No. 17-117725-S

IN THE SUPREME COURT OF THE STATE OF KANSAS

HOWARD JOHNSON III,
Claimant-Appellant

v.

U.S. FOOD SERVICE and
AMERICAN ZURICH INSURANCE CO.,
Respondents-Appellees

STATE OF KANSAS *ex rel.*
ATTORNEY GENERAL DEREK SCHMIDT,
Intervenor

PETITION FOR REVIEW

Appeal from the Workers Compensation Appeals Board
Docket No. 1,075,741

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PRAYER FOR REVIEW

The State of Kansas respectfully requests that this Court grant review and reverse the Court of Appeals' decision. This appeal is subject to review as a matter of right under K.S.A. 60-2101(b) since the Court of Appeals found a state statute to be unconstitutional. Alternatively, this Court should grant review under K.S.A. 20-3018(b) given the important constitutional question presented and the Court of Appeals' incorrect analysis.

DATE OF THE DECISION OF THE COURT OF APPEALS

The Court of Appeals' decision was issued on August 3, 2018.

STATEMENT OF THE ISSUE FOR REVIEW

1. Whether the Legislature's adoption of the Sixth Edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment as the guide to be used for measuring permanent impairment under the Kansas Workers Compensation Act violates Section 18 of the Kansas Constitution's Bill of Rights.

STATEMENT OF THE FACTS

The facts concerning Mr. Johnson's injuries as stated by the Court of Appeals are accurate as far as the State is aware, but the Court of Appeals' description of the Sixth Edition of the AMA Guides is skewed.

For instance, the Court of Appeals' opinion cites one doctor as claiming that there is no scientific support for the ratings in the Sixth Edition. Opinion at 29. But the opinion fails to acknowledge the substantial legislative history to the contrary.

When the Legislature was considering a return to the Fourth Edition, the Kansas Medical Society—the statewide organization representing Kansas physicians—opposed the proposed change, explaining: "The current Sixth Edition of the AMA Guides reflects the current best science and expert consensus. The Fourth Edition is out of date by two decades." See Attachment 6. And Dr. J. Mark Melhorn, an orthopedic surgeon and professor at the University of Kansas School of Medicine, speaking on behalf of the Kansas Medical Society, testified that "the majority of physicians favor using the 6th Edition, which is based on the most recent science." *See* Attachment 7.

Similarly, the Court of Appeals' opinion states that ratings are 40% to 70% lower under the Sixth Edition than the Fourth Edition. Opinion at 29. It is unclear where this alleged fact comes from, but it certainly was not a factual finding of any lower tribunal. *See* Attachments 2 and 3 (administrative decisions). In fact, one study has shown that average whole person ratings under the Sixth Edition are not significantly less than average ratings under the Fourth Edition. Attachment 6 at 3; Attachment 8 at 5. Some ratings are lower based on advancements in medical knowledge. *See* Attachment 4 at 4 (noting that for the spine, previous editions did not take into account improved outcomes with newer surgical techniques); Attachment 6 at 1 (noting that the Fourth Edition did not take the benefits of healthcare into consideration for many conditions and in particular spinal ratings); Attachment 6 at 10 ("Spine surgery has changed significantly over the last 20 years."). But the Sixth Edition also provides increased ratings for other conditions.

See Attachment 8 at 2 (noting that the Sixth Edition includes ratings for conditions that previously did not result in ratable impairment, such as nonspecific spinal pain and certain soft-tissue conditions); Attachment 8 at 4 (study finding that 27% of diagnoses with no impairment rating under the Fourth Edition had one under the Sixth Edition); Attachment 4 at 4 (noting that previous editions did not provide methods for rating some commonly occurring workplace conditions in the upper limb, such as trigger digit, wrist ganglion, TFCC tear, and elbow epicondylitis). "In addition, many procedures now being commonly performed by surgeons treating injured workers can be rated by the Sixth Edition, but are not mentioned in the Fourth Edition, because they had not yet been developed. Examples include total shoulder replacement, reverse total shoulder replacement, total ankle replacement, cervical artificial disc replacement, lumbar artificial disc replacement, etc." Attachment 6 at 2.

The Court of Appeals is not a fact finding body and erred in cherry-picking alleged facts, in the absence of relevant factual findings by a lower tribunal, to support its conclusion that the Sixth Edition is unconstitutional.

ARGUMENT WHY REVIEW IS WARRANTED

I. This appeal is subject to review as a matter of right.

This appeal is taken as a matter of right under K.S.A. 60-2101(b), which provides:

> [A]ny decision of the court of appeals shall be subject to review by the supreme court as provided in subsection (b) of K.S.A. 20-3018, and amendments thereto, *except that any party may appeal from a final decision of the court of appeals to the supreme court, as a matter of*

> *right, whenever a question under the constitution of either the United States or the state of Kansas arises for the first time as a result of such decision.*

(Emphasis added.) Admittedly, the meaning of the italicized language is less than clear. But the provision should be read as authorizing an appeal as a matter of right when a statute is determined to be unconstitutional for the first time by the Court of Appeals.

This interpretation makes the most sense given the context of this provision. The statute earlier provides that "[a]n appeal from a final judgment of a district court in any civil action in which a statute of this state or of the United States has been held unconstitutional shall be taken directly to the supreme court." K.S.A. 60-2101(b). It would be odd to have an appeal as of right to the Supreme Court (bypassing the Court of Appeals) from a district court decision holding a statute unconstitutional but not an appeal as of right when the Court of Appeals holds a statute to be unconstitutional for the first time (either because the district court upheld the statute or because, as here, the administrative agency below had no jurisdiction to address the constitutional challenge).

II. This Court should grant review under K.S.A. 20-3018(b).

Even if an appeal as of right is not provided by law, this Court should grant review under K.S.A. 20-3018(b) given the important constitutional question presented and the Court of Appeals' questionable analysis.

A. This Court should grant review given the important constitutional question presented.

Review is warranted in this case given the "general importance of the question presented" as well as the need for this Court to exercise its supervisory authority. K.S.A. 20-3018(b); *see also* S. Ct. Rule 8.03(b)(6)(E)(i) (the "presence of an issue of public importance, consequence, or attention" is a reason for review). The separation of powers requires that statutes must be presumed constitutional. *See State ex rel. Morrison v. Sebelius*, 285 Kan. 875, 883-84, 179 P.3d 266 (2008). When a lower court takes the momentous step of invalidating a statute passed and signed by the coordinate branches of government—comprised of officials who have sworn to abide by the Constitution, *see* Kan. Const. art. 15, § 14; K.S.A. 54-106—respect for those coequal branches counsels that this Court should review the decision.

Review is also warranted because this case presents an issue of first impression. *See* S. Ct. Rule 8.03(b)(6)(E)(ii). This Court has never before addressed the constitutionality of the Sixth Edition of the AMA Guides. And while the Court of Appeals held the Sixth Edition unconstitutional *as applied* in an earlier case, *Pardo v. United Parcel Service*, ___ Kan. ___, 422 P.3d 1185 (2018), this is the first case to hold the Sixth Edition *facially* unconstitutional.

This is also an "issue likely to recur that is in need of immediate resolution by the court." S. Ct. Rule 8.03(b)(6)(E)(vii). Numerous workers compensation claims are decided each year, and the amount of compensation in many of those claims may depend on which edition is used. The lack of review by this Court would result in continuing uncertainty and confusion, particularly since a decision of one Court

of Appeals panel is not binding on future panels. *See Osterhaus v. Toth*, 39 Kan. App. 2d 999, 1008, 187 P.3d 126 (2008).

Finally, as discussed below, the decision of the Court of Appeals "reaches an incorrect result." S. Ct. Rule 8.03(b)(6)(E)(vi).

B. The adoption of AMA Guides based on current medical knowledge does not violate Section 18 of the Kansas Bill of Rights.

It is doubtful that the adoption of the Sixth Edition of the AMA Guides even implicates Section 18 of the Kansas Bill of Rights. The AMA Guides only address the medical question of how much a particular injury impairs a person. While this indirectly affects the amount of compensation an employee may receive, the Legislature has not directly restricted or revoked any remedy.

Medical understanding of impairment and the ability to treat injuries has drastically changed since Section 18 was adopted in 1859. Surely Section 18 does not require freezing impairment levels based on the state of medical knowledge and treatment in 1859 or, for that matter, 1993, when the Fourth Edition of the AMA Guides was issued. Advances in medical knowledge and treatment may affect the degree to which a person is determined to be impaired based on a particular injury. Acknowledging those advances by adopting current medical understanding on the extent of a person's impairment does not amount to the Legislature modifying or eliminating a remedy for purposes of Section 18.

Suppose, for example, that the AMA published impairment guidelines in 1859 and that a particular injury would have resulted in a 40% impairment rating

at the time. But now, because of advances in medicine, the injury would only result in an impairment of 10%, or even 0%. Surely the Legislature's adoption of current medical guidelines—even though it would result in less compensation—would not be considered a modification or elimination of the common-law remedy.

Johnson attacks the medical science behind the Sixth Edition, but the Legislature received plenty of evidence establishing that the Sixth Edition is based on current medical knowledge and is superior to the Fourth Edition. Dr. J. Mark Melhorn, an orthopedic surgeon and professor at the University of Kansas School of Medicine, explained in detail why the Sixth Edition is better than earlier editions, testifying that "[t]he current Sixth Edition of the AMA *Guides* reflects the current best science and expert consensus. The Fourth Edition is out of date by two decades." *See* Attachments 4 and 6. Dr. Peter V. Bieri, a Kansas physician with extensive experience in issuing impairment ratings under the AMA Guides, testified that the Sixth Edition "represents a good-faith effort by a large group of physicians to bring disability evaluation into the modern era of evidence-based medicine and outcomes." *See* Attachment 5. And Dr. Melhorn, speaking on behalf of the Kansas Medical Society, testified that "the majority of physicians favor using the 6th Edition, which is based on the most recent science." *See* Attachment 7.

Kansas is not alone in its preference for the Sixth Edition. Numerous other States and the federal government use it too. *See* Attachments 4 and 6. In adopting the Sixth Edition for purposes of the Federal Employees' Compensation Act (FECA),

the U.S. Department of Labor's Division of Federal Employees' Compensation (DFEC) explained:

> The American Medical Association (AMA) has periodically issued new editions of the Guides in order to keep pace with advances in medical treatment, diagnoses and philosophy. The stated goal of each new edition is to provide a fair and authoritative impairment guide based on the most recent medical advances. As injuries sustained by individuals covered by the FECA run a very wide gamut and so that injured workers have the benefit of the most current medical thinking, DFEC has consistently adopted each new edition of the Guides as it became available. In order to consider injured workers' permanent impairment in light of the most recent medical treatment evolution, DFEC has consistently adopted each new edition of the Guides as the standard in determining percentage of impairment, and DFEC's decision to adopt the Sixth Edition is in keeping with this long history of use.

See https://www.dol.gov/owcp/dfec/AMAGuideEvalPermImpair6thEd.htm (last visited September 4, 2018). The Kansas Legislature likewise made a reasonable decision to adopt the Sixth Edition for purposes of the Kansas Workers Compensation Act.

To be sure, some doctors opposed adoption of the Sixth Edition. But the Legislature listened to the debate, found the proponents of the Sixth Edition more persuasive, and reasonably concluded based on the testimony that the Sixth Edition should be adopted. The Court of Appeals should not have second-guessed the Legislature's resolution of this issue. *See Injured Workers of Kansas v. Franklin*, 262 Kan. 840, 863, 942 P.2d 591 (1997) ("The legislature heard all the evidence and relied on the evidence it found to be the most persuasive. It is not this court's job to second-guess the legislature's decision-making process."); *cf. Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) ("The Court has given state and federal legislatures wide

discretion to pass legislation in areas where there is medical and scientific uncertainty."). At the very least, determining whether the Fourth Edition or the Sixth Edition is more medically accurate is a complicated factual question that the Court of Appeals, as an appellate court and not a fact-finding body, was not in a position to address.

Even if some particular aspect of the Sixth Edition were medically flawed, in order to prevail on his facial challenge, Johnson must show that "no set of circumstances exists under which the Act would be valid." *State v. Watson*, 273 Kan. 426, 435, 44 P.3d 357 (2002) (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987)). He has failed to demonstrate that there are no situations in which the Sixth Edition is more medically accurate than the Fourth Edition.

C. The Court of Appeals improperly focused on the compensation available under the Fourth Edition as opposed to the remedy available at common law.

The Court of Appeals only found the Sixth Edition unconstitutional under the second step of the Section 18 analysis, which "asks whether the legislature has provided an adequate substitute remedy or a quid pro quo *for the abrogation of a common-law remedy*." *Lemuz v. Fieser*, 261 Kan. 936, 949, 933 P.2d 134 (1997) (emphasis added); *see also Leiker v. Gafford*, 245 Kan. 325, 361, 778 P.2d 823 (1989) (holding that Section 18 only protects remedies provided "by the common law as it existed at the time our constitution was adopted" in 1859), *disapproved of on other grounds by Martindale v. Tenny*, 250 Kan. 621, 829 P.2d 561 (1992).

But rather than compare the remedy available under current law to the remedy available at common law, the Court of Appeals erroneously found the Sixth Edition unconstitutional because it provides less compensation than the Fourth Edition. Section 18 does not protect, or require an adequate substitute for, the compensation Johnson would have received under a prior version of the Act. The Court of Appeals never found that the Sixth Edition provides less compensation than would have been available at common law—much less in all cases, as required to find the Sixth Edition facially unconstitutional. In fact, Johnson's own situation demonstrates this flaw.[1] Johnson has been able to return to his old job and suffers no ongoing wage loss, so it is doubtful he would have been able to obtain *any* compensation for future economic loss at common law. And while Johnson's doctors estimate there is a 20% to 30% chance he will need additional surgery at some point in the future—and that he should receive more compensation for this risk than is provided under the Sixth Edition—damages for this uncertain possibility are far too speculative to have been recoverable at common law. *See Cerretti v. Flint Hills Rural Elec. Co-op. Ass'n*, 251 Kan. 347, 360, 837 P.2d 330 (1992) ("Recovery may not be had where the alleged damages are too conjectural or speculative to form a basis for measurement.").

[1] The Court of Appeals claimed that the remedy available to Johnson is irrelevant because he brings a facial rather than an as applied challenge. Opinion at 30. But if the Act provides Johnson with an adequate substitute remedy, the Act is constitutional in at least his circumstance and therefore cannot be facially invalid.

The Court of Appeals also failed to consider the remedy provided by the Act as a whole. The Act continues to provide compensation even without a showing of negligence or fault, and in situations where recovery would have been barred at common law due to contributory negligence, assumption of risk, the fellow-servant rule, or a waiver of liability. The Act caps attorney's fees at 25%, *see* K.S.A. 44-536(a), when they would likely be much higher in a common-law tort action. And the Act continues to provide for medical benefits, temporary disability payments, and permanent partial disability compensation, with impairment levels based on current medical science. It cannot be said that the adoption of the Sixth Edition so "emasculate[d] the [Act] to a point where it is no longer a viable and sufficient substitute remedy." *Injured Workers*, 262 Kan. at 886 (quoting *Bair v. Peck*, 248 Kan. 841, 844, 811 P.2d 1176 (1991)).

