04-91-00565-CV, 1993 WL 302683 at *19 (Tex. Ct. App. Aug. 11, 1993) (citation omitted).

187. *Id.* at *22; *see* notes 23-26 and accompanying text.

188. *Texas Workers' Compensation Comm'n*, 1993 WL 302683 at 24.

189. *Id.*

190. *Id.* at *63 (Peoples, J. dissenting).

191. *See supra* notes 162-66 and accompanying text.

192. *Texas Workers' Compensation Comm'n*, 1993 WL 302683 at *55 (Peoples, J. dissenting).

193. *Id.* at *67.

194. *Id.*

195. *See id.* at *21-22.

196. NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, *supra* note 9, at 69.

rationally related to valid goals."[197] As such, any criticism of the *Guides* based on the *Garcia* decisions is misplaced and unpersuasive.

2. Improper Use.—Any contribution that the *Guides* makes to a permanent partial benefit system requires its proper use. The text is "complicated and technical"[198] and is intended to be used as an aid to the physician to "estimate" the extent of impairment of nearly any human organ system.[199] Unfortunately, evidence suggests that many physicians in Indiana fail to adhere to *Guides*' criteria in both evaluating and reporting impairment.

The *Guides* prescribes the components of a proper impairment evaluation. "[T]he first key to effecting an accurate impairment evaluation is a review of office and hospital records maintained by the physicians who have cared for the patient since the onset of the medical condition."[200] The second step is to show that the medical condition "has been present for a period of time, is stable, and is unlikely to change in future months in spite of treatment."[201] Third, the physician is advised to perform an impairment evaluation "to obtain enough clinical information to characterize [the injury] in accordance with the *Guides* requirements."[202] The final step is to compare the findings of the evaluation with the clinical information already available and determine whether the two sources of information are consistent.[203] If they are inconsistent, further evaluation should be performed in an attempt to satisfactorily resolve any discrepancies.[204]

Under the *Guides,* physicians are expected to complete a comprehensive report containing a description and analysis of every finding used to support a permanent partial impairment rating.[205] For example, the physician should include the following in his report: (1) a narrative history of the medical condition; (2) a description of the results of the most recent clinical evaluation; (3) a statement of plans for future treatment, rehabilitation, and reevaluation; (4) the diagnoses and clinical impressions; (5) an explanation of the impact of the medical condition on life activities; (6) the medical basis for concluding

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197. *Texas Workers' Compensation Comm'n*, 1993 WL 302683 at *67 (Peoples, J. dissenting).

198. *Id.* at *15.

199. GUIDES, *supra* note 10, at 7.

200. *Id.* at 3. The text of the *Guides* provides:

> Such records include clinical notes, medical consultation reports, hospital records, admission and discharge summaries, notes on operations, pathology and laboratory test reports, and reports on special test and diagnostic procedures. Using multiple sources of information and attempting to ensure that the sources are objective can help eliminate bias, an error introduced by selecting or encouraging one outcome over another.

Id.

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.* at 10.

that the medical condition and patient's symptoms have or have not become stable; (7) a discussion about restrictions or accommodations with respect to daily activities or activities that are required to meet personal, social, and occupational demands; (8) explanation of each impairment value with reference to the applicable criteria of the *Guides*; and (9) a description of the specific clinical findings related to each impairment, with reference to how the findings relate to and compare with the criteria in the *Guides*.[206]

In practice, few of these reporting requirements are satisfied by most Indiana physicians.[207] Impairment evaluation reports typically contain only the name of the claimant, the date of accident, a brief description of the part of the body injured, and the impairment rating at the smallest organ level with translations to successively large organs up to the whole person.[208] Few, if any reports contain a narrative history of the medical condition, a description of the most recent clinical evaluation with reference to the *Guides*, a statement that the condition is stable, conclusions regarding restrictions or accommodations, or any of the other requirements in the *Guides*.[209]

Interviews with a variety of health care professionals actively involved in occupational medicine in Indiana also indicate that there is a significant degree of deviation from evaluation techniques prescribed by the *Guides*, and a wide range of evaluation methods employed by physicians.[210]

In whole or in part, impairment evaluations are sometimes delegated to nurses, physical therapists, occupational therapists, and other health-care professionals.[211] Some physicians repeat these evaluations while others rely exclusively on the findings of these professionals.[212] Clinical notes from physical therapy, occupational therapy, functional capacity evaluations, and clinical findings of other doctors are sometimes ignored by physicians.[213] Other physicians, with less confidence in evaluating impairment, rely heavily on this data to support their impairment estimates.[214] Occasionally, physicians performing independent medical evaluations to assess impairment do not have a patient's complete medical history, treatment records, or even

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206. *Id.*

207. Telephone Interview with Shal Marie McPherson, Claims and Statistics, Worker's Compensation Board of Indiana (Nov. 10, 1993).