D. The Court of Appeals misconstrued the Act to create an alleged constitutional defect.

In holding that the adoption of the Sixth Edition rendered the Act unconstitutional, the Court of Appeals misconstrued the text of K.S.A. 44-510e(a)(2)(B), which provides:

> The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein, until January 1, 2015, but for injuries occurring on and after January 1, 2015, based on the sixth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

The Court of Appeals interpreted this provision as meaning that after January 1, 2015, impairment is no longer to be "established by competent medical evidence." In other words, the court read the phrase "after January 1, 2015, based on the sixth edition of the American medical association guides" as replacing *both* "as established by competent medical evidence" *and* "based on the fourth edition of the American medical association guides." The Court of Appeals found the statute unconstitutional for precisely this reason. Opinion at 29 ("In amending K.S.A. 2015 Supp. 44-510e(a)(2)(B), the Legislature also eliminated any reliance on competent medical evidence to measure impairment and instead refers exclusively to establishing impairment based on the Sixth Edition of the AMA Guides.").

This interpretation of the statute is wrong. The much better reading is that after January 1, 2015, "based on the sixth edition of the American medical association guides" replaces the parallel phrase "based on the fourth edition of the American medical association guides" but does not supplant "as established by competent medical evidence." The Court of Appeals misconstrued the statute to hold it unconstitutional. Even if there were ambiguity, the proper course would have been to interpret the statute as preserving the use of competent medical evidence—which is a plausible reading at the very least—to avoid this alleged constitutional defect. *See, e.g.*, *Morrison*, 285 Kan. at 883-84 ("If there is any reasonable way to construe a statute as constitutionally valid, the court must do so." (quoting *Martin v. Kansas Dept. of Revenue*, 285 Kan. 625, 629, 176 P.3d 938 (2008))) .

E. The Court of Appeals' remedy was improper.

Not only was the finding of unconstitutionality wrong, the remedy—reinstating the Fourth Edition—was improper. The Legislature clearly expressed its intent that the Fourth Edition should no longer be used after January 1, 2015. And for good reason: not only is the Fourth Edition outdated, it is not even still in print. Attachment 6 at 4. There is no constitutional basis to mandate the use of the Fourth Edition when the Legislature rejected it.

The more appropriate remedy in the event of a constitutional violation would be to require consideration of impairment ratings under the Sixth Edition but to allow divergence from those ratings if and when a claimant can prove that the rating is not medically accurate. This remedy is most consistent with legislative intent as expressed in the text of the Act, which requires that the degree of functional impairment should be "based on" the Sixth Edition. *See* K.S.A. 44-510e(a)(2)(B). An impairment rating might be said to be "based on" the Sixth Edition if the Sixth Edition "serve[s] as a foundation" or as "[t]he starting point" for the rating. *Cf. Hughes v. United States*, 138 S. Ct. 1765, 1775 (2018) (quoting Black's Law Dictionary 180 (10th ed. 2014) (definition of "base")) (holding that a sentence is "based on" the advisory federal sentencing guidelines when the guidelines range is a basis for the court's exercise of discretion).

This remedy would also reflect the nature of Johnson's constitutional challenge. Whatever else can be said, Johnson certainly has not shown that the Sixth Edition is medically inaccurate in all situations or that none of the changes

from the Fourth to the Sixth Edition are supported by medical science. Indeed, medical professionals presenting testimony to the Legislature (including the Kansas Medical Society) supported the change. While this should be enough to reject Johnson's facial challenge to the Sixth Edition, requiring consideration of the Sixth Edition but allowing divergence if and when a claimant can prove that the Sixth Edition is not medically accurate in a particular situation would be the most appropriate remedy in the event a constitutional violation is found.

CONCLUSION

Given the important constitutional question presented in this case and the questionable analysis of the Court of Appeals, this Court should grant review.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of September 2018, the above Petition for Review was electronically filed with the Clerk of the Court using the Court's electronic filing system, which will send a notice of electronic filing to registered participants, and copies were electronically mailed to:

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Attachments

Attachment 1: Court of Appeals opinion

Attachment 2: Workers Compensation Appeals Board decision

Attachment 3: ALJ decision

Attachment 4: Dr. J. Mark Melhorn letter to the Kansas Legislature (Mar. 2013)

Attachment 5: Dr. Peter V. Bieri letter to the Kansas Legislature (Mar. 2013)

Attachment 6: Testimony of Dr. J. Mark Melhorn on behalf of the Kansas Medical Society in opposition to SB 167 (Feb. 12, 2015)

Attachment 7: Minutes of the February 18, 2015, meeting of the House Committee on Commerce, Labor and Economic Development

Attachment 8: Christopher R. Brigham et al., *Comparative Analysis of AMA* Guides *Ratings by the Fourth, Fifth, and Sixth Editions*, AMA Guides Newsletter (January/February 2010)

Attachment 1:

Court of Appeals Opinion

No. 117,725

IN THE COURT OF APPEALS OF THE STATE OF KANSAS

HOWARD JOHNSON III,
Appellant,

v.

U.S. FOOD SERVICE,

and

AMERICAN ZURICH INSURANCE CO.,
Appellees.

SYLLABUS BY THE COURT

1.

Section 18 of the Kansas Constitution Bill of Rights guarantees an individual's right to a remedy: "All persons, for injuries suffered in person, reputation or property, shall have remedy by due course of law."

2.

Under the Fourteenth Amendment of the United States Constitution, no State shall "deprive any person of life, liberty, or property without due process of law."

3.

The Legislature may substitute a statutory remedy for one available at common law. But due process requires that the substitute provides an adequate remedy for the common-law remedy that has been abolished.

4.

Once the Legislature has established a substitute remedy, it cannot constitutionally proceed to emasculate the remedy by amendments to the point that it is no longer a viable substitute remedy.

5.

The Kansas Workers Compensation Act provides an administrative procedure for providing compensation to injured workers in exchange for the relinquishment of the injured worker's common-law right to sue a negligent employer in tort for damages.

6.

When our Legislature enacts changes in our Workers Compensation Act, for the changes to satisfy the constitutional requirement of due process (1) the changes must be reasonably necessary in the public interest to promote the general welfare of the people of Kansas, and (2) the Act in its currently modified form must continue to provide an adequate substitute remedy for an injured worker's right to bring a common-law action for the recovery of damages.

7.

After the adoption in K.S.A. 2015 Supp. 44-510d(b)(23) and (b)(24) and K.S.A. 2015 Supp. 44-510e(a)(2)(B) of the Sixth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (6th ed. 2008) as the Guide to be used for measuring the permanent impairment of injured workers, our Kansas Workers Compensation Act no longer provides an adequate substitute remedy for injured workers who suffer a permanent impairment on or after January 1, 2015, and K.S.A. 2015 Supp. 44-510d(b)(23) and (b)(24) and K.S.A. 2015 Supp. 44-510e(a)(2)(B) violate the constitutional requirement for due process.

8.

Because K.S.A. 44-574(b) provides for the severability of a provision in the Kansas Workers Compensation Act which is found to be unconstitutional, the appropriate remedy in this case is to strike from K.S.A. 2015 Supp. 44-510d(b)(23) and (b)(24) and K.S.A. 2015 Supp. 44-510e(a)(2)(B), the provisions requiring the use of the Sixth Edition of the AMA Guides, thereby leaving the Fourth Edition of the AMA Guides as the applicable Guide in the evaluation of an injured worker's permanent impairment.

Appeal from Workers Compensation Board. Opinion filed August 3, 2018. Reversed and remanded with directions.

Mark E. Kolich, of Lenexa, for appellant.

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Jeffrey A. Chanay, chief deputy attorney general, *Toby Crouse*, solicitor general, and *Dwight R. Carswell* and *Bryan C. Clark*, assistant solicitors general, for amicus curiae State of Kansas.

Before MCANANY, P.J., LEBEN and SCHROEDER, JJ.

MCANANY, J.: Our opinion in this workers compensation appeal follows on the heels of the recent opinion in *Pardo v. United Parcel Services*, 56 Kan. App. 2d 1, ___ P.3d ___ (No. 116,842 filed June 1, 2018). In *Pardo*, a panel of our court determined that the use of the Sixth Edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (6th ed. 2008) as mandated by K.S.A. 2015 Supp. 44-510d(b)(23) was unconstitutional as applied to Pardo, an injured worker. 56 Kan. App. 2d at 25. Today, we are asked to declare that the use of the Sixth Edition of the AMA Guides is unconstitutional on its face.

FACTUAL AND PROCEDURAL HISTORY OF JOHNSON'S INJURY CLAIM

On October 16, 2015, Howard Johnson, who had been employed by U.S. Food Service since 2002 as a delivery driver, suffered an on-the-job injury to his neck when he tried to dislodge a partially frozen trailer door at work.

Later that month, Dr. Harold Hess, a neurosurgeon, examined Johnson for the first time. Johnson complained of neck and left arm pain along with numbness and weakness in his left arm. Dr. Hess ordered an MRI scan of Johnson's neck which disclosed a spinal cord compression due to disc herniations at levels C5-C6 and C6-C7. Physical findings confirmed this injury. Dr. Hess diagnosed Johnson with cervical myeloradiculopathy.

On November 17, 2015, Johnson filed a claim for workers compensation benefits.

In January 2016, Dr. Hess operated on Johnson's neck. He removed the disc material at C5-C6 and C6-C7 and replaced it with bone from a cadaver in order to "create a fusion across the two vertebral bodies, across the disc space." He also screwed a metal plate into the vertebrae as a temporary stabilizer.

On April 15, 2016, Johnson was released to return to work, but he continued to experience symptoms from the injury to his neck and has modified the way he performs his duties to accommodate his injury.

Dr. Hess used the Sixth Edition of the AMA Guides in rating Johnson's permanent impairment at 6% of the whole person. Dr. Hess noted that if he had used the Fourth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (4th ed. 1995), which had been in effect until January 1, 2015, Johnson's rating would have been 25%. Dr. Hess testified that he believed that the 25% impairment

rating was representative of Johnson's true impairment considering his loss of range of motion and his potential need for future surgery. He explained that 20% to 30% of fusion patients experience accelerated degeneration of adjacent discs in the neck within 10 years and require additional surgery.

Dr. Hess has been performing cervical fusions since 1988. He testified that other than the use of cervical plates that began in the 1990s, there has been no change in the surgical technique for cervical fusions, and the expected surgical outcome remains the same. According to Dr. Hess, there have been no advancements in medical treatment or science that would warrant the lower impairment ratings provided in the Sixth Edition of the AMA Guides.

Dr. Preston Brent Koprivica, a physician with an expertise in occupational medicine, testified that he has been performing independent medical evaluations for more than 30 years using the Third, Third Revised, Fourth, and Sixth Editions of the AMA Guides. He stated that all versions of the AMA Guides before the Sixth Edition specify a minimum of 25% impairment rating for an injury similar to Johnson's. He agreed with Dr. Hess that Johnson's impairment rating would have been a minimum of 25% under the Fourth Edition. Dr. Koprivica testified:

> "[I]n his case he's had damage to his spinal cord. That's what the myelopathy part that Dr. Hess was talking about in his treatment record and deposition testimony is referring to. So structurally there's been damage to his spinal cord. Now, he's recovered neurologically, which is what you hope for, but there's still some permanent damage there. That's of significance.
>
> "The second thing that I think is of great significance is the spine has been permanently structurally changed. In order to do your treatment you've changed the original anatomic makeup of the spine. Two motion segments no longer move. That's what a fusion is. You prevent movement at those motion segment levels.

"The problem with that is that what's observed in that patient population is that adjacent segments to the fused segments break down. They have an accelerated degeneration that occurs and those structural changes are of significance. They get changes in their facet joints, get greater arthritis, they get ligament changes in terms of hypertrophy of those ligaments trying to absorb forces.

"That's what your body does whenever you're put under unusual stresses. You try to adapt and your body will adapt for that by increasing the size of the ligament. But that has an implication. It takes up space in the spinal canal area. It causes narrowing. The discs at those motion segments adjacent degenerate and part of that degeneration process is there's a much greater propensity to herniate."

Dr. Koprivica opined that there is a 25% to 30% probability that Johnson will need further surgery within 10 years. He concluded that 25% is representative of Johnson's true impairment rating given the severity of his injury. According to Dr. Koprivica, there is no scientific support for the reduced ratings in the Sixth Edition of the AMA Guides, as there has been no progression of medical knowledge, technology, or skill which would account for or justify the lower ratings. Dr. Koprivica stated that the ratings represent a consensus of opinion of a small committee of physicians.

If Johnson's impairment had been calculated under the Fourth Edition of the AMA Guides, his award for a 25% impairment would have been $61,713.70. But under the Sixth Edition of the AMA Guides, Johnson's impairment rating was only 6%, for an award of $14,810.80. Had Johnson been injured before January 1, 2015, rather than nine months later, the award for his impairment would have been nearly $47,000 greater.

Attorney Jeff Cooper, a workers compensation practitioner, testified about major proposed changes to the Workers Compensation Act (Act) before 2011:

"Well, for the last I would say eight years before 2011, there had been a series of bills proposed in the legislature, all of which were designed to reduce benefits to injured workers. It was Senate Bill 418 and Senate Bill 181, I believe were the numbers in corresponding years. We had been able on behalf of injured workers, and I testified on behalf of KTLA, we'd been able to avoid some of those draconian measures against injured workers because we had some moderate Republicans in the Senate that generally were not real eager to disadvantage injured workers in the state of Kansas, so we'd been able to basically avoid those changes being made.

"As you may recall, in 2010 there was an election in Kansas and the Kansas Chamber of Commerce made an organized effort to get all those moderates replaced on the Senate and with the exception of maybe one moderate senator out of Topeka, they were successful in all those endeavors.

"So the landscape had changed from the standpoint of what we perceived to be a worker friendly or at least a worker neutral Senate to one that was no longer friendly to workers, and also we had large Republican majorities in the House that were similarly situated and had campaigned on changing workers' compensation benefits.

"So the meeting was held because there were proposed major changes to the Workers' Compensation Act in Kansas. There were rumors of going to a Texas system and those kind of things, and the informal meeting was had basically to try to work out something that would be at least fair to injured workers."

According to Cooper, an agreement was reached during the 2011 negotiations among a number of groups with an interest in workers compensation—a group that drafted the proposed 2011 changes—that any changes to the Act would not include a change in the method for determining the extent of impairment, and both sides agreed that the Fourth Edition of the AMA Guides would continue to be used. Of course, the final decisions remained the prerogative of the Legislature and the Governor, not these groups. And two years later, the Legislature amended K.S.A. 44-510e and adopted the Sixth Edition of the AMA Guides for all injuries sustained after January 1, 2015.

Following the final hearing on Johnson's claim, the administrative law judge (ALJ) awarded $14,804.70 for Johnson's 6% impairment rating under the Sixth Edition of the AMA Guides. The Board affirmed. Neither the ALJ nor the Board addressed Johnson's constitutional issue because they lacked the jurisdiction to do so.

Johnson's appeal brings the matter to us. The sole issue on appeal is the constitutionality of the requirement in the 2013 amendment to K.S.A. 44-510e that permanent impairment ratings for workers injured on or after January 1, 2015, be calculated using the Sixth Edition of the AMA Guides.

JOHNSON'S CLAIM ON APPEAL AND OUR STANDARDS FOR APPELLATE REVIEW

Johnson contends that the change in K.S.A. 2015 Supp. 44-510e which requires the use of the Sixth Edition of the AMA Guides violates § 18 of the Kansas Constitution Bill of Rights and the Fourteenth Amendment of the United States Constitution. He claims that the reduction in workers compensation awards diminishes or abrogates a remedy protected by due process without promoting the general welfare and without providing an adequate substitute remedy.

Determining a statute's constitutionality is a question of law over which we have unlimited review. We presume statutes are constitutional and resolve all doubts in favor of a statute's validity. We interpret a statute in a way that makes it constitutional if there is any reasonable construction that would maintain the Legislature's apparent intent. Before striking down a statute as unconstitutional, the violation must be clear. *Solomon v. State*, 303 Kan. 512, 523, 364 P.3d 536 (2015).

THE HISTORY OF THE WORKERS COMPENSATION SCHEME IN KANSAS AND ITS CONSTITUTIONAL FOUNDATIONS

The statutory provision at issue in this case is found in K.S.A. 2015 Supp. 44-510e, which provides:

> "(a) In case of whole body injury resulting in temporary or permanent partial general disability not covered by the schedule in K.S.A. 44-510d, and amendments thereto, the employee shall receive weekly compensation as determined in this subsection during the period of temporary or permanent partial general disability not exceeding a maximum of 415 weeks.
>
> . . . .
>
> (2)(B) The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein, until January 1, 2015, but for injuries occurring on and after January 1, 2015, based on the sixth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein."

The constitutional provisions at play are found in § 18 of the Kansas Constitution Bill of Rights and the Fourteenth Amendment of the United States Constitution.

Section 18 of the Kansas Constitution Bill of Rights states: "All persons, for injuries suffered in person, reputation or property, shall have remedy by due course of law, and justice administered without delay." Remedy by due course of law as used in § 18 means "reparation for injury, ordered by a tribunal having jurisdiction, in due course of procedure and after a fair hearing." *Hanson v. Krehbiel*, 68 Kan. 670, Syl. ¶ 2, 75 Pac. 1041 (1904).

In *Samsel v. Wheeler Transport Services, Inc.*, 246 Kan. 336, 353, 789 P.2d 541 (1990), in which our Supreme Court considered the statutory cap on noneconomic tort damages, the court determined that § 18 provides "an injured party . . . a constitutional right to be made whole." As stated in *Miller v. Johnson*, 295 Kan. 636, 655, 289 P.3d 1098 (2012): "The purpose of economic and noneconomic damages is to make the injured party whole by restoring the person to the position he or she was in prior to the injury. [Citations omitted.]"

Section 18 guarantees the right to a remedy, and it is satisfied when the Legislature provides an adequate substitute remedy, or quid pro quo (Latin for "something for something"), for the abolition of a common-law remedy. See *Injured Workers of Kansas v. Franklin*, 262 Kan. 840, 855, 942 P.2d 591 (1997).

Finally, § 18 is a fundamental constitutional right. See *Ernest v. Faler*, 237 Kan. 125, 131, 697 P.2d 870 (1985); *Bourne v. Atchison, T. & S. F. Rly. Co.*, 209 Kan. 511, 515, 497 P.2d 110 (1972); *State v. Larraco*, 32 Kan. App. 2d 996, 999, 93 P.3d 725 (2004).

The Fourteenth Amendment of the United States Constitution prohibits the deprivation "of life, liberty, or property without due process of law." Johnson argues that he had a property interest in receiving adequate workers compensation benefits sufficient to invoke Fourteenth Amendment due process protections.

Against this constitutional backdrop we examine the various iterations of our workers compensation laws, which we collectively refer to as the Act, along with related decisions from our Supreme Court and the United States Supreme Court.

In 1911, the Kansas Legislature first adopted workers compensation legislation. On March 14 of that year, Kansas and Washington became the first two states in the nation to establish a scheme of workers compensation for work-related injuries in exchange for relinquishment of the common-law rights of workers to bring civil tort actions against their employers for injuries caused by the negligence of their employers. Several other states quickly followed suit. Domenico Gagliardo, *The First Kansas Workmen's Compensation Law*, 9 Kan. Hist. Q. 384 (1940).

In *Howard Delivery Service, Inc. v. Zurich American Ins. Co.*, 547 U.S. 651, 662-63, 126 S. Ct. 2105, 165 L. Ed. 2d 110 (2006) (quoting P. Lencsis, Workers Compensation: A Reference and Guide 9 [1998]), the United States Supreme Court explained:

> "'[W]orkers compensation . . . involves a classic social trade-off or, to use a Latin term, a *quid pro quo*. . . . What is given to the injured employee is the right to receive certain limited benefits regardless of fault. . . . What is taken away is the employee's right to recover full tort damages, including damages for pain and suffering, in cases in which there is fault on the employer's part.'"

In 1914 our Supreme Court, in *Shade v. Cement Co.*, 93 Kan. 257, 260, 144 Pac. 249 (1914), found the Act to be constitutional, primarily because it was elective in nature.

In 1917, the United States Supreme Court considered in *New York Cent. R. Co. v. White*, 243 U.S. 188, 205, 37 S. Ct. 247, 61 L. Ed. 667 (1917), the trade-off between benefits under New York's workers compensation law and the loss of the common-law right to sue. In upholding the constitutionality of the New York act, the Court stated: "This, of course, is not to say that any scale of compensation, however insignificant on the one hand or onerous on the other, would be supportable." 243 U.S. at 205. It would

do "violence to the constitutional guaranty of 'due process of law'" if the Legislature set aside common-law tort liability "without providing a reasonably just substitute." 243 U.S. at 201.

In 1967, the Legislature changed the Act to provide immunity from suit for negligent fellow employees when the injured employee receives compensation under the Act. See L. 1967, ch. 280.

In 1974, the Legislature substantially revised the Act. Coverage under the Act became mandatory for employees working for an employer with an annual payroll over $10,000. See L. 1974, ch. 203.

In 1983, our Supreme Court upheld as constitutional the 1967 amendments to the Act in *Rajala v. Doresky*, 233 Kan. 440, 441-43, 661 P.2d 1251 (1983).

In 1987, the Act was amended to include compensation for functional impairment which had to be established by competent medical evidence. These amendments did not include a requirement to use any AMA Guides. See L. 1987, ch. 187.

In 1991 our Supreme Court decided *Bair v. Peck*, 248 Kan. 824, 811 P.2d 1176 (1991), which indirectly applies to the Act. There, the court considered the constitutionality of a provision in the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 *et seq.* enacted in 1976, which abrogated the common-law vicarious liability of an employer health care provider under certain circumstances. The court stated: "No one has a vested right in common-law rules governing negligence actions which would preclude substituting a viable statutory remedy for one available at common law. The legislature can modify the common law so long as it provides an adequate substitute remedy for the right infringed or abolished." 248 Kan. 824, Syl. ¶ 11. But the

Legislature is restricted as to how much it may reduce an individual's right to obtain a remedy:

> "We recognize that there is a limit which the legislature may not exceed in altering the statutory remedy previously provided when a common-law remedy was statutorily abolished. The legislature, once having established a substitute remedy, cannot constitutionally proceed to emasculate the remedy, by amendments, to a point where it is no longer a viable and sufficient substitute remedy." 248 Kan. at 844.

In 1997, the court revisited the Health Care Provider Insurance Availability Act in *Lemuz v. Fieser*, 261 Kan. 936, 959, 933 P.2d 134 (1997), and, while again upholding the enactment, observed:

> "In summary, this court struggles with the bottom line figure as to how much a quid pro quo can be amended and still remain an adequate quid pro quo. As in *Bair*, 248 Kan. at 844, this court realizes that an original quid pro quo cannot be emasculated to a point where it is no longer a viable and sufficient substitute remedy."

In 1993, the Legislature adopted sweeping changes to the Act.

- Before 1993, an injured worker's failure to give timely notice of an accident did not bar a claim unless the employer showed prejudice. Under the 1993 change, the lack of timely notice barred a claim even if the lack of timely notice did not prejudice the employer.
- Before 1993, shoulder injuries were treated as permanent partial general disabilities. Under the 1993 changes, a shoulder injury became a scheduled injury for which compensation amounted to 2/3 of the worker's average weekly wage for 225 weeks, regardless of the worker's lost earning capacity due to the inability to perform the type of work performed before the accident. Such an award is

typically less than what an injured worker would have received under the pre-1993 law.

- Before 1993, an injured worker's Social Security retirement benefits were an offset against workers compensation benefits received. Under the 1993 changes, the offset was expanded to include the employer's contribution (and apparently the earnings thereon) to any private retirement plan.
- The 1993 changes disallowed recovery for a preexisting injury even though the aggravation of the injury was caused by work-related activity.
- The 1993 changes repealed an injured worker's right to vocational rehabilitation.
- The 1993 changes limited the healing period for scheduled injuries solely to those involving amputations.
- The 1993 changes set the top wage rate for computing an injured worker's wage at $450 per week, regardless of the worker's actual wages.
- The 1993 changes set a $50,000 cap on compensation for a functional impairment regardless of the severity of the worker's impairment.
- The 1993 changes made conclusive the prior presumption against work disability when the injured worker earns a comparable wage. See L. 1993, ch. 286.

In 1997, our Supreme Court decided *Injured Workers*, in which the court reviewed the 1993 legislative changes. In analyzing the due process claim, the court applied a two-step test in determining whether the legislative changes were constitutionally sound. For the legislation to stand, both of the following two questions must be answered in the affirmative: (1) Is the legislative change reasonably necessary in the public interest to promote the general welfare of the state? (2) Has the Legislature provided an adequate substitute remedy to replace the remedy that was restricted? 262 Kan. at 854. The court drew extensively on its decision in *Bair* and quoted the above cited language from *Bair* and from *Lemuz*. The court concluded:

> "While several of the amendments at issue do restrict an employee's right to receive workers compensation benefits, several other amendments have been enacted with the intent to expand an employee's rights. (However, the expansion pales in comparison to what was taken away.)
>
> "With these rights still available to injured workers under the amended Act, it cannot be said that the Act, which originally provided an adequate substitute remedy for the abrogation of an employee's common-law right to sue an employer for negligence, has been emasculated to the point where it is no longer an adequate quid pro quo." *Injured Workers*, 262 Kan. at 888.

In his dissent, Justice Allegrucci observed: "I am unable to determine at what point, if any, the majority would conclude the legislature went too far in altering a substitute remedy." 262 Kan. at 889 (Allegrucci, J., dissenting).

In 2011, the Legislature again enacted major revisions to the Act which reduced the employer's liability to pay compensation to injured workers.

- The revision to the Act effectively reversed our Supreme Court's holding in *Bergstrom v. Spears Manufacturing Co.*, 289 Kan. 605, 610, 214 P.3d 676 (2009), and imposed on injured workers the duty to mitigate the employer's liability to pay compensation for a work disability by seeking post-injury employment.
- K.S.A. 44-501 shifted its focus from compensation for injured workers to disallowances and reductions predicated on fault-based concepts familiar to tort law.
- K.S.A. 44-508(f)(2) was changed to adopt the prevailing factor standard for causation. More on this later. Injured workers now have the burden of proving that a work-related accident or repetitive trauma was the primary factor in causing their injury.

- Under the 2011 version of K.S.A. 44-508(f)(2), "An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic." Under this provision, workers are not entitled to benefits when a work accident causes a dormant condition to become symptomatic and disabling. The work accident must be the prevailing factor in causing the injury or the medical condition and the resulting disability or impairment.
- Under the 2011 version of K.S.A. 44-508(f)(3)(A), injuries arising out of neutral risks, personal risks, and idiopathic causes are not compensable. This nullifies previous cases allowing compensation in those instances if the nature of employment enhanced the risk of harm. See *Hensley v. Carl Graham Glass*, 226 Kan. 256, 597 P.2d 641 (1979).
- As noted earlier, under the 1993 amendments, the lack of timely notice of an accident barred a claim even if the employer was not prejudiced by the tardy notice. Further, notice had to be provided within 10 days of an accident. But under the 1993 amendments, the 10-day notice requirement could be extended if the claimant showed good cause. The 2011 amendments eliminate the good cause extension and compel the absolute denial of a claim unless notice is given within 30 days after the accident or 20 days from the date medical treatment is sought, whichever date is *earlier*. Under the 2011 version, if the worker is no longer employed by the employer from whom benefits are sought, notice must be given within 20 days after the last day of actual work for the employer.
- Before 2011, K.S.A. 44-525 provided that an employer's right to medical treatment reasonably necessary to cure and relieve the effects of an injury was not limited by time or amount. But the amended K.S.A 44-525 prohibits an award for

future medical care unless it is proven that the need is probable, which is difficult for many medical experts to predict.

- The 2011 version of K.S.A. 44-510k(a)(3) created a presumption that medical care is no longer needed as a result of a work injury if no treatment is received within two years from the date of an award for future medical care. This allowed the employer to obtain a postaward order terminating the worker's future medical rights. The burden is now on the injured worker to come forward with competent medical evidence to overcome the presumption.
- The 2011 version of K.S.A. 44-510e measured work disability by calculating the difference between the average weekly wage the employee was earning at the time of the injury and the average weekly wage the employee was capable of earning after the injury. Under the prior law, the comparison was to the injured worker's actual post-injury wage. Moreover, an injured worker must now demonstrate a functional impairment in excess of 7.5% to the whole person before a work disability claim can be made. Combining this threshold with the lower ratings provided in the Sixth Edition to the AMA Guides makes recovery for a work disability rare. For someone like Johnson, a work disability claim would not be possible if the worker is unable to return to work because a 6% functional impairment rating is below the work disability threshold.
- The 2011 version of K.S.A. 44-523(f)(1) allows dismissal with prejudice of claims for lack of prosecution that do not reach trial or settlement within three years of the filing date, even if the injured worker has not reached maximum medical recovery within that period.
- The 2011 version of the Act provided several amendments that favored employees: (1) temporary partial disability benefits can now be collected for scheduled injuries; (2) the maximum recovery for permanent partial disability was increased from $100,000 to $130,000; and (3) the cap for permanent total disability was raised from $125,000 to $155,000. But Johnson argues that these

changes are meaningless for those workers who no longer have viable claims because of the new limits on compensability.

- Under the 2011 version of the Act, the Fourth Edition of the AMA Guides continued in effect. See L. 2011, ch. 55.

In 2013, the Legislature further amended the Act by adopting the Sixth Edition of the AMA Guides for measuring permanent impairment from injuries occurring on or after January 1, 2015. See L. 2013, ch. 104, §§ 8, 9.

In 2015, SB167 was introduced in an effort to reverse the 2013 adoption of the Sixth Edition of the AMA Guides. The Senate Commerce Committee conducted hearings on the bill, which attracted considerable attention. Secretary of State Kris W. Kobach, a former law school professor who taught constitutional law for 15 years, supported the bill to discontinue use of the Sixth Edition of the AMA Guides. His written submission to the committee included the following points:

- "[A]ny fair constitutional analysis of the [shift from the Fourth Edition to the Sixth Edition of the AMA Guides] will yield the conclusion that employees are denied due process for certain injuries." If the quid pro quo justifying an injured worker's denial of access to the courts for relief "disappears or becomes inadequate, then the exclusive remedy rule dissolves. Due process requires that the employee must have some avenue to seek a meaningful remedy."
- The Sixth Edition "reduces some classes of injuries to zero compensation" and "reduces other injuries to pathetically inadequate compensation levels, by anyone's reckoning."
- The Sixth Edition materially changed compensation awards over what was awarded under the Fourth Edition for certain injuries even though "nothing

changed in this area of medicine between the publications of the 4th and 6th Editions."

- "Kansas is now the only state in the union that combines the 6th Edition with the prevailing-factor rule. That puts Kansas in a class by itself, and it results in a denial of due process to Kansas workers."
- "[T]he 6th Edition takes away from the administrative judge the ability to tailor a remedy to the specific circumstances of a particular case. It replaces a range of values with a one-size-fits-all approach. If the employee loses the ability to have the decision-maker consider the specific facts of his case and modify the remedy accordingly, he has been denied due process."

Professor Bill Rich, James R. Ahrens Chair in Torts and Constitutional Law and Professor of Law at the Washburn University School of Law, also provided testimony in support of the restoration of the Fourth Edition. He stated:

> "Because of changes made in the new edition of the AMA Guides, some injured workers no longer receive a '*quid pro quo*' (or adequate substitute) for their traditional right of recovery when they experience certain work-related injuries. As a result, the Kansas Workers Compensation Act no longer provides an adequate substitute for the lost right to a jury trial. Because no valid remedy at law remains for this category of injured workers, they will not receive the protection that the Kansas Bill of Rights guarantees."