208. *Id.*

209. *Id.*

210. Telephone interviews were conducted with health care professionals in central Indiana specializing in orthopaedics, physiatry, hand surgery, occupational and physical therapy, and occupational medicine (Sept. 1993) (interview notes are available from the author) [hereinafter Telephone Interviews with Central Indiana Healthcare Professionals].

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

impairment evaluations performed by other physicians before rendering their opinion on impairment.[215]

There are several reasons why impairment evaluations and reports fail to meet the criteria in the *Guides,* none of which are directly attributable to the *Guides* itself.

One of the most significant reasons for deviation from the *Guides* is that the Board's agreement approval process for permanent partial impairment benefits does not require submission of a complete report based on the criteria prescribed by the *Guides.* Most permanent partial benefits are paid by agreement between the employer and the employee.[216] In the agreement process, the physician renders an impairment rating and the employer completes an agreement that delineates the portion of the body rated, the rating number, and the calculation of the permanent partial benefit.[217] The employee and employer both sign the agreement and submit it to the Board for approval.[218] The agreement must be accompanied by the medical report containing the impairment rating[219] and a waiver of the employee's right to obtain another impairment evaluation.

The Board employs a two-step agreement review process: (1) the agreement is checked to be sure that the proper part of the body was rated; and (2) the benefit is re-calculated to ensure that no computational errors were made.[220] If the proper part of the body was rated and the calculations are correct, the Board will approve the agreement.[221] The agreement is then returned to the employer who pays the permanent partial benefit. Other than checking to be sure the correct part of the body has been rated, there is no attempt to review the adequacy of the medical report submitted with the agreement, nor an attempt to review the adequacy of the medical evaluation.[222] Under these circumstances, even the most conclusive impairment reports are sufficient to obtain approval from the Board. Doctors may not be aware that impairment ratings are subject to such cursory review procedures, but this fact is certainly known to the insurance companies and employers who request these reports. This process provides little incentive to produce a report or conduct an evaluation that even approximates the *Guides*' requirements.

Some deviation from the *Guides* can also be traced to cost considerations and time pressures placed on doctors from insurance companies, employers,

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215. *Id.*

216. Interview with Douglas Meagher, *supra* note 37. The agreement is usually consummated by completing an "Agreement to Compensation of Employee And Employer," State Form 1043 (R/S-88).

217. Telephone interview with Rita Bradley, *supra* note 110.

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

and lawyers. The cost of an evaluation that complies with criteria from the *Guides* can be as high as $500.00 and obtaining such a report can take anywhere from four to six weeks or longer.[223]

Another reason for deviation from the *Guides* is that some treating physicians disdain performing an impairment evaluation because it has very little to do with treating or rehabilitating a patient.[224] These doctors are more likely to deviate from the *Guides'* evaluation process.

The variety of methods used by physicians in evaluating impairment may also be caused by disparities in training and knowledge among physicians concerning impairment evaluations.[225] One Indiana physician who has received special training in performing impairment evaluations with the *Guides* said that "many doctors think they are using the *Guides* correctly but only a very small percentage actually do."[226]

In most instances, doctors receive no special training in medical school to perform impairment evaluations.[227] Some doctors are exposed to the process through their residency training.[228] The level of exposure in residency depends on the specialty of the doctor and the setting for the program.[229] For example, a doctor in an orthopaedic residency program located near a highly industrialized area might gain some experience in conducting impairment evaluations.[230] Conversely, the same resident in a university setting would be less likely to deal with occupational injuries and have less of an opportunity to gain experience in impairment evaluations.[231]

Once in practice, most doctors develop whatever impairment evaluation skills they may have through practical experience or educational programs and seminars.[232] Although the level of involvement in educational programs and seminars focusing on impairment evaluation skills is difficult to assess, this sort of activity does not appear to be having much of an impact on the quality of reporting and evaluation techniques used by many physicians. Perhaps more substantial and focused training is required. At least two organizations offer specialized training, information, and accreditation for evaluating

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223. Telephone interviews with Central Indiana Healthcare Professionals, *supra* note 210.

224. Mark D. Sullivan, M.D. & John d. Loeser, M.D., *The Diagnosis of Disability Archives of Internal Med., Am. Med. Ass'n*, Sept. 1992, at 2 (available in LEXIS GENMED Library, ARIM File) (citations omitted) .