Litigators on both sides—representing claimants and representing employers—testified in support of the bill. Support came from the Mayor/CEO of the Wyandotte County/Kansas City Unified Government, as well as numerous employers from around the state. Opposition to the bill came from other business owners and business groups around the state, including the Kansas Chamber which suggested that the committee "not succumb to the argument over constitutionality. Constitutionality arguments are a dime a dozen." Opposition was also voiced by the American Medical Association and the Kansas

Medical Society. Larry G. Karns, the Director of the Division of Workers Compensation of the Kansas Department of Labor, stated that the Department "does not have concerns with reverting to the use of the 4th Edition." He noted:

> "The current issue before the legislature is the edition of the AMA Guides to use for impairment ratings. Which Guide to use impacts the level of benefits awarded to the employee. The use of the 6th Edition in place of the 4th Edition will result in lower impairment ratings and an even greater reduction in workers benefits. The 2011 Amendments did not include adoption of the 6th Edition. The 6th Edition was adopted in 2012 legislation. Reverting back to the 4th Edition will return the formula back to where it was when the 2011 amendments were negotiated and enacted."

The Legislature failed to adopt S.B.167.

On January 1, 2015, the Sixth Edition of the AMA Guides came into effect. Johnson's accident occurred about nine months later on October 16, 2015.

ANALYSIS

In considering Johnson's constitutional argument, we apply the two-part test from *Injured Workers*: (1) Is the change in the Act reasonably necessary in the public interest to promote the general welfare of the people of Kansas? (2) Does the Act in its current form provide an adequate substitute remedy for an injured worker's right to bring a common-law action for the recovery of injuries and damages? For the Act in its present form to pass constitutional muster, both questions must be answered in the affirmative.

In the first part of the test we determine "whether the legislative means selected . . . has a real and substantial relation to the objective sought." *Injured Workers*, 262 Kan. at 854. Here, the "legislative means selected" is the adoption of the Sixth Edition of the

AMA Guides. As stated in *Bonin v. Vannaman*, 261 Kan. 199, 217, 929 P.2d 754 (1996): "The first question in a due process analysis is whether there is a significant public interest to justify [the statutory amendment] and whether this [amendment] has a real and substantial relation to the objective sought." Our Supreme Court has explained that this step in the analysis "is similar to a rational basis test." *Lemuz*, 261 Kan. at 949. To supply a rationalization for the adoption of the Sixth Edition of the AMA Guides, "[a]ll the State [has] to do [is] offer '*any* state of facts [which] reasonably may be conceived to justify'" the change, which in our case is the change from the Fourth Edition to the Sixth Edition of the AMA Guides. *Injured Workers*, 262 Kan. at 863 (quoting *Peden v. Kansas Dept. of Revenue*, 261 Kan. 239, 252-53, 930 P.2d 1 [1996]).

This test was applied to the adoption of the Sixth Edition of the AMA Guides in our recent decision in *Pardo*. There, the court determined: "The State satisfied this low burden by showing that the amendment to the Act was justified by offering parts of the legislative history supporting that the Sixth Edition was more medically sound than the Fourth Edition." 56 Kan. App. 2d at 17. We need not rehash that analysis here because the main thrust of Johnson's argument is directed at the second test under *Injured Workers*: that the Act in its present form does not provide an adequate substitute remedy for the rights at common law that were set aside with the initial adoption of the Act.

The second step in the analysis is more stringent than the first. Even if the modification of a remedy within the Act is consistent with public policy needs under the first *Injured Workers* test, this does not satisfy due process concerns. There still must be an adequate substitute remedy conferred on those individuals whose rights are adversely affected. *Miller*, 295 Kan. at 657. If a legislative amendment to the Act reduces the remedy or makes it more difficult to obtain a remedy, it is the task of the courts to determine if the revised Act still provides an adequate remedy. If not, the quid pro quo is

inadequate and the legislative amendment violates due process. *Injured Workers*, 262 Kan. at 856.

This notion of an adequate quid pro quo is fundamental to the constitutionality of the Act. The Act created a system in which an injured worker trades the right to a common-law tort recovery for a work-related injury for a fixed and relatively prompt payment for such injuries after an administrative hearing and without the need to show the employer's negligence, albeit also without compensation for any pain and suffering or punitive damages for willful or wanton conduct. As recognized in *New York Cent. R. Co.*, it would do "violence to the constitutional guaranty of 'due process of law'" if the Legislature set aside common-law tort liability "without providing a reasonably just substitute." 243 U.S. at 201.

The changes to the Act over the years have been found constitutional by our Supreme Court, but its most recent decision doing so came in 1997 in *Injured Workers*, in which the court upheld the 1993 amendments. Since then there were substantial amendments to the Act in 2011 and again in 2013 when the Sixth Edition of the AMA Guides was adopted, effective January 1, 2015.

When our Supreme Court last considered the constitutionality of the Act, it observed that "the expansion [of workers' rights under the Act] pales in comparison to what was taken away." 262 Kan. at 888. Nevertheless, the court concluded that "it cannot be said that the Act, which originally provided an adequate substitute remedy for the abrogation of an employee's common-law right to sue an employer for negligence, has been emasculated to the point where it is no longer an adequate quid pro quo." *Injured Workers*, 262 Kan. at 888. To this, Justice Allegrucci wondered what it would take for the court to conclude that "the legislature went too far." 262 Kan. at 889 (Allegrucci, J., dissenting).

The gradual erosion of the fair exchange between rights under the Act and common-law rights to tort recovery have, for the injured worker, amounted to death by a thousand paper cuts. What is the last slice that tips the balance from a fair exchange of rights and remedies to one that is unconstitutionally inadequate from the injured worker's point of view?

While our Supreme Court declared that the tipping point had not been reached with the 1993 amendments, we conclude that the tipping point has now been reached with the adoption of the Sixth Edition of the AMA Guides. We do not opine on the constitutionality of the Act as amended in 2011, though it is clear that those amendments at least moved the Act closer to the tipping point. But adoption of the Sixth Edition of the AMA Guides leaves the injured worker who suffers a permanent impairment in a situation not unlike that of Monty Python's Black Knight.

As noted earlier, with the 2011 amendments claimants' rights to recovery were diminished in a number of ways:

Claimants are now required to mitigate the employer's liability for compensation payments, an obligation that the Act had not specifically imposed before 2011. See L. 2011, ch. 55.

Under the 2011 amendments, the focus of the Act, as expressed in its first provision, shifted from the right of claimants to compensation for work-related injuries to the various fault-based provisions available to the employer for denying compensation. For example, injuries from horseplay among coworkers formerly was compensable in some circumstances. See *Jordan v. Pyle, Inc.*, 33 Kan. App. 2d 258, 101 P.3d 239 (2004). Now, injuries resulting from horseplay are not compensable under any circumstances. Previously, an employee's refusal to submit to a drug test was grounds for refusing

benefits if the employer had probable cause to believe the employee was under the influence of drugs. See the Board's decision in *Anderson v. Custom Cleaning Solutions*, No. 1,070,269, 2016 WL 5886183 (Kan. WCAB September 19, 2016). Now, an employer can deny benefits regardless of whether the employer has probable cause to believe the employee was actually under the influence of drugs when the work accident occurred so long as the employer has a policy requiring testing and the employee refuses the test.

The 2011 amendments adopted the prevailing factor rule for determining causation. The work-related injury must now be the prevailing factor in the injury. This narrowed the concept of causation from the pre-2011 Act. See *Nam Le v. Armour Eckrich Meats*, 52 Kan. App. 2d 189, 364 P.3d 571 (2015). The pre-2011 standard required a showing of "some causal connection between the accidental injury and the employment." *Siebert v. Hoch*, 199 Kan. 299, 303, 428 P.2d 825 (1967).

A claim for aggravation of a preexisting condition is no longer compensable. Nor is a claim for injuries arising out of a neutral risk, a personal risk, or an idiopathic cause. The Act previously allowed compensation for the aggravation of a preexisting condition. See *Demars v. Rickel Mfg. Corp.*, 223 Kan. 374, 573 P.2d 1036 (1978). Injuries cause by neutral risks had been compensable in the past. See *McCready v. Payless*, 41 Kan. App. 2d 79, 200 P.3d 479 (2009). Likewise, injuries from idiopathic causes had been compensable before this amendment. See *Graber v. Dillon Companies*, 52 Kan. App. 2d 786, 377 P.3d 1183 (2016), *rev. granted* 306 Kan. 1317 (2017).

The time for providing a notice of accident can no longer be extended for good cause shown. A claim will be denied if the Act's strict notice deadlines are not met.

An award for future medical treatment is not permitted under the 2011 amendments absent a showing that future medical care will probably be needed. See *Woods v. Farmers Insurance Group, Inc.*, No. 116,184, 2017 WL 1296136, at *7 (Kan. App. 2017) (unpublished opinion). In *Woods*, the court observed:

> "The 2011 amendments to the Workers Compensation Act were significant in many ways, and these provisions represented a departure from prior law. Before the 2011 amendments, claims for future medical benefits were left open as a matter of right—meaning an award for compensation always included the possibility of future medical benefits. [Citations omitted.] . . . Here, the legislature reversed the general policy that future medical benefits be left open to a general policy in which further medical benefits would not be available after maximum medical improvement unless the employee proved that the need for future treatment was probable."

Moreover, it is now presumed that medical care is no longer needed if no treatment is received within two years from the date of an award for future medical care.

In calculating an entitlement to work disability, the threshold for such a claim has been raised. Now, a claimant's functional impairment must be in excess of 7.5% to the whole person to allow a work disability claim. K.S.A. 2015 Supp. 44-510e(a)(2)(C).

A claim can now be dismissed with prejudice for lack of prosecution if it is not tried or settled within three years of the filing date, even though the claimant had not been dilatory in pursuing the claim, had not abandoned the claim, and has not reached maximum medical recovery. See *Glaze v. J.K. Williams, LLC*, 53 Kan. App. 2d 712, 390 P.3d 116, *rev. granted* 306 Kan. 1317 (2017).

An injured worker is entitled to medical care "reasonably necessary to cure and relieve the effects of the injury." K.S.A. 2015 Supp. 44-510h. But the employer has the

right to designate the treating physician and the injured employee must wait for the employer to authorize treatment, which delays the receipt of prompt care.

Economic loss is compensated, but only partially. Temporary total disability compensation is paid for 2/3 of the average weekly wage with a cap of 75% of the state's average weekly wage. See K.S.A. 2015 Supp. 44-510c(a)(1). Here, the applicable maximum claim was $610 per week. Taking Johnson's circumstances as an example, he earned considerably more than the state's average weekly wage. Thus, his recovery was less than the 2/3 of his actual wage loss for the six months he was unable to work.

When one considers the Act as a whole, including the major amendments made in 1993 and in 2011, we conclude that an adequate substitute remedy no longer remained after the adoption of the Sixth Edition of the AMA Guides.

There is a significant difference between the Fourth Edition and the Sixth Edition of the AMA Guides. The Sixth Edition shifts the focus from functional impairment that affects job performance to basic standards of health. As noted by the authors, the Sixth Edition "introduces a paradigm shift in the assessment of impairment" by introducing a new definition of functional impairment. AMA Guides Sixth Edition, p. 3. The model introduced in the Sixth Edition is not geared specifically to measuring functional impairment of an injured worker, but rather it is designed as a multipurpose classification intended for a wide range of uses. AMA Guides Sixth Edition, p. 5. The assessment of functional impairment in the Sixth Edition is no longer tied to the ability to do activities associated with work. Instead, when it comes to functional impairment the focus is on life-care activities. A disability evaluation "must be further integrated with contextual information typically provided by nonphysician sources regarding psychological, social, vocational, and avocational issues." AMA Guides Sixth Edition, p. 6.

The new definition of functional impairment is inconsistent with the Act, specifically in the assessment of permanent partial disability. Under the Act, compensation is based on the worker's disability. Disability refers to the effect of impairment on the ability to perform a job or task. A disability under the Act may be temporary or permanent, partial or total. Permanent total disability—defined in K.S.A. 2015 Supp. 44-510c(a)(2)—exists when the injury has rendered the worker completely and permanently incapable of engaging in any type of substantial gainful employment. See *Casco v. Armour-Swift-Eckrich*, 283 Kan. 508, 526, 154 P.3d 494 (2007). When permanent total disability follows permanent partial disability, compensation is paid as provided in K.S.A. 2015 Supp. 44-510d and K.S.A. 2015 Supp. 44-510e. See K.S.A. 2015 Supp. 44-510c(c). This method of compensation is consistent with the Act's overall purpose of compensating the injured worker for the loss of earning power.

But the use of the Sixth Edition conflicts with this principle by measuring disability in terms of the ability to perform activities of daily living rather than measuring an impairment in terms of the inability to do a job at work. Rather than focusing on the impairment in terms of the ability to work, the Sixth Edition describes an impairment rating as a "consensus-derived percentage estimate of loss of activity reflecting severity for a given health condition, and the degree of associated limitations in terms of [activities of daily living]." AMA Guides Sixth Edition, p. 5. Activities of daily living are described in the Sixth Edition as basic self-care activities such as bathing, showering, dressing, eating, functional mobility, personal hygiene, toilet hygiene and management, sleep, and sexual activity. AMA Guides Sixth Edition, p. 7. None of the listed activities measures tasks with physical demands associated with work such as standing, walking, bending, squatting, twisting, climbing, carrying, or lifting.

The Fourth Edition also described activities of daily living, and in doing so, it specifically included "work activities." AMA Guides Fourth Edition, p. 1. It identified

activities that required physical demands often associated with a work setting such as standing, walking, stooping, squatting, lifting, pushing, lifting, and carrying. AMA Guides Fourth Edition, p. 317. By including specific functional and intrinsic physical activities into the description of activities of daily living, the Fourth Edition provided a tool to measure impairment and disability in terms related to the ability to do work. With the adoption of the Sixth Edition, the focus has shifted to measuring impairment in terms of activities of daily living. Any reference to work or work-related physical activities has been eliminated from the examples of activities of daily living provided in the Sixth Edition.

The Sixth Edition provides concrete impairment ratings that leave no room for the knowledge and expertise of the evaluating physician. In contrast, the Fourth Edition allowed physicians to use their experience, training, skill, and thoroughness in examining the patient in applying the Guides. AMA Guides Fourth Edition, p. 3. The Fourth Edition explained that using these attributes and involving the physician in the evaluation process "compose part of the 'art' of medicine, which, together with a foundation in science, constitute the essence of medical practice." AMA Guides Fourth Edition, p. 3.

With the legislation adopting the Sixth Edition, K.S.A. 2015 Supp. 44-510e(a)(2)(B) specifically provides:

> "The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as *established by competent medical evidence and based on the fourth edition* of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein, until January 1, 2015, *but for injuries occurring on and after January 1, 2015, based on the sixth edition* of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein." (Emphases added.)

The previous versions of the Guides deferred to the physician's discretion in providing an impairment rating. They left room for adjustments needed to meet the evolving demands of medical science. See *Milpitas United School District v. Workers Compensation Appeals Board*, 187 Cal. App. 4th 808, 823, 115 Cal. Rptr. 3d 112 (2010) (physician discretion was an integral part of past versions of the AMA Guides). The statute no longer refers to "competent medical evidence" when dealing with injuries after January 1, 2015. This discretion has been removed from the Sixth Edition.

The Guides should measure the extent of permanent impairment, which directly relates to the ability to continue working—a driving factor behind the Act.

> "[R]ecovery for loss of earning power is a basic purpose of the act. In accordance with this principle we conclude a workman is entitled to recover an award equal to the percentage of his physiological capabilities lost by reason of an injury occurring within the scope of his employment. Stated more distinctly, he should recover his functional disability." *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, 196, 558 P.2d 146 (1976).

But under the Sixth Edition of the AMA Guides, impairment ratings are 40% to 70% lower than those provided in the Fourth Edition. According to Dr. Koprivica, there is no scientific support for the reduced ratings in the Sixth Edition. In amending K.S.A. 2015 Supp. 44-510e(a)(2)(B), the Legislature also eliminated any reliance on competent medical evidence to measure impairment and instead refers exclusively to establishing impairment based on the Sixth Edition of the AMA Guides. The Legislature's decision to adopt the Sixth Edition and slash the amount of permanent partial disability compensation through lower impairment ratings has deprived the injured worker of a basic purpose of the Act, which is to restore lost earning capacity.

When enacting the Act, "[w]hat the Legislature had in mind was compensation for loss of earning power as a workman as a result of injury." *Gorrell v. Battelle*, 93 Kan. 370, 375, 144 P. 244 (1914). Because compensation for permanent partial impairment is a necessary and essential component of the Act's quid pro quo, the drastic reduction of compensation for permanent partial impairment for injured Kansas workers has tipped the Act over the constitutional edge.

In his amicus brief, the Kansas Attorney General directs us to two letters and testimony provided to the Legislature by Dr. J. Mark Melhorn and Dr. Peter Bieri who supported the use of the Sixth Edition. They testified before the Committee on Commerce in opposition to S.B.167, which called for the reinstatement of the Fourth Edition. Their testimony supports the rather easily met first constitutional test under *Injured Workers*: whether the change in the Act is reasonably necessary in the public interest to promote the general welfare of the people of Kansas. Their testimony does not address the adequacy of the quid pro quo necessary to sustain the constitutionality of the enactment.

The Attorney General also asserts that Johnson failed to show that the quid pro quo is constitutionally insufficient because he has not demonstrated that he would have recovered more compensation in a common-law tort action than he received under the current version of the Act using the Sixth Edition. We are not persuaded by this assertion.

The challenge here is not an as-applied challenge. Johnson claims the adoption of the Sixth Edition of the AMA Guides is facially unconstitutional and merely uses his situation as an example of the unconstitutional scheme.

Besides, the Attorney General's argument presents an insurmountable barrier for any injured worker. The Act establishes an administrative procedure that makes no provision for calculating the comparative fault of the injured worker, the employer, and

third parties who may have contributed to cause the accident and resulting injuries. There is no provision for developing and documenting evidence of conduct on the part of the employer or a third party that could be the basis for a claim of punitive damages in a common-law tort action. There is no provision for documenting evidence of noneconomic damages that otherwise would be recoverable in a tort action. There is no discovery available to a claimant on these issues, so there could be nothing in the administrative record with which to measure an actual award against a hypothetical common-law recovery.

As a final point on this issue, what our injured workers have given up in exchange for our administrative process under the Act is the *right to seek* recovery in a common-law tort action presented in a public trial to a jury of their peers. We have traditionally viewed this exchange of rights strictly in economic terms. The economic outcome of the administrative process is certainly the key element in measuring the value of the administrative side of the bargain. But in measuring the value of the other side of the bargain, those who have participated in trials of tort actions, either as lawyers or as judges, know that justice involves more than the ca-ching of a cash register.

In a public trial, plaintiffs seek the recognition of their peers of the propriety of their conduct and a recognition of the misconduct of their adversaries. They want their community to know the consequences of that misconduct on their lives and their fortunes. They want a public answer to the common question from friends and neighbors when they learn of the accident: "So what happened, and who's at fault?" In short, they want to be heard. As Linda Loman said of her husband in Act I of Arthur Miller's *Death of a Salesman*:

> "I don't say he's a great man. Willy Loman never made a lot of money. His name was never in the paper. He's not the finest character that ever lived. But he's a human being,

> and a terrible thing is happening to him. So attention must be paid. . . . Attention, attention must finally be paid to such a person."

Answers must not only be uncovered but publicly expressed. For an injured plaintiff the value of a public trial of a common-law tort action encompasses all these things. Wrongdoing must be uncovered and its consequences laid bare. Attention must be paid.

The Sixth Edition of the AMA Guides significantly reduced the amount of benefits an injured worker with a permanent impairment is entitled to receive and resulted in a drastic change to the Act. We hold that with the adoption of the Sixth Edition of the AMA Guides, the Act has been emasculated to the point that it is no longer an adequate quid pro quo for injured workers who suffer a permanent impairment as a result of an injury occurring on or after January 1, 2015. The Act no longer provides an adequate substitute remedy for the abrogation of an injured worker's common-law right to sue an employer for negligence. The Legislature went too far with the adoption of the Sixth Edition, and we agree that the Act no longer comports with due process for injured workers who sustain a permanent impairment as a result of an injury occurring on or after January 1, 2015.

THE APPROPRIATE RELIEF

The issue before us involves only a challenge to the adoption of the Sixth Edition of the AMA Guides as of January 1, 2015. In devising a remedy, we are guided by a provision set forth in the Act. In K.S.A. 44-574(b), the Legislature provided a severability clause. This clause provides a remedy in the event that provisions of the Act are found to be invalid. K.S.A. 44-574(b) provides:

> "If any provision or clause of this act or application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable."

Our Supreme Court has considered whether it is proper to sever a provision from a statute to uphold the remaining statutory provisions as constitutional. Each time, this court has emphasized that the determination of whether the provision may be severed "'depends on the intent of the legislature.' [Citations omitted.]" *State v. Limon*, 280 Kan. 275, 302, 122 P.3d 22 (2005); see *State v. Carpenter*, 231 Kan. 235, 240-41, 642 P.2d 998 (1982); *Gumbhir v. Kansas State Board of Pharmacy*, 228 Kan. 579, 588, 618 P.2d 837 (1980). And although the decision to strike language from a statute does not depend on the presence of a severance provision, "'[t]he enactment of a severability clause in a statute or series of statutes evidences the intent of the legislature that if some portion or phrase in the statute is unconstitutional, the balance shall be deemed valid.' [Citation omitted.]" *Limon*, 280 Kan. at 304.

Here, the Legislature unequivocally expressed its intent that if a portion of the Act is found to be invalid, the remaining provisions of the Act should stand and be applied. Accordingly, the proper remedy is to strike the provisions in K.S.A. 2015 Supp. 44-510d(b)(23) and (b)(24) and K.S.A. 2015 Supp. 44-510e(a)(2)(B) that mandate the use of the Sixth Edition. Such a remedy will effectively reinstate the use of the Fourth Edition as the basis for determining impairment ratings. In oral arguments before us all parties agreed that this would be the appropriate remedy.

The Board's decision is reversed, and the case is remanded to the ALJ for further proceedings on Johnson's claim using the Fourth Edition of the AMA Guides.

Attachment 2:

Workers Compensation Appeals Board Decision

BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

HOWARD A. JOHNSON, III, Claimant, V.	)	
US FOOD SERVICE, Respondent, AND	)	Docket No. 1,075,741
AMERICAN ZURICH INSURANCE CO., Insurance Carrier.	)	

ORDER

Claimant requests review of the April 4, 2017, Award by Administrative Law Judge (ALJ) Kenneth J. Hursh.

APPEARANCES

Mark E. Kolich appears for claimant. Michelle Daum Haskins appears for respondent and its insurance carrier (respondent).

RECORD, STIPULATIONS AND ISSUES

The Administrative Law Judge found claimant's permanent functional impairment is 6 percent to the body as a whole. Future medical benefits were also awarded. Claimant timely sought Board review.

Before the ALJ, claimant challenged the constitutionality of the Act's requirement to use the Sixth Edition of the AMA Guides in determining functional impairment. The ALJ held he had no jurisdiction to rule on constitutional issues.

Claimant's Application for Review by Workers Compensation Board states the only issue for review is "[w]hether the legislative mandate to use the criteria of the 6th Edition of the A.M.A. Guides is unconstitutional."[1]

---

[1] Claimant raised the issue of future medical treatment before the ALJ and that issue is mentioned in claimant's application for Board review. However, given the parties' agreement reflected in the Application for Expedited Decision, the Board finds future medical is no longer an issue.

The facts are adequately set forth in the Award and are adopted by the Board.

On April 17, 2017, an Application For Expedited Decision, approved by counsel for all parties, was filed with the Board. That instrument provides:

> COME NOW the Claimant, Respondent and Insurance Carrier and make application for an expedited decision without the necessity for filing briefs and oral argument. In support of this application the parties state that the sole issue on appeal pertains to the constitutionality of the statutory requirement for use of the 6th Edition of the A.M.A. Guides. Since the Board has previously held in Pardo v. United Parcel Service, (Docket No. 1,073,268) that it "does not have jurisdiction to review the constitutionality of the Act," there does not appear to be a valid reason to require briefs and oral argument.

The Board entered an Order on April 13, 2017 placing this claim on its summary docket.

PRINCIPLES OF LAW AND ANALYSIS

The Board is not a court established pursuant to Article III of the Kansas Constitution and does not have the authority to hold an enactment of the Kansas Legislature unconstitutional.[2] Accordingly, the Board must affirm the ALJ's decision.

CONCLUSION

The Board has no jurisdiction to address claimant's constitutional arguments and otherwise affirms the underlying Award.

AWARD

WHEREFORE, the Board is without authority to rule on the constitutional issue raised by claimant and otherwise affirms the underlying Award.

IT IS SO ORDERED.

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[2] See *Anderson v. Custom Cleaning Solutions*, No. 1,070,269, 2016 WL 5886183 (Kan. WCAB Sept. 19, 2016); *Houston v. University of Kansas Hospital Authority*, No. 1,061,355, 2016 WL 3669848 (Kan. WCAB June 17, 2016); *Anderson v. Custom Cleaning Solutions*, No. 1,070,269, 2014 WL 5798476 (Kan. WCAB Oct. 27, 2014); *Carrillo v. Sabor Latin Bar & Grille*, No. 1,045,179, 2014 WL 5798458 (Kan. WCAB Oct. 24, 2014); *Pinegar v. Jack Cooper Transport*, No.1,059,928, 2014 WL 1758036 (Kan. WCAB Apr. 9, 2014).

Dated this 17 day of May, 2017.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Mark E. Kolich, Attorney for Claimant
mek@kolichlaw.com
justjulie1@yahoo.com

Michelle Daum Haskins, Attorney for Respondent and its Insurance Carrier
mhaskins@constangy.com

Kenneth J. Hursh, Administrative Law Judge

Workers Compensation Director

MAY 23 2017

Certificate of the Workers Compensation Director. The above is a true and correct copy of the original instrument which is on file or of record in the office of the Division of Workers Compensation.

Attachment 3:

ALJ Decision

BEFORE THE DIVISION OF WORKERS COMPENSATION
STATE OF KANSAS

HOWARD JOHNSON III
Claimant

VS

US FOOD SERVICE
Respondent

AND

AMERICAN ZURICH INS CO
Insurance Carrier

DOCKET NO. 1,075,741

AWARD

Decision rendered this 4th day of April, 2017.

APPEARANCES

The claimant, Howard Johnson III, appeared by his attorney, Mark Kolich of Lenexa, Kansas. The respondent, US Food Service, and its insurance carrier, American Zurich Insurance Company, appeared by their attorney, Michelle Daum Haskins of Kansas City, Missouri.

RECORD

The record consists of the pleadings and correspondence contained within the Court's administrative file, along with the following:

1. Deposition of Harold A Hess, M.D. held January 6, 2017 including exhibits;
2. Deposition of P. Brent Koprivica, M.D. held January 27, 2017 including exhibit;
3. Transcript of Regular Hearing held February 2, 2017;

4. Deposition of Jeff Cooper held February 6, 2017; and

5. Deposition of Frederick Greenbaum held February 13, 2017.

STIPULATIONS

The parties stipulated to the following:

1. Claimant met with personal injury by accident on October 16, 2015;

2. Claimant's accidental injury arouse out of and in the course of employment with respondent;

3. Respondent admits timely notice;

4. Respondent admits the relationship of employer and employee existed on the date of the accident;

5. Respondent admits the parties are covered by the Kansas Workers Compensation Act (Act);

6. Claimant's average weekly wage was sufficient for the maximum weekly benefit on the date of the accident;

7. Temporary total disability benefits were paid at $610.00 per week for 25.43 weeks for a total of $15,511.42;

8. Hospital and medical expenses were paid in the amount of $48,947.09;

9. Respondent admits that the accident or repetitive trauma was the prevailing factor causing the injury, the medical condition, need for treatment and the resulting disability or impairment;

10. Respondent has made a lump sum payment of $14,804.70, the value of a 6% permanent partial disability benefit.

ISSUES TO BE DETERMINED

1. The nature and extend of claimant's impairment;

2. Whether claimant is entitled to future medical treatment;

3. Whether the legislative mandate to use the criteria of the 6th Edition of the AMA Guides is unconstitutional; and

4. Whether the 2011 amendments limiting an injured worker's right to future medical treatment is unconstitutional.

FINDINGS

Nature and extent of permanent disability. The claimant, a delivery driver, suffered a work related cervical spine injury on October 16, 2015 while opening a door that had become stuck. The treating physician, Harold Hess, M.D., found herniated discs at the C5-C6 and C6-C7 levels. Because the claimant suffered cervical myelo-radiculopathy, radicular symptoms affecting both upper and lower extremities, Dr. Hess recommended immediate surgery and performed a two level fusion.

The claimant eventually returned to his job as a delivery driver. He testified the surgery helped with the radicular symptoms, though he now has limited range of motion in his neck. He said that due to the neck symptoms, he cannot move as much product at one time as he used to, and it now takes him longer to complete deliveries.

Cervical spine injuries do not appear on the K.S.A. 44-510d schedule of injuries, so permanent disability in this case is governed by K.S.A. 44-510e. That section provides, for injuries occurring on or after January 1, 2015, permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 6th Edition if the impairment is contained therein.

The competent medical evidence showed the claimant has 6% permanent whole person impairment. Dr. Hess testified the claimant's good result from surgery qualified for 6% impairment under the *Guides*, 6th Edition. P. Brent Koprivica, M.D. reviewed the claimant's medical records and agreed 6% impairment was appropriate under the *Guides*, 6th Edition. It is held the claimant's permanent partial disability is 6% to the body as a whole.

Future medical. K.S.A. 44-510h provides a presumption the employer's liability for medical expenses terminates upon maximum medical improvement. The presumption may be overcome with medical evidence that it is probably more true than not additional medical treatment will be required after maximum medical improvement. Additional "medical treatment" does not include home exercise programs or over-the-counter medications.

Dr. Hess found the claimant at maximum medical improvement on July 28, 2016. Dr. Hess testified that with cervical fusions there is a 20 to 30% probability of breakdown of adjacent cervical disks as the result of added stress from the fusion within the first ten years of the fusion.

Dr. Koprivica testified it was likely the claimant would need additional treatment. He said the 20 to 30% probability in the first ten years was the likelihood of additional surgery, while the claimant would likely require some kind of additional treatment—medication, therapy, or epidurals, if not surgery—for adjacent disk breakdown.

Dr. Koprivica's testimony was medical evidence sufficient to overcome the K.S.A. 44-510h presumption. The claimant shall be awarded future medical benefits.

Constitutionality of 6th Edition and future medical provisions. Much of the record was directed at the claimant's arguments K.S.A. 44-510e(a)(2)(B)'s use of the *Guides*, 6th Edition for injuries occurring on or after January 1, 2015 and K.S.A. 44-510h(e)'s rules regarding future medical benefits are unconstitutional. This administrative court is not a court established pursuant to Article III of the Kansas Constitution and does not have the authority to hold an Act of the Kansas Legislature unconstitutional. Therefore, this court makes no findings on the constitutional issues. The issues and the parts of the record relevant to the issues are preserved for appeal.