225. Telephone interview with Central Indiana Healthcare Professionals, *supra* note 210.

226. *Id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. *Id.*

impairment.[233] Unfortunately, their role in the Indiana medical community is presently very limited.

Although, misuse of the *Guides* appears to be widespread, it is imperative to recognize that its causes are rooted in the way that the text is used and not in the text itself. Moreover, the causes of misuse are not intractable and simple measures could be taken to ensure that medical evaluations comply with *Guides*-based criteria. For example, the Board agreement review process could require that all medical reports conform to a standard format with reporting criteria that ensures complete and thorough impairment evaluations.[234] Standard reports could be easily scanned for completeness and the content of randomly selected reports could be completely evaluated for accuracy and correct evaluative methodology with little disruption of claims processing. This change would force insurance companies and employers to request more complete reports and evaluations from physicians. Additionally, the Board's power to reject inadequate evaluations would provide an incentive for physicians to develop their impairment evaluation skills. The Board might even go a step further and require that all physicians who perform impairment evaluations receive special training or accreditation.

3. Inequity of a Guides-based Rating.—An effective delivery system for permanent partial benefits must distribute benefits equitably. In order to be

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233. The first organization is the Work Fitness & Disability Section ("WFDS") of the American College of Occupational & Environmental Medicine ("ACOEM"). WFDS was formed "to bring together those physician members of ACOEM who have a special interest in or who practice in the field of Work Fitness and or Disability [evaluation]." *Draft Bylaws of Section of Work Fitness and Disability Evaluation*, WORK FITNESS & DISABILITY EVALUATION, SECTION NEWSLETTER, AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE, Nov.-Dec. 1992, at Attachment C. WFDS produces a newsletter and sponsors meetings, seminars, and other functions to promote the education of its members and to facilitate the exchange of information, problems, and solutions on disability and impairment evaluation issues. WFDS does not have an accreditation process and membership is somewhat limited in Indiana - the section has only ten members in its five-state central region. Telephone Interview with Carl Otten, M.D. (Oct. 12, 1993). There are 137 ACOEM members in Indiana. The central region consists of Illinois, Indiana, Wisconsin, Iowa, and Missouri.

The American Academy of Disability Evaluating Physicians ("AADEP") is another organization offering physicians an opportunity to develop and sharpen their impairment rating skills. AADEP was formed in 1987 and its primary objective is "to advance uniform standards in the evaluation of an individual who would have a disability." AMERICAN ACADEMY OF DISABILITY EVALUATING PHYSICIANS, AADEP MEMBERSHIP DIRECTORY, 1992-93, at 2. AADEP's goals are to: (1) "foster, develop, support and augment knowledge of the rolls and responsibilities of fully qualified doctors of medicine and osteopathy in the performance of disability evaluations"; (2) "[e]stablish qualifications and promote specialized training programs that lead to these qualifications in this specialized area of the practice of medicine"; and (3) "[r]ecognize the attainment and maintenance of the competency in the Disability Evaluation field through various levels of membership and certification." *Id.* AADEP divides membership into two classes: (1) Active Member, and (2) Fellow. Presently, five AADEP Fellows and one Active Member practice medicine in Indiana. *Id.* at 63, 92.

234. Such a form can be found in the *Guides*. *See* GUIDES, *supra* note 10, at 11-12.

equitable, impairment estimates under the *Guides* must be valid and reliable.[235] The *Guides* is a valid tool for measuring impairment if its rules produce appropriate and acceptable conclusions about impairment.[236] The *Guides* is a reliable tool if its results are reproducible.[237] In other words, if two physicians perform separate impairment evaluations of one worker, the evaluations should draw similar conclusions about the workers' physical functional ability.

Certain characteristics of the impairment evaluation process and the *Guides* impairment rating scheme may introduce inequities into the system that cause impairment ratings to be invalid and unreliable. For example, one facet of doctor behavior that affects the validity and reproducibility of impairment ratings is the concurrent roles that most doctors play—treating physician and rating physician.

In Indiana, most permanent partial impairment ratings are prepared by the physician who originally treated the worker. The *Guides* does not sanction this practice, nor does it disapprove of it. As a practical matter, a treating doctor is most often the rating doctor because it is more efficient for a doctor who is familiar with a patient's history to rate that patient's impairment. Combining treatment and rating functions in one doctor could cause impairment to be understated. An impairment rating is in some measure an assessment of the treating doctor's success in restoring functional ability.[238] Therefore, treating physicians who rate their own patients are to some extent evaluating their own work and may be less likely to complete an objective evaluation.

The *Guides* impairment rating scheme also appears to detract from the validity and reproducibility of a *Guides*-based impairment evaluation. Several areas of the *Guides* require the rating physician to assess "activities of daily living" as part of the impairment evaluation.[239] An impairment evaluation based on activities of daily living is less objective and reproducible than one that requires the use of devices or objective diagnostic tests to measure functional and anatomical impairment.[240] Which activities of daily living are relevant to a patient's impairment, and to what degree, must be determined by the rating physician and are likely to vary from practitioner to practitioner thereby diminishing the likelihood of valid and reproducible impairment ratings.

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235. Ellen Smith Pryor, *Flawed Promises: A Critical Evaluation of the American Medical Association's Guides to the Evaluation of Permanent Impairment*, HARV. L. REV. 964, 973 (1990) (book review).

236. *Id.*

237. *Id.*

238. Telephone interviews with Central Indiana Healthcare Professionals, *supra* note 210.

239. *See infra* note 276.

240. Pryor, *supra* note 235, at 974.

Patient values and goals may also negate the validity and reproducibility of an impairment evaluation.[241] In assessing impairment, doctors face the daunting task of separating patients who cannot perform a physical function from those who will not perform a physical function.[242] *Guides*-based criteria for measuring impairment, such as range of motion, endurance, and strength, all depend upon what the patient cannot do as well as what the patient will not do. The task is to separate function that cannot be performed from function that will not be performed because the former is compensable while the latter is not.

Most employees probably do not embellish the magnitude of their injury by intentionally limiting function or malingering,[243] but there is a contingent of workers who are adept at this tactic of benefit maximization.[244] There are a variety of forces that contribute to such behavior. A worker might act this way because other workers' compensation benefits (i.e., temporary total or temporary partial benefits)[245] usually fail to fully compensate most workers for their disability from work. For example, the weekly wage replacement benefit is limited to sixty-six and two-thirds of the average weekly wage in Indiana[246] and the average weekly wage is subject to maximum levels contained in the Act.[247] Additionally, it is not uncommon for an injured worker to be angry with his employer for having been injured at work, especially when the injury was caused by an actual or perceived unsafe work practice. This worker may be prone to adopt behavior intended to draw attention to his situation or to make the company pay for his injury.

Job dissatisfaction caused by a lost promotion, conflicts with co-workers, disputes with managers and supervisors, monotonous work, or other forms of social distress are "regularly transformed into medical distress as pain. For example, among the strongest predictors of disabling back pain developing on the job are work satisfaction and social relations in the work place."[248] Here inability to function is caused by social factors rather than a physiological condition.

Inability to function that has little to do with physical injury or physical impairment has a definite impact on evaluations through self-limiting behavior during the impairment evaluation. There is another impact that is less obvious. Workers who behave this way may also indirectly inhibit their recovery of physical function through decreased effort during rehabilitation.[249]

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241. Sullivan, *supra* note 224, at *7.
242. *Id.* at *6.
243. GUIDES, *supra* note 10, at 298.
244. Kerr, *supra* note 3, at A1.
245. *See supra* Part I.B.
246. IND. CODE § 22-3-3-8 (Supp. 1992).
247. IND. CODE § 22-3-3-22 (Supp. 1992).
248. Sullivan & Loeser, *supra* note 224, at *10.
249. *Id.* at *8.

One way of diminishing the impact of these problems on the validity and reproducibility of impairment evaluations using the *Guides* is to make an impairment rating as dependent on objective criteria as possible. The *Guides* does this in various areas by offering a doctor the option of assessing impairment on the basis of a diagnosis rather than a physical examination.[250] Impairment based on diagnosis focuses on objective clinical findings whereas impairment based on a physical examination incorporates subjective considerations that affect function. For example, diagnosis based impairment for a partial meniscectomy of the knee is ten percent permanent partial impairment to the leg.[251] Examination based impairment for such a condition might result in no permanent partial impairment if the knee functions normally after surgery.