AWARD

WHEREFORE AN AWARD OF COMPENSATION IS HEREBY MADE IN ACCORDANCE WITH THE ABOVE FINDINGS IN FAVOR of the claimant, Howard Johnson III, and against the respondent, US Food Service, and the insurance carrier, American Zurich Insurance Company, for an accidental injury sustained on or about October 16, 2015.

1. The respondent and insurance carrier shall pay all authorized medical expenses related to treatment of the claimant's injuries subject to the Kansas workers compensation schedule of medical fees. All known medical expenses to date, totaling $48,947.09, have been paid. The claimant is awarded future medical benefits.

2. The respondent and insurance carrier shall pay the claimant 25.43 weeks of temporary total disability at the rate of $610 per week, a total of $15,511.42, which has already been paid.

3. The respondent and insurance carrier shall pay the claimant 24.27 weeks of permanent partial disability benefits at the rate of $610 per week for a 6%

impairment to the body as a whole, a total due and owing of $14,804.70, which has already been paid.

4. The claimant attorney's contract of employment (attached to the application for hearing) conforms to K.S.A. 44-536 and is approved. The claimant's attorney shall receive a fee of 25% of the permanent partial disability awarded.

5. Fees necessary to defray the expenses of administration of the Workers Compensation Act hereby assessed against the respondent to be paid direct as follows:

Richard Kupper & Associates:

Deposition of Dr. Harold Hess	$ 250.65
Deposition of Dr. P. Brent Koprivica	336.00
Deposition of Jeff Cooper	462.75
Deposition of Frederick Greenbaum	149.75
	Total $1,199.15

Metropolitan Court Reporters:

Regular Hearing transcript	$ 207.75

IT IS SO ORDERED.

KENNETH J. HURSH

ADMINISTRATIVE LAW JUDGE

Original to: Director Larry Karns

E-Mail Copies to: Mark Kolich
Michelle Daum Haskins

Workers Compensation Director

MAY 23 2017

Certificate of the Workers Compensation Director. The above is a true and correct copy of the original instrument which is on file or of record in the office of the Division of Workers Compensation.

Attachment 4:

Dr. J. Mark Melhorn letter to the Kansas Legislature (Mar. 2013)

(316) 688-5656 Appointments
(316) 688-5757 Patient Accounts & Billing

(316) 688-5454 Medical Records
(316) 683-8787 Fax

The Hand Center
ORTHOPAEDICS OF THE HAND & UPPER EXTREMITY

To: Members of the Kansas Legislature

Brief Overview of AMA *Guides* to the Evaluation of Permanent Impairment, Sixth Edition

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Disclaimer: I have been a contributor to the AMA *Guides* 4th, 5th, and 6th edition and I am on the editorial staff of the AMA *Guides* Newsletter. I am a volunteer faculty member for many professional organizations that teach how to use the AMA Guides (for example AADEP, AAOS, ACOEM, ODG) and I am an author and editor of books and materials for which I receive a royalty. I do not receive any direct royalty from the sales of the AMA Impairment *Guides* or the Newsletter. This overview is partially based on materials made available to me through my work with the AMA and are used with the AMA's permission.

Summary

The Sixth Edition of the **AMA *Guides* to the Evaluation of Permanent Impairment** (*Guides*) provides a step forward in our understanding of impairment and disability. Criticisms of previous editions were address by the authors in the Sixth Edition. The Sixth Edition allows for rating conditions that could not be clearly and accurately rated previously using the Fifth or earlier Editions. Each new edition reflects an increased understanding of the science and the improvements from appropriate medical or surgical treatment. The Sixth Edition is not perfect. As the Sixth Edition is used, additional questions and concerns will develop. The AMA has developed a supplement to the AMA *Guides*, the AMA *Guides* Newsletter that is published 6 times per year. The AMA *Guides* Newsletter is used by the AMA to address these questions and concerns and help physicians consistently and appropriately used the *Guides*. Articles in the Newsletter are then used to improve future editions. The *Guides* Newsletter should be considered an integral part of the AMA *Guides*.

Introduction

The American Medical Association's *AMA Guides to the Evaluation of Permanent Impairment (AMA Guides)* are the recognized international standard for assessing impairment. The Sixth

Edition,[1] published in 2007, introduced new approaches to medical ratings of permanent impairment (PI), a key component in determining permanent impairment and partial disability awards (PPD) for workers' compensation (WC) and other benefit programs. Attached is a listing of "Who uses the AMA Guides™ Sixth Edition".

ICF Model

In 2001, the World Health Organization (WHO) published the *International Classification of Functioning, Disability and Health (ICF)*[2] to replace the earlier and outdated *International Classification of Impairments, Disabilities and Handicaps (ICIDH)*.[3] This new system of classification of disease and disability embodies the biopsychosocial model of disease and depicts the interactive relationship and potential determinants of disability for any individual with a health condition, disorder, or disease.

The ICF recognizes that the normal state for individuals includes a range of variability in *body functions and body structures,* and that individuals also exhibit a normal range of variance in their ability to execute an *activity* (task or action within their personal sphere) and *participation* (involvement in life situations.) The ICF defines *impairments* as problems in body function or structure such as a significant deviation or loss from normal; *activity limitations* are difficulties an individual may have in executing activities and *participation restrictions* are problems an individual may experience in their involvement in life situations.

The Sixth Edition has adopted the ICF terminology, definitions, and conceptual framework for disablement to replace the ICIDH terminology of earlier editions. They define *impairment rating* as a "consensus-derived percentage estimate of loss of activity reflecting severity for a given health condition and the degree of associated limitations in terms of Activities of Daily Living (ADLs)". In so doing, they are promoting metrics specific to the medical (eg, anatomical, physiological) aspects of organ system pathology and disease and to their potential effects on basic human functioning (ie mobility and basic self-care).

Five changes to the new *AMA Guides Sixth Edition*

Periodic advances in medical and surgical care and associated improvements in functional outcomes with treatment of disabling conditions need to be taken into account when developing and maintaining impairment rating guidelines. Furthermore, criticisms of earlier editions of the *AMA Guides* remain largely unanswered and inadequately addressed by the Fifth Edition and earlier editions of the *AMA Guides*. See, for example, the following unanswered criticisms[2]:

- "Confusing, inconsistent, and antiquated terminology of disablement."
- "Inadequate evidence-base."
- "Ratings fail to reflect perceived or actual loss of function."
- "Validity and reliability of ratings remains questionable."
- "Lack of internal consistency."

In addition, the Fifth Edition has major inadequacies in its own right. These included gross inconsistencies across organ systems in terms of methodology, magnitude of ratings, treatment

outcomes, number of rating classes, and even whether or not to rate impairment at all. The problem of how to rate mental and behavioral disorders was left unresolved in the Fifth and earlier editions. There is a general consensus that pain ratings were poorly handled in the Fifth edition. There was lack of attention to activities of daily living (ADLs) although their measurement is implied as part of the AMA definition of impairment rating – this is particularly problematic in the musculoskeletal organ systems (Spine, Upper, and Lower Extremity), which comprise the majority of conditions towards which the *AMA Guides* is typically applied.[3]

The Sixth Edition maintained a focus upon and inclusion of the four essential elements of physician evaluation and reporting about their patients as follows:

- What is the clinical problem (diagnosis)?
- What difficulty does the patient report (symptoms, functional loss)?
- What are the examination findings?
- What are the results of clinical studies?

In order to address the above mentioned criticisms directly, the *AMA Guides* Sixth Edition embraced five axioms of change delimited below:

- Adopt the terminology and biopsychosocial model of disablement of the *International Classification of Functioning, Disability and Health (ICF)*[2] to replace the outdated terminology of the *International Classification of Impairments, Disabilities and Handicaps (ICIDH),*[3] which is imbedded in the Fifth and earlier editions of the *AMA Guides*.
- Functional (ADL-based) assessment is introduced into impairment ratings in general. The Sixth Edition has adopted an ADL-based functional history and ordinal measures of ADL assessment as important modifiers of impairment ratings where applicable, and for musculoskeletal organ systems in particular.
- Changes were needed to promote internal consistency. In response, Sixth Edition has adopted a uniform ICF-based template utilizing five functionally-based impairment classes across all organ systems.
- There is increased emphasis upon the diagnosis-based approach to impairment ratings, and for musculoskeletal organ systems in particular, whereby a broader array of diagnoses are available, buttressed by a higher resolution of diagnostic criteria to choose from. This enables the impairment classes to be defined more precisely with improved resolution of impairment grades within a given impairment class, thereby promoting transparency and ostensibly improving the reliability and reproducibility of the ratings themselves.
- It remains difficult to promote an improved evidence base in support of the magnitude of the rating percentages themselves, given the limited research actually done on this topic. In fact, the impairment percentages currently in use are largely driven by consensus and historical precedent. Rather, by moving towards an increased emphasis on diagnosis-based rating

criteria, the AMA has enabled the ongoing advancement of the evidence-based foundation for these diagnostic criteria over time.

Diagnosis-based Impairment (DBI) methodology simplifies rating for most conditions
The DBI methodology adopted for *AMA Guides* Sixth Edition is an outgrowth of the diagnosis-related estimate (DRE) approach of earlier editions with important additions and changes, which are evident in the musculoskeletal organ system in particular. To illustrate, using the musculoskeletal organ system, a uniform platform now has been adopted which applies a template (grid) with five columns for functionally-based impairment classes (classes 0 – 4) patterned after the ICF. Whereas all organ systems can potentially be viewed within this scheme, not all conditions within a given organ system will qualify for the higher class ratings. Accordingly, the conditions are hierarchically arranged under the left most column headings according to rows beginning with the least severe ratable conditions at the top and ending with potentially the most severe ratable conditions at the bottom (eg, soft tissue conditions at the top, followed by muscle and tendon traumas, followed by ligament, bone, and joint conditions.)

Previous editions did not provide methods for rating some commonly occurring workplace conditions in the upper limb such as trigger digit, wrist ganglion, TFCC tear, and elbow epicondylitis. Previous editions provided limited methods for lower extremity strains, tendonitis. Previous editions for the spine did not take into account improved outcomes with newer surgical techniques.

Implications to adoption/continued use of the *AMA Guides* Sixth
Physician feedback on the Sixth Edition has generally been positive since there is a consistent approach to assessing impairment based on a more contemporary framework. There is a learning curve for physicians to use the 6th edition, which may require additional training, but once familiar with the approach, the methodology is consistent for all chapters which results in improved intra- and inter-rater reliability.

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American Academy of Orthopedic Surgeons. Available at: www.aaos.org
American Academy of Disability Evaluating Physicians. Available at: www.aadep.org.
American College of Occupational and Environmental Medicine. Available at: www.acoem.org

Attachment 5:

Dr. Peter V. Bieri letter to the Kansas Legislature (Mar. 2013)

Members of the Kansas Legislature

I have been informed of a move to adopt the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition (AMA 6th) as the standard for impairment ratings in Kansas workers compensation cases, supplanting AMA 4th. If this is so, I wish to support such a change.

My professional experience consists exclusively of independent medical evaluations over the last twenty years, supported by board-certification in disability evaluation, with cases mostly limited to Kansas jurisdiction. During this period the law required first the use of AMA 3rd Ed Rev, and currently the AMA 4th, in use since 1993. The AMA has since published AMA 5th and AMA 6th. I have used the first two references extensively for over ten thousand independent medical evaluations, the majority at the request of our administrative law judges for neutral independent evaluations, and have contributed, at the request of the AMA, from an academic standpoint to the finished products of AMA 5th and AMA 6th as a recognized Reviewer in the preface to each edition. While I claim no particular genius in disability evaluation, I doubt there are more than a handful of Kansas doctors more experienced in issuing impairment ratings under the AMA Guides.

The AMA 6th represents a good-faith effort by a large group of physicians to bring disability evaluation into the modern era of evidence-based medicine and outcomes, concepts that are utilized extensively in the new Affordable Care Act, and are widely considered to be the hallmarks of a new emphasis in modern medicine. After twenty years, it only makes sense for disability evaluation, as a professional discipline, to be on a level playing field. We constantly strive for consistency, simplicity (when possible), ability to reproduce results by different evaluators presented with the same clinical data, and, most importantly, results that make sense to our administrative, judicial, and legal colleagues.

I believe adoption of the AMA Guides 6th Ed will help us greatly toward these goals.

Thank you for your indulgence.

Peter V. Bieri, M.D.
Fellow, American Academy of Disability Evaluating Physicians
3110 Mesa Way, Suite C, Lawrence, KS 66047

Attachment 6:

Testimony of Dr. J. Mark Melhorn on behalf of the Kansas Medical Society in opposition to SB 167 (Feb. 12, 2015)

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(316) 688-5757 Patient Accounts & Billing

(316) 688-5454 Medical Records
(316) 685-8787 Fax

The Hand Center
EXCELLENCE IN THE HAND & UPPER EXTREMITY

February 12, 2015

Chairwoman Lynn, members of the Committee, thank you for the opportunity to appear today. My name is Mark Melhorn. I am here today on behalf of the Kansas Medical Society and the science that was used to develop the Sixth Edition of the AMA *Guides to the Evaluation of Permanent Impairment*. After you have reviewed the science, I believe that you will understand why I am here today to encourage you to vote "no" on SB 167.

I graduated from the University of Kansas, School of Medicine and after completing my residency in Wichita and my fellowship at the University of Southern California, returned to Wichita, Kansas. I have been practicing in Wichita since 1986 and I am currently on the faculty of KUMC-Wichita as an Associate Clinical Professor of Orthopaedics.

I would like the committee to be aware that I have been a volunteer (nonpaid) contributor to the Fourth, Fifth, and Sixth Editions of the *Guides* and the AMA *Guides Newsletter*. I have no financial interest in either product, my full disclosure is provided in this document.

Summary

The Fourth Edition was created in 1992 and first printed in June 1993. The First Edition was printed in 1971 and the Sixth Edition in 2007. Each edition has reflected and incorporated the improved science of impairment and assessment, along with the improvements in medical treatments, which have resulted in better outcomes. The current Sixth Edition of the AMA *Guides* reflects the current best science and expert consensus. The Fourth Edition is out of date by over two decades.

The AMA *Guides* recommends that the current edition be used. This recommendation is based on the fact that the current best science was used to develop the "newest" edition. Currently there are over 22 states which have moved to the Sixth Edition along with the United States Department of Labor.

Spinal impairments in Fourth Edition were based primarily on the condition (diagnosis) at any time from the onset of the condition to the end of treatment or maximum medical improvement (MMI), this is known as "injury based" impairment. So the diagnosis was driving the impairment, not the final outcome. The trend in the Fifth and Sixth is to rate at MMI which is the international standard known as "outcome based" impairments. In other words, if the condition is improved by the treatment the impairment should be less. The goal of all treatment, including surgery, should be to improve function and decrease impairment. The Fourth Edition did not take the benefits of healthcare into consideration for many conditions and in particular spinal ratings. Again, impairment should be based on what is wrong (functional loss) when improvement with time and

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treatment is complete. Functional loss is best determined by current medical science. See Supporting Science below for details.

When the Fourth Edition was developed, in many states individuals with work injuries were seen late in their condition and therefore had more significant functions loss. With patients being seen sooner, earlier intervention has resulted in improved outcomes and reduced impairments. In addition, changes in surgical technique have resulted in small incisions ("minimally invasive surgery") resulting in faster recovery and more complete recovery, so patients who are currently treated have better outcomes than those treated in the 1980s (on which the impairments in the Fourth Edition were based). Therefore, the overall impairments have gradually decreased reflecting the improved science and quality of healthcare, but the *AMA Guides Sixth* Edition has retained the ability to provide higher impairments for individuals with significant impairments at the end of their treatment.