Generally, the evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient.[252] The doctor might choose one over the other method based on prophylactic concerns,[253] whichever rating is greater,[254] whether the objective findings fit specific criteria,[255] or whether the doctor expects the patient to have greater impairment in the future.[256]

One problem with diagnosis based impairment is that the inference from objective criteria to functional deficit is "often spurious."[257] For example,

> [i]n back pain, typical roentgenographic findings such as degenerative disk disease correlate poorly with observed functional deficits or pain: 80% of individuals complaining of back pain have roentgenographically demonstrable lumbar disk disease, but so do 70% of asymptomatic adults. Reference to structural abnormalities increases the objectivity of disability rating without increasing their validity. Many parameters shape function besides structure.[258]

Another problem with diagnosis based impairment is that Indiana law does not require employers to pay permanent partial benefits unless there has been an actual loss of physical function.[259]

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250. This is done for the lower extremity and the spine. For the spine the process is called a "diagnosis-related estimate" and for the lower extremity it is called a "diagnosis-based estimate." GUIDES, *supra* note 10, at 84-88, 94.

251. *Id.* at 83.

252. *Id.* at 84.

253. *Id.*

254. "For instance, a patient with a femoral neck fracture with nonunion, who requires one crutch, should be rated for use of the crutch or for the nonunion plus the range of motion restriction, whichever is greater." *Id.*

255. *Id.* at 94.

256. Telephone interviews with Central Indiana Healthcare Professionals, *supra* note 210.

257. Sullivan & Loeser, *supra* note 224, at *9.

258. *Id.*

259. In Sears Roebuck & Co. v. Murphy, 508 N.E.2d 825 (Ind. Ct. App. June 11, 1987)

Although diagnoses based impairment may not adequately address the inequities of a *Guides* based impairment evaluation, the *Guides* remains "the best written study or text for determining impairment."[260] Further, with the exception of incorporating activities of daily living, the inequities previously discussed do not find their genesis in the *Guides*' impairment rating scheme nor does there appear to be any impairment rating tool that is equipped to deal with factors like values and motivation. By the *Guides*' own admission, complete objectivity in evaluating impairment is impossible because the process involves not only objective and scientific data but also a physician's skill, training, experience, and judgment—all attributes that "compose part of the 'art' of medicine."[261] The *Guides'* impairment rating scheme was designed to increase objectivity and enhance equity by enabling "physicians to evaluate and report medical impairment in a standardized manner, so that reports from different observers are more likely to be comparable in content and completeness."[262] To increase objectivity, the *Guides* makes use of "medically accepted and scientifically derived data on normal functioning . . . " whenever possible.[263] When objective data on normal function was unavailable, the *Guides*' contributors "estimated the extent of impairments on the basis of their clinical experience, judgment, and consensus."[264] The subjective nature of a *Guides*-based impairment evaluation is important and sometimes overlooked by legislators who prescribe its use.[265] In fact, one critic argued that the *Guides*' claim of objectivity is "deeply flawed" because it "obscures" from the reader the normative decisions of its editors and of evaluating physicians.[266]

4. Obscured Normative Decisions.—The latest version of the *Guides*, like the preceding editions, incorporates the normative decisions of its editors and of evaluating physicians through its impairment rating scheme. In a review of

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plaintiff Murphy injured his knee at work and submitted to surgical removal of a portion of the medial meniscus or internal fibro-cartilage of his knee joint. The treating physician estimated Murphy's impairment as five percent of the leg on the basis that Murphy had lost part of his medial meniscus and might have functional loss in the future. The Board awarded Murphy five percent permanent partial impairment and the Indiana Third District Court of Appeals reversed, holding that the mere loss of cartilage in a knee without more is not the kind of loss that is compensable in Indiana. Permanent partial impairment must not be based on a concern for future problems or the actual loss of a body structure. *Id.* It must be based on present functional loss. *Id.*

260. Texas Workers' Compensation Comm'n v. Garcia, No. 04-91-00565 CV, 1993 WL 302683, at *55 (Tex. Ct. App. Aug. 11, 1993) (Peoples, J. dissenting).

261. GUIDES, *supra* note 10, at 3.

262. *Id.* at 5.

263. *Id.* at 3.

264. *Id.*

265. Pryor, *supra* note 235, at 965.

266. *Id.* at 964-65. Pryor was examining the third edition of the Guides but her criticisms appear equally applicable to the fourth edition.

the third edition of the *Guides*, Ellen Smith Pryor concluded that those who prescribe the *Guides*' use must be aware of this fact and should not view the *Guides* as purely technical or medical in nature.[267]

Pryor first notes that impairment exists at both the organ and whole person level.[268] Measures of organ level impairment are based on comparisons between healthy and non-healthy appearance and function.[269] Measurement at the whole person level is based on the person's ability to perform activities of daily living.[270] Activities of daily living might include such things as self-care and personal hygiene; communication; sitting, lying down, and standing; walking and climbing stairs; driving, riding, and flying; grasping, lifting, tactile discrimination; having normal sexual function and participating in usual sexual activity; restful sleep; and having the ability to participate in group activities.[271]

According to Pryor, normative judgments enter the impairment evaluation through the *Guides* in at least two ways. First, at both the organ and whole person level, the selection of the activities to be measured, and the decision about what level of activity or ability will serve as the norm, introduces the editors' non-medical subjective considerations into the impairment rating. This occurs at the whole person level than the organ level where one might argue that there is a general consensus about normal function.[272]

Second, organ level impairment ratings are often expressed in terms of whole person impairment thereby incorporating normative characteristics into the rating at the organ level.[273] The *Guides* accomplishes this by providing physicians with tables that translate organ level impairments into whole person impairment, and encourages physicians to express all impairments in terms of the whole person.[274] The whole person impairment levels in these tables, concludes Pryor, "must rest on the authors' assessment of how the measured losses (e.g., range of motion loss) affect the person's ability to carry on activities of daily living."[275]

Several chapters of the *Guides* also expressly define impairment criteria in terms of the restrictions or limitations that impairments impose on a patient's ability to carry out activities of daily living.[276] This puts the

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267. *Id.* at 968.
268. *Id.* at 967.
269. *Id.*
270. *Id.*
271. GUIDES, *supra* note 159, at 243.
272. Pryor, *supra* note 236, at 968
273. *Id.*
274. *Id.* at 971; GUIDES, *supra* note 10, at xviii ("The *Guides* continues to espouse the principles that all impairments affect the individual as a whole and that all impairments should be expressed as impairments of the 'whole person.'").
275. Pryor, *supra* note 235, at 971.
276. *See* GUIDES, *supra* note 10, at 141 (The Nervous System), 170 (The Cardiovascular

selection and weighing of activities of daily living in the hands of the physician. Thus, the physician's personal biases and assumptions concerning activities of daily living also become part of the impairment evaluation.[277] Even more significant, guidelines and examples of activities of daily living contained in the *Guides* also evidence a strain of gender bias that may influence an evaluator.[278]

Pryor's point is valid—it is important to appreciate the subjective nature of a *Guides'*—based impairment evaluation and the manner in which it is obscured from the reader. It is equally important to understand that certain aspects of Indiana's permanent partial benefit system reduce the practical importance of normative decisions by the *Guides'* editors and evaluating physicians and thereby diminish the importance of these concerns.

First, as discussed earlier, the permanent partial impairment benefit might be thought of as a proxy for lost earning capacity.[279] As such, the incorporation of normative factors from the *Guides*, or anywhere else, is absolutely inconsequential as long as the final benefit approximates a workers' lost earning capacity—something the Indiana system appears to accomplish.[280]

Second, for injuries at the organ level, benefits are most often paid for impairment to the organ and not on the basis of impairment to the whole person.[281] This is done to ensure that proper credit can be taken for previous injuries, and so that credit can be taken for injuries to the same organ in the future.[282] Therefore, the incorporation of normative considerations through translation of organ level impairment to whole person impairment is greatly diminished.

Third, the Indiana system does not rely solely on an impairment rating to determine the level of impairment. At a hearing, the authority to decide which activities of daily living are relevant to the level of impairment ultimately rests with the Board who must weigh the relative probative value of prooffered

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System), 202 (The Hematopoietic System), 301 (Mental and Behavioral Disorders), 307 (Pain).

277. Pryor, *supra* note 235, at 969-71.

278. *Id.* at 969. The fourth edition of the *Guides* also contains examples indicating gender bias. *See, e.g.*, *Guides*, *supra* note 10, at 179 ("A 62-year- old woman . . . was able to care for her house and perform other activities without symptoms . . ."); *id.* at 183 ("A 52-year-old woman . . . had had increasing breathlessness during daily activities, such as climbing stairs, mopping, or cleaning."). *But see id.* at 182 ("A 35-year-old woman . . . avoided participation in sports at the advice of physicians.").

279. *See supra* notes 71-76 and accompanying text.

280. *See* LEWIS, *supra* note 71, at 13.

281. *See* IND. CODE § 22-3-3-10 (Supp. 1992).

282. *See* IND. CODE § 22-3-3-12 (1988). This provision reads:

> [I]f the permanent injury for which compensation is claimed, results only in the aggravation or increase of a previously sustained permanent injury or physical condition, . . . the board shall determine the extent of the previously sustained permanent injury . . . and shall award compensation only for that part of such injury . . . resulting from the subsequent permanent injury.

expert medical opinion and lay testimony regarding an injury's impact on activities of daily living. [283]

C. Mandating the Guides' Use

The criticisms analyzed in Part III.B do not, on balance, significantly diminish the *Guide*' usefulness in a pure impairment system like the Indiana system. Indeed, a compelling case can be made for Indiana to mandate the use of the *Guides* to rate permanent partial impairment.