Evidence based medicine has resulted in improved understanding for the need for inter-rater and intra-rater reliability. This approach is required to be fair to each injured worker. In statistics, intra-rater reliability is the degree of agreement among repeated administrations of a diagnostic test performed by a single person, or same rater. The second requirement is inter-rater reliability which is the level of agreement or concordance among different individuals (different impairment raters) when presented with the same information. The homogeneity or consensus of the scores determines if a particular scale is appropriate for measuring a particular variable. If various raters do not agree, either the scale is defective or the raters need to be re-trained.

Benefits to the injured worker

Medical studies demonstrate that early return to work is in the injured workers best interest. Examples include improved quality of life and a greater likelihood of remaining employed. Inter-rater and intra-rater reliability reduces unnecessary time off work during the phase of the litigation process from impairment to settlement. This reduced conflict is beneficial to the workers' compensation system and to the injured worker. See Supporting Science below for details.

Ratable conditions

The Sixth Edition has greatly increased the number of conditions that can be rated. With our improved understanding of impairment, more conditions can be rated. For example, impairment ratings are now included for conditions that may result in functional loss, but previously did not result in a ratable impairment such as trigger finger, lateral epicondylitis (tennis elbow), nonspecific shoulder pain, nonspecific neck pain, nonspecific low back pain, hip bursitis, hip strains, etc. In addition many procedures now being commonly performed by surgeons treating injured workers can be rated by the Sixth Edition, but are not mentioned in the Fourth Edition, because they had not yet been developed. Examples include total shoulder replacement, reverse total shoulder replacement, total ankle replacement, cervical artificial disc replacement, lumbar artificial disc replacement, etc.

Why is there resistance to change?

Studies demonstrate that people resist change:

- When the reason for the change is unclear.

- When the proposed users have not been consulted about the change and the change is offered to them as an accomplished fact.
- When the change threatens to modify established patterns of working relationships between people.
- When change threatens their perceived financial interests regardless of the benefits to others.
- When the benefits for making the change are not seen as adequate for the trouble involved.

The impact of changing from the Fourth to the Sixth

The January/February 2010 AMA *Guides Newsletter* report on a "Comparative Analysis of AMA *Guides* Ratings by the Fourth, Fifth, and Sixth Editions.

Two hundred cases were assessed, and the clinical data were used to determine the resulting whole person permanent impairment according to each of these 3 editions. If the case reflected more than 1 diagnosis, each diagnosis was rated, and if both extremities were involved (eg, a bilateral carpal tunnel syndrome), each was rated as a separate diagnosis since each would be associated with a separate impairment.

The difference between average whole person impairment ratings was tested using a paired sample t-test analysis, with an alpha level set at the .05 level of significance. This analysis revealed a statistically significant difference between average whole person impairment ratings when comparing the Sixth Edition with the Fifth Edition, but not when comparing the Sixth Edition results with those of the Fourth Edition.

With the Sixth Edition there were meaningful changes in impairment ratings as a result of not providing additional impairment for surgical (therapeutic) spine procedures, improved outcomes with surgical release for carpal tunnel syndrome, and improved outcomes with total knee and hip replacement.

Examples of some specific impairments

The global value above demonstrated no significant different between the Fourth and Sixth Edition, but certainly one can select a specific diagnosis and see a difference. In other words, if you total all of the increases and all of the decreases, the total impact was not statistically significant. A few examples would be helpful.

1. Symptoms of neck pain but no objective findings: Fourth Edition page 103 Cervicothoracic Spine DRE 1 = 0% impairment, Sixth Edition page 564 = 1 to 3% WPI.

2. Symptoms of low back pain but no objective findings: Fourth Edition page 102 Lumbosacral Spine DRE 1 = 0% impairment, Sixth Edition page 570 = 1 to 3% WPI.

3. Single or multiple level fractures of lumbar vertebra with > 50% compression of one vertebral body with or without retropulsion with or without pedicle and/or posterior element fracture, healed with or without surgical interventions with residual deformity and with or without documented radiculopathy at a single clinically appropriate level present at the time of examination: Fourth Edition page 102 DRE IV = 20%, Sixth Edition page 574 Class 3 range 15 to 23%.

4. Intervertebral disk herniation or Alteration of Motion Segment Integrity (AOMSI) at a single level with medically documented findings , with or without surgery, and with documented residual radiculopathy at the clinically appropriate level present at the time of examination.: Fourth Edition 102 DRE III radiculopathy = 10%, Sixth Edition page 570 Class 2 range 10 to 14%.

5. Carpal tunnel syndrome post-surgery with residual subjects symptoms and NCT with conduction delay: Fourth Edition section 3.1k range 1 to 7 % upper limb, table 16 page 57 10%, Fifth Edition page 495 range 0 to 5%, Sixth Edition 1 to 3 %. However, if severe and axon loss is present the range is 7 to 9%.

The advantage of the Sixth Edition provides a range instead of the Fourth Edition where one rating "fits" all individuals with the same diagnosis regardless of their treatment outcome. See Supporting Science below for details.

Impairment and Disability

It is important to remember the difference between impairment and disability. Impairment is defined by the AMA *Guides* as a significant deviation, loss or loss of use of any body structure or function in an individual with a health condition, disorder, or disease. This is different than disability which is defined as an umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease. Impairment is determined the medical science while disability is determined by the judicial system which can take into consideration individual functional limitations in the workplace and in non-workplace activity based on social justice. An additional advantage of the Sixth Edition is that the physician can include the injured workers' reported symptoms in the final impairment. This provides the ability to adjust impairment per individual outcomes. The Fourth Edition does not have this option. Again, this is another example of our improved understanding of the science of impairment.

Availability

Print copies of the Fourth Edition may soon become unavailable as future reprinting is unlikely. This will result in limited access for new physicians.

Exclusive remedy

As the name suggests, an exclusive remedy clause exhaustively spells out the remedies available to a party for a particular event. All other remedies are excluded. To date, there have been no issues regarding exclusive remedy in the other states or Federal jurisdictions with use of the Sixth Edition.

Other considerations

Although not part of the medical consideration when reviewing SB 167, if the goal is fair compensation for the injured worker, I see no basis for changing the current threshold as listed on page 5 line 21 regarding "An employee may be eligible to receive permanent partial general disability compensation in excess of the percentage of functional impairment ("work disability") if: (i) The percentage of functional impairment determined to be caused solely by the injury ~~exceeds 7½%~~ equals or exceeds 10% to the body as a whole or the overall functional impairment is equal to

or exceeds ~~10%~~ 12 ½ % to the body as a whole in cases where there is preexisting functional impairment; and
(ii) the employee sustained a post-injury wage loss, as defined in ~~subsection (a)(2)(E) of~~ K.S.A. 44-510e(a)(2)(E), and amendments thereto, of at least 10% which is directly attributable to the work injury and not to other causes or factors.

In conclusion, the Fourth Edition is over two decades old and is out of date. We would not consider practicing medicine based on an outdated textbook, especially when previous approaches were found to be wrong. Rather, we should want to practice using the current best science. We should take the same approach when assessing impairment.

Thank you for the opportunity to appear before you today. I would be happy to stand for questions at the appropriate time.

Sincerely,

J. Mark Melhorn, MD

Supporting Science

Summary

Materials obtained from The Guides Newsletter January/February 2008 (used with permission)

The Guides Newsletter

Expert advice, practical information, and current trends on impairment evaluation

January/February 2008

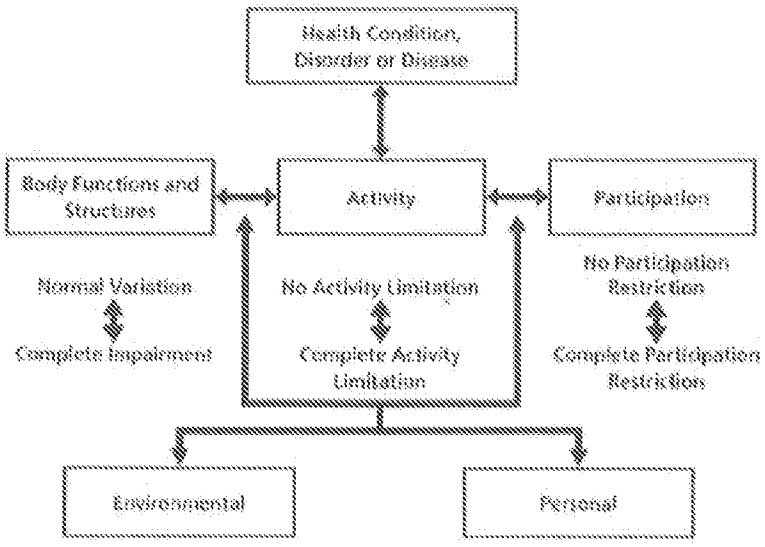
In upcoming issues

Upper Extremities: Sixth Edition

Sixth Edition: the New Standard

by Christopher R. Brigham, MD, MMS, Robert D. Rondinelli, MD, PhD, Elizabeth Genovese, MD, MBA, Craig Uejo, MD, MPH and Marjorie Eskay-Auerbach, MD, JD

Figure 1. ICF Model of Disablement



The following definitions are used in the ICF to facilitate communications and standardization:

- Body functions: physiological functions of body systems (including psychological functions).
- Body structures: anatomic parts of the body such as organs, limbs, and their components.
- Activity: execution of a task or action by an individual.
- Participation: involvement in a life situation.
- Impairments: problems in body function or structure such as a significant deviation or loss.
- Activity limitations: difficulties an individual may have in executing activities.
- Participation restrictions: problems an individual may experience in involvement in life situations.

Improvements in the 6th

- Standardize assessment of Activities of Daily Living (ADL) limitations associated with physical impairments.
- Apply functional assessment tools to validate impairment rating scales.
- Include measures of functional loss in the impairment rating.
- Improve overall intrarater and interrater reliability and internal consistency.
- The most contemporary evidence-based concepts and terminology of disablement from the ICF.
- The latest scientific research and evolving medical opinions provided by nationally and internationally recognized experts.
- Unified methodology that helps physicians calculate impairment ratings through a grid construct and promotes consistent scoring of impairment ratings.
- A more comprehensive and expanded diagnostic approach.
- Precise documentation of functional outcomes, physical findings, and clinical test results, as modifiers of impairment severity.
- Increased transparency and precision of the impairment ratings.
- Improved physician interrater reliability.

Figure 3. Diagnosis-Based Grid Template

Diagnostic Criteria	Class 0	Class 1	Class 2	Class 3	Class 4
RANGES	0%	Minimal%	Moderate%	Severe%	Very Severe%
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
History	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Physical Findings	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Test Results	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem

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Ratable conditions
The impact of changing from the Fourth to the Sixth
Materials obtained from The Guides Newsletter January/February 2010 (used with permission)

AMA Guides™ Newsletter

Expert advice, practical information, and current trends on impairment evaluation

January/February 2010

In this issue

Comparative Analysis of AMA *Guides* Ratings by the Fourth, Fifth, and Sixth Editions*

By Christopher R. Brigham, MD, Craig Uejo, MD, MPH, Aimee McEntire, and Leslie Dillbeck

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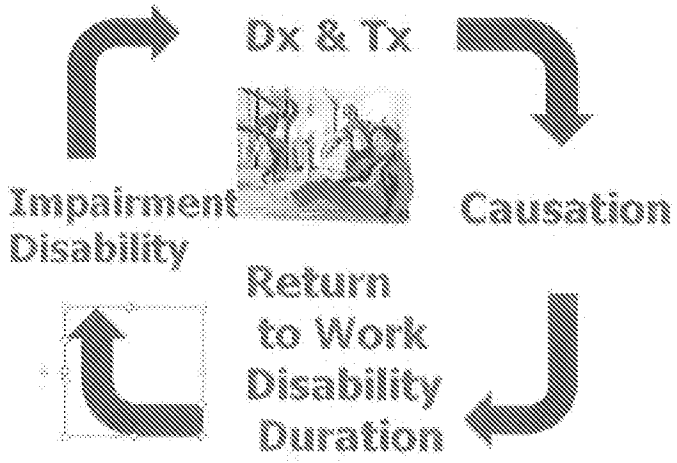
* This comparative study was commissioned by the American Medical Association and performed by Impairment Resources, LLC.

Benefits to the injured worker

J. B. Talmage, J. M. Melhorn, and M. H. Hyman. The Guides to the Evaluation of Work Ability and Return to Work, Chicago, IL: American Medical Association, 2011. 510 pages.

J. M. Melhorn. Working with Upper Limb Conditions. In: 16th Annual AAOS Workers' Compensation and Musculoskeletal Injuries: Improving outcomes with back-to-work, legal and administrative strategies, edited by J. M. Melhorn and I. B. Fries, Rosemont, IL:American Academy of Orthopaedic Surgeons, 2014.

J. M. Melhorn. Causation for Upper Limb Conditions. In: 16th Annual AAOS Workers' Compensation and Musculoskeletal Injuries: Improving outcomes with back-to-work, legal and administrative strategies, edited by J. M. Melhorn and I. B. Fries, Rosemont, IL:American Academy of Orthopaedic Surgeons, 2014.



E. Kilgour, A. Kosny, D. McKenzie, and A. Collie. Interactions Between Injured Workers and Insurers in Workers' Compensation Systems: A Systematic Review of Qualitative Research Literature. J Occup Rehabil, 2014.{12996} reviewed 1006 articles screened to 18, reviewed bibs for 27 reduced to 13 articles. The concluded:
1. Involvement in compensation systems contributes to poorer outcomes for claimants.
2. Interactions between insurers and injured workers were interwoven in cyclical and pathogenic relationships, which influence the development of secondary injury in the form of psychosocial consequences instead of fostering recovery of injured workers.

G. M. Grant, M. L. O'Donnell, M. J. Spittal, M. Creamer, and D. M. Studdert. Relationship between stressfulness of claiming for injury compensation and long-term recovery: a prospective cohort study. JAMA Psychiatry 71 (4):446-453, 2014.{12966} found that many claimants experience high levels of stress from engaging with injury compensation schemes and this experience resulted in poor long-term recovery.

Examples of some specific impairments
Outcome impairments reflect changing healthcare.
Spine surgery has changed significantly over the last 20 years. The pedicle screw was introduced in 1996, anterior cervical plates and fusion techniques have improved, and laminoplasties are replacing laminectomies.
Nguyen TH, Randolph DC, Talmage JB, Succop P, Travis R: Long-term outcomes of lumbar fusion among workers' compensation subjects: a historical cohort study. Spine (Phila Pa 1976) 36:320-331, 2011.
Sasso RC, Anderson PA, Riew KD, Heller JG: Results of cervical arthroplasty compared with anterior discectomy and fusion: four-year clinical outcomes in a prospective, randomized controlled trial. J Bone Joint Surg Am 93:1684-1692, 2011.
Allain J, Delecrin J, Beaurain J, et al: Stand-alone ALIF with integrated intracorporeal anchoring plates in the treatment of degenerative lumbar disc disease: a prospective study on 65 cases. Eur Spine J 23:2136-2143, 2014.
Awad BI, Lubelski D, Shin JH, et al: Bilateral Pedicle Screw Fixation versus Unilateral Pedicle and Contralateral Facet Screws for Minimally Invasive Transforaminal Lumbar Interbody Fusion: Clinical Outcomes and Cost Analysis. Global Spine J 3:225-230, 2013.
Chen F, Kang Y, Li H, et al: Treatment of Lumbar Split Fracture-dislocation with Short- or Long-segment Posterior Fixation and Anterior Fusion. J Spinal Disord Tech 2014.
Dangelmajer S, Zadnik PL, Rodriguez ST, Gokaslan ZL, Sciubba DM: Minimally invasive spine surgery for adult degenerative lumbar scoliosis. Neurosurg Focus 36:E7-2014.