1. State of the Art.—Most experts agree that there is "no better written study or text in determining impairment" [284] than the *Guides.* Its impairment rating methodology is thorough and comprehensive[285] and reflects the most current research and expertise in evaluating impairment.[286] In light of these facts, it is not surprising that the *Guides* is presently the most widely used impairment rating tool in workers' compensation systems across the country.[287] If the use of any impairment rating tool is to be mandated in Indiana, it should be the *Guides.*

2. Eliminate Needless Complexity.—The existence of multiple impairment rating tools in Indiana makes the present permanent partial benefit system needlessly complex. If Indiana were to mandate the use of the *Guides*, the system could be greatly simplified.

In most cases, an impairment rating is derived from the *Guides* and applied to the schedule in the Act.[288] Some finger injuries, however, are not rated using the *Guides*. The Board has promulgated a rule that automatically awards an employee thirty-three percent impairment of the finger for an injury causing loss of bone to the distal interphalangeal joint of a finger.[289] An impairment rating based on any other source, including the *Guides*, that fails to award at least a thirty-three percent impairment of the finger for such an injury, will be rejected by the Board.[290] Additionally, a single injury involving more than one finger on the same hand is assessed with only partial reference to the *Guides.* The Board has developed a multiple digital loss schedule that provides the minimum value at which permanent partial benefits for injuries to more than one finger on the same hand should be calculated.[291] The multiple digital loss schedule is intended to compensate such

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283. *See supra* notes 110-12 and accompanying text.

284. Texas Workers' Compensation Comm'n v. Garcia, No. 04-91-00565 CV, 1993 WL 302683, at *55 (Tex. Ct. App. Aug. 11, 1993) (Peoples, J. dissenting).

285. *See supra* notes 200-06 and accompanying text.

286. Johns, *supra* note 156, at 198-99.

287. *See supra* note 167.

288. Telephone interview with Douglas Meagher, *supra* note 37.

289. Telephone interview with Rita Bradley, *supra* note 110.

290. *Id.*

291. Memorandum from the Worker's Compensation Board of Indiana, *Compensation Table*

injuries as an impairment to the arm below the elbow and is based, "to the closest degree possible," on the following formula: "1. Find the total value of the loss of the separate digital and phalange members. 2. Find the percentage of this value in relation to 40 degrees.[292] 3. Increase the total allowance of the separate values by this percentage."[293]

Application of a *Guides*-based impairment rating to the schedule in the Act adds an unnecessary step to the calculation of impairment. The values in the schedule were arbitrarily determined long ago[294] and have remained unchanged despite significant advances in the understanding of the relationship between specific injuries and the extent of impairment.[295] Additionally, the relative value of individual organs to whole body impairment in the *Guides* is inconsistent with the values assigned in the schedule[296] and superimposing the *Guides*-based impairment rating scheme on the schedule in the Act confounds the impairment rating. The schedule may have once "provide[d] a short cut to the determination of benefits to be paid,"[297] but it has outlived its usefulness with the development of impairment rating tools like the *Guides*.[298] Mandating the use of the *Guides* would allow Indiana to dispose of this archaic, arbitrary, and duplicative rating tool and thereby simplify the impairment rating process.

Similarly, the Board's bone loss rule adds a needless layer of complexity to the system and should be abandoned and replaced by the *Guides*. This rule was promulgated in large part to reduce disputes over impairment ratings.[299]

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for Multiple Digital Loss to the Hand (undated) (on file with author).

292. 40 degrees represents 100% loss of use of the arm below the elbow. IND. CODE § 22-3-3-10(c)(1) (Supp. 1992).

293. Memorandum from the Worker's Compensation Board of Indiana, *supra* note 292. For example, "[l]oss of the first phalanges of the thumb and index finger would be computed under this formula as follows:

Value of the first phalange of the thumb = 6 degrees
Value of the first phalange of the index finger = 2.67 degrees
Total specific loss = 8.67 degrees
8.67 degrees = 21% of 40 degrees
21% of 8.7 degrees = 1.82 degrees
1.82 degrees plus the specific 8.7 degrees = 10.5 degrees." *Id.*

294. Centlivre Beverage Co. v. Ross, 125 N.E. 220, 221 (Ind. Ct. App. 1919) (The schedules in the Act "provide arbitrarily that for certain injuries there shall be awarded compensation for a certain period definitely fixed.").