Carpal tunnel surgery has changed as most individuals now present early with symptoms before permanent muscle loss occurs. Routine surgery is performed in the office with local anesthetic instead of a 2 day hospital admission with general anesthesia and 4 weeks in a cast splint.
American Academy of Orthopaedic Surgeons (AAOS) Clinical Guideline on Diagnosis of Carpal Tunnel Syndrome, Rosemont, IL: American Academy of Orthopaedic Surgeons, 2007. 125 pages.

American College of Occupational and Environmental Medicine. Hand, Wrist, and Forearm Disorders ACOEM Practice Guidelines. In: ACOEM Occupational Medicine Practice, edited by K. T. Hegmann, Elk Grove Village, IL: American College of Occupational and Environmental Medicine, 2011, p. 571-927.

Full disclosure

The Hand Center
MAP Mangers, owner of CtdMAP
PHI = Physical Health Index – Health Assessment
Books: Physician's Guide to Return To Work, Guides to the Evaluation of Disease and Injury Causation, etc
Professional Organizations: ABA, AMA, AADEP, AAOS, ACOEM, ASSH, AAHS, IAIABC, SDPM, etc
Organizations: MDA, ODG, SEAK, etc
Speaker: multiple national and state level organizations
Reviewer: multiple journals and books
Any other task or job that will improve outcomes for injured workers

Other considerations

Example of DBI tables for a better understanding of the Sixth Edition.

Cervical Spine Regional Grid

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (WPI %)	0	1%–8%	9%–14%	15%–24%	25%–30%
SOFT TISSUE AND NON- SPECIFIC CONDITIONS					
Non-specific chronic, or chronic recurrent neck pain (also known as chronic sprain/strain, symptomatic degenerative disc disease, facet joint pain, chronic whiplash, etc)	0 Documented history of sprain/strain-type injury, now resolved, or occasional complaints of neck pain with no objective findings on examination	1 1 2 3 3 Documented history of sprain/strain-type injury with continued complaints of axial and/or nonverifiable radicular complaints; similar findings documented on multiple occasions (see Section 17.2 General Considerations)			
MOTION SEGMENT LESIONS					
Intervertebral disc herniation and/or AOMSI[a] *Note:* AOMSI includes instability (specifically as defined in the *Guides*), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	4 5 6 7 8 Intervertebral disk herniation(s) or documented AOMSI at a single level or multiple levels with medically documented findings; with or without surgery *and* for disk herniation(s) with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate level(s) present at the time of examination[b]	9 10 11 12 14 Intervertebral disk herniation and/or AOMSI at a single level with medically documented findings; with or without surgery *and* with documented residual radiculopathy at the clinically appropriate level present at the time of examination *(see Table 17-7 to grade radiculopathy)*	15 17 19 21 23 Intervertebral disk herniations or AOMSI at multiple levels, with medically documented findings; with or without surgery *and* with documented signs of residual radiculopathy at a single clinically appropriate level present at the time of examination *(see Table 17-7 to grade radiculopathy)*	25 27 28 29 30 Intervertebral disk herniation(s) or AOMSI, with medically documented findings; with or without surgery *and* with documented signs of residual bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination *(see Table 17-7 to grade radiculopathy)*
Pseudarthrosis *Note:* Only applies after spinal surgery intended for fusion with resultant documented motion (not necessarily AOMSI by definition provided in footnote) with consistent radiographic findings or hardware failure; with or without surgery to repair	0	4 5 6 7 8 Pseudarthrosis (post surgery) at a single level or multiple levels with medically documented findings *and* with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate level present at the time of examination	9 10 11 12 14 Pseudarthrosis (post surgery) at a single level with medically documented findings *and* with documented radiculopathy at the clinically appropriate level present at the time of examination *(see Table 17-7 to grade radiculopathy)*	15 17 19 21 23 Pseudarthrosis (post surgery) at a multiple levels with medically documented findings *and* with documented radiculopathy at a single clinically appropriate level present at the time of examination *(see Table 17-7 to grade radiculopathy)*	25 27 28 29 30 Pseudarthrosis (post surgery) at a multiple levels with medically documented findings *and* with documented signs of bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination *(see Table 17-7 to grade radiculopathy)*

[a] See footnote [a] on page 571.
[b] Or AOMSI in the absence of radiculopathy, or with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate levels present at the time of examination.

Lumbar Spine Regional Grid

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (WPI %)	0	1%–9%	10%–14%	15%–24%	25%–33%
SOFT TISSUE AND NON-SPECIFIC CONDITIONS					
Non-specific chronic, or chronic recurrent low back pain (also known as: chronic sprain/strain, symptomatic degenerative disc disease, facet joint pain, SI joint dysfunction, etc)	0 Documented history of sprain/strain-type injury, now **resolved**, or **occasional complaints of back pain with no objective findings** on examination	1 2 3 3 Documented history of sprain/strain type injury with continued complaints of **axial and/or nonverifiable radicular complaints** and similar findings on multiple occasions (see Sec. 17.2, General Considerations)			
MOTION SEGMENT LESIONS					
Intervertebral disk herniation and/or AOMSI[*] *Note:* AOMSI includes instability (specifically as defined in the *Guides*), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	5 6 7 8 9 Intervertebral disk herniation(s) or documented AOMSI, at a **single level or multiple levels** with medically documented findings; with or without surgery *and* for disk herniation(s) with documented **resolved radiculopathy or nonverifiable radicular complaints at clinically appropriate level(s)**, present at the time of examination[*]	10 11 12 13 14 Intervertebral disk herniation or AOMSI at a **single level** with medically documented findings; with or without surgery *and* with documented **residual radiculopathy at the clinically appropriate level** present at the time of examination *(see Physical Examination adjustment grid in Table 17-7 to grade radiculopathy)*	15 17 19 21 23 Intervertebral disk herniations or AOMSI at **multiple levels**, with medically documented findings; with or without surgery *and* with documented **residual radiculopathy at a single clinically appropriate level** present at the time of examination *(see Table 17-7 to grade radiculopathy)*	25 27 29 31 33 Intervertebral disk herniations and/or AOMSI, at **multiple levels**, with medically documented findings; with or without surgery *and* with documented signs of **residual bilateral or multiple-level radiculopathy at the clinically appropriate levels** present at the time of examination *(see Table 17-7 to grade radiculopathy)*
Pseudarthrosis *Note:* Only applies after spinal surgery intended for fusion with resultant documented motion (not necessarily AOMSI by definition provided in footnote) with consistent radiographic findings or hardware failure; with or without surgery to repair	0	5 6 7 8 9 Pseudarthrosis (post surgery) at a **single level or multiple levels** with medically documented findings *and* with documented **resolved radiculopathy or nonverifiable radicular complaints** at the clinically appropriate level(s) present at the time of examination	10 11 12 13 14 Pseudarthrosis (post surgery) at a **single level** with medically documented findings may have documented signs of **radiculopathy at the clinically appropriate level** present at the time of examination *(see Table 17-7 to grade radiculopathy)*	15 17 19 21 23 Pseudarthrosis (post surgery) at a **multiple levels** with medically documented findings may have documented **radiculopathy at a single clinically appropriate level** present at the time of examination *(see Table 17-7 to grade radiculopathy)*	25 27 29 31 33 Pseudarthrosis (post surgery) at a **multiple levels** with medically documented findings may have documented signs of **bilateral or multiple level radiculopathy at the clinically appropriate levels** present at the time of examination *(see Table 17-7 to grade radiculopathy)*

[*] Or AOMSI in the absence of radiculopathy, or with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate levels present at the time of examination.

Shoulder Regional Grid

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES (upper extremity %)	0	1%–13% UE	14%–25% UE	26%–49% UE	50%–100% UE
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
SOFT TISSUE*					
Shoulder pain,* nonspecific shoulder pain following injury or occupational exposure	0 No significant symptoms or signs at MMI	0 0 1 1 1 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime)			
Shoulder contusion or crush injury* with healed minor soft tissue or skin injury		1 2 2 2 3 Residual symptoms and consistent objective findings at MMI			
Shoulder bursitis					
MUSCLE/TENDON*					
Shoulder pain* nonspecific shoulder pain post acute injury or surgery (not otherwise specified)	0 No significant symptoms or signs at MMI	0 0 1 1 1 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime)			
Sprain/strain*: No residual instability or loss of motion but persisting pain at MMI	0 No significant objective abnormal findings of muscle or tendon injury at MMI	0 1 1 2 2 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime)			

Foot and Ankle Regional Grid (LEI)

DIAGNOSTIC CRITERIA (KEY FACTOR)	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
IMPAIRMENT RANGES	0% LE	1%–13% LE	14%–25% LE	26%–49% LE	50%–100% LE
SEVERITY GRADE		A B C D E	A B C D E	A B C D E	A B C D E
SOFT TISSUE					
Nail abnormalities secondary to trauma Callus/recurrent healed plantar ulceration under post traumatic bony prominence; contusion/crush injury; plantar fasciitis; plantar fibromatosis; symptomatic soft tissue mass (ganglion, etc); retrocalcaneal bursitis	0 No significant objective abnormal findings on examination or radiographic studies at MMI	0 1 1 2 2 Significant consistent palpatory findings and/or radiographic findings			
MUSCLE / TENDON		**Do not use PE range of motion if used for diagnostic criteria**			
Strain; tendonitis; or h/o ruptured tendon, specifically involving posterior tibial, anterior tibial, achilles, or peroneal tendon (all other tendons below)	0 No significant objective abnormal findings of muscle or tendon injury at MMI	0 1 1 2 2 Palpatory findings and/or radiographic findings 3 4 5 6 7 Mild motion deficits 7 8 10 12 13 Moderate motion deficits and/or significant weakness	14 15 16 17 18 Flexible deformity and loss of specific tendon function	28 31 34 37 40 Fixed deformity and loss of specific tendon function	
Strain; tendonitis; or h/o ruptured tendon All other tendons	0 No significant objective abnormal findings of muscle or tendon injury at MMI	0 1 1 2 2 Palpatory findings and/or radiographic findings 1 2 2 2 3 Mild motion deficits 3 4 5 6 7 Moderate motion deficits and/or significant weakness			

Attachment 7:

Minutes of the February 18, 2015, meeting of the House Committee on Commerce, Labor and Economic Development

House Status: Adjourned until Monday, January 09, 2017 at 02:00 p.m.
Senate Status: Adjourned until Monday, January 09, 2017 at 02:00 p.m.

Minutes for SB167 - Committee on Commerce

Short Title

Workers compensation use of American medical association guides to the evaluation of permanent impairment.

Minutes Content for Wed, Feb 18, 2015

Chairperson Lynn opened the hearing on SB 167. She reminded the Committee that four years ago the Legislature adopted significant reforms to Workers Compensation. These reforms corrected unintended consequences derived from a series of court decisions. Two years later, in 2013, some interests believed it was necessary to revisit the reforms. Among these proposals was a switch from the *4th Edition of the AMA Guides for Permanent Impairment Evaluation* to the *6th Edition*, allowing the *6th Edition* to take effect starting this year. Now, SB 167 is before the Committee, a bill that would take Workers Compensation back to the *4th Edition*.

Chairperson Lynn recognized the following conferees.

Secretary of State Kris Kobach provided testimony in support of the bill. (Attachment 1)

Bill Rich, Professor of Law, Washburn University, provided testimony in support of the bill. (Attachment 2)

Dr. P. Brent Koprivica, PBK and Associates PA, Kansas City, Kansas, provided testimony in support of the bill. (Attachment 3)

Fred Greenbaum, President and Managing Partner, McAnany, Van Cleave and Phillips, provided testimony in support of the bill. (Attachment 4)

John David Jurcyk, Partner and Principal, McAnany, Van Cleave and Phillips, provided testimony in support of the bill. (Attachment 5)

Jodi Fox, Attorney and Shareholder, McAnany, Van Cleave and Phillips, provided testimony in support of the bill. (Attachment 6)

Keith Mark, Attorney, Mark and Burkhead Attorneys-at-Law, provided testimony in support of the bill. (Attachment 7)

Mark Holland, Mayor and CEO, Unified Government of Wyandotte County in Kansas City, Kansas, provided testimony in support of the bill. (Attachment 8)

Mark Prance, Owner of Boulevard Auto Truck Repair, Kansas City, Kansas, provided testimony in support of the bill. (Attachment 9)

Bart Thomas, Owner of Kansas Outdoor Advertising, Manhattan, Kansas, provided testimony in support of the bill. (Attachment 10)

Mark Walls, Vice President of Communications and Strategic Analysis for Safety National, on behalf of Kansas Self-Insurers Association, provided testimony in opposition to the bill. (Attachment 11)

Dr. Mark Melhorn, on behalf of the Kansas Medical Society, provided testimony in opposition to the bill. (Attachment 12)

Dr. David Hufford, Mid-America Orthopedics, provided testimony in opposition to the bill. (Attachment 13)

Mike O'Neal, CEO, The Kansas Chamber, provided testimony in opposition to the bill. (Attachment 14)

Douglass Hobbs, on behalf of the Kansas Society for Human Resources, provided testimony in opposition to the bill. (Attachment 15)

Written-only testimony in support of the bill was provided by:

- Denise Tomasic, Attorney, Kansas City, Kansas (Attachment 16)

- Jeff Cooper, Attorney in Private Practice (Attachment 17)

- Timothy Voegeli, Manager, Tubeless Solutions, LLC (Attachment 18)

- Mike Scanga, Owner, Bicycle X-Change, Wichita, Kansas (Attachment 19)

- Rick Martens, Owner, SOLO, LLC, Olathe, Kansas (Attachment 20)

- Art Davis and Robin Van Hoss, Owners, Traditions Furniture, Wichita, Kansas (Attachment 21)

Written-only testimony in opposition to the bill was provided by:

- Adam Mills, President and CEO, Kansas Restaurant and Hospitality Association (Attachment 22)

- Kevin McFarland, Leading Age Kansas. (Attachment 23)

- Mike Beam, Senior Vice-President, Kansas Livestock Association (Attachment 24)

- Roy T. Artman, Kansas Building Industry Workers' Compensation Fund (Attachment 25)

- Don McNeely, Secretary, Kansas Automobile Dealers Workers' Compensation Fund (Attachment 26)

- Dan Murray, National Federation of Independent Business (Attachment 27)

- Steven Graham, Spirit AeroSystems (Attachment 28)

- Dr. James L. Madara, American Medical Association (Attachment 29)

- Jason Watkins, Wichita Metro Chamber of Commerce (Attachment 30)

Written-only testimony neutral to the bill was provided by:

- Larry Karns, Director, Division of Workers Compensation, Kansas Department of Labor (Attachment 31)

There were questions concerning the number of states utilizing the *4th* and *5th Editions* of the *AMA Guides for Permanent Impairment Evaluation*. Dr. Melhorn stated he believed the majority of physicians favor using the *6th Edition*, which is based on the most recent science.

At the conclusion of the question and answer session, Senator Lynn closed the hearing on SB 167.

Attachment 8:

Christopher R. Brigham et al., *Comparative Analysis of AMA* Guides *Ratings by the Fourth, Fifth, and Sixth Editions*, AMA Guides Newsletter (January/February 2010)

AMA Guides™ Newsletter

Expert advice, practical information, and current trends on impairment evaluation

January/February 2010

In this issue

In upcoming issues

Archived Issues Available!

Past issues of the newsletter—since its 1996 debut—are now available at www.ama-assn.org/go/guides-newsletter for purchase and immediate download. A cumulative index arranged by subject and the table of contents for each issue is available to help you quickly locate relevant content.

The *Guides Newsletter* provides updates