295. NAT'L COMM'N ON STATE WORKMAN'S COMPENSATION LAWS, *supra* note 9, at 69.

296. For example, complete loss of use of a thumb is valued as 22% of the whole person in the *Guides*. *See* GUIDES, *supra* note 10, at 18-20. Under the Act, the thumb is worth 12% of the person. IND. CODE § 22-3-3-10(c)(1) (Supp. 1992). Complete loss of use of the leg in the *Guides* is worth 40% of the person. GUIDES, *supra* note 10, at 83. Under the Act, the same loss is worth 45% of the person. IND. CODE § 22-3-3-10(c)(1).

297. NAT'L COMM'N ON STATE WORKMEN'S COMPENSATION LAWS, *supra* note 9, at 69.

298. *Id.*

299. Telephone interview with Rita Bradley, *supra* note 110.

The *Guides* provides an adequate and complete method for determining impairment in such cases.[300] Few doctors know about the bone loss rule[301] and it produces a fair amount of confusion and delay in processing claims because, despite the rule, many ratings rely initially on criteria from the *Guides* or other sources.[302] Further, the rule does not measure true physical impairment and is inconsistent with judicial interpretations of the Act because it is based on diagnosis rather than an examination of impairment.[303] Under the *Guides*, approximately two-thirds of the distal interphalangeal joint must be amputated before impairment of the finger reaches thirty-three percent while, under the rule, any loss of bone yields the same rating.[304] Under the *Guides* impairment due to bone loss could be as low as two or three percent of the finger.[305]

The Board's multiple digit loss schedule could also be eliminated by mandating use of the *Guides*. Its values are arbitrary and as compared to *Guides* criteria, the schedule overstates impairment between ten and twenty percent depending on the combination of fingers lost.[306] Because most doctors are unfamiliar with its provisions, the multiple digital loss schedule also tends to delay the payment of benefits.

3. Enhance Equity and Reduce Potential for Litigation.—In most cases, the present system does not specify what tool must be used to rate impairment.[307] Physicians are free to use any tool or combination of tools they desire. Because each impairment rating tool employs its own impairment rating scheme, it is possible for employees with similar injuries to receive largely disparate impairment ratings. Mandating use of one tool, like the *Guides*, would greatly diminish this potential inequity and enhance the likelihood of employees receiving similar benefits for similar injuries.

Similarly, failure to require that all impairment ratings derive from one source makes comparisons between competing impairment ratings very difficult. For example, an employee might obtain an impairment rating from their doctor based on the outdated Disability Evaluation and Treatment of Compensable Injuries,[308] while the employer's physician might rate the impairment with the fourth edition of the *Guides*. Resolving a discrepancy between the two ratings is clearly a problematic task simply because the ratings are based on two different impairment rating methodologies. This

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300. GUIDES, *supra* note 10, at 30.

301. Telephone interviews with Central Indiana Healthcare Professionals, *supra* note 210.

302. Telephone interview with Shal-Marie McPherson, *supra* note 207.

303. *See supra* note 260 and accompanying text.

304. *See* GUIDES, *supra* note 10, at 30; Memorandum from the Worker's Compensation Board of Indiana, *supra* note 291.

305. GUIDES, *supra* note 10, at 30.

306. *See* GUIDES, *supra* note 10, at 35.

307. *See supra* notes 152-54 and accompanying text.

308. *See* Johns, *supra* note 156, at 198-99.

difficulty is likely to prevent the parties from amicably resolving this issue thereby increasing the likelihood of litigation. The *Guides* was designed to make impairment ratings more comparable in content and completeness[309] and mandating its use would diminish the likelihood of litigation.

V. CONCLUSION

When the Indiana Act was amended in 1991, significant changes were made to the method of computing permanent partial benefits, but the method of rating and evaluating impairment was not modified.

The Guides to the Evaluation of Permanent Impairment is presently an important part of the Indiana permanent partial benefit system but it appears to be frequently misused. Other than this difficulty, which could be easily corrected by revising the Board's agreement review process, criticism of the *Guides* is largely unpersuasive. In fact, the *Guides* is a tool that appears to have been tailor-made for the Indiana workers' compensation system. Requiring that all impairment ratings be based on the *Guides* and eliminating all other impairment rating tools would simplify the present system, enhance equity, and move the Worker's Compensation Act of Indiana one step closer to Governor Bayh's worthy goal of making the system accessible and understandable to the persons it was intended to serve—Indiana's injured workers.

309. GUIDES, *supra* note 10, at 5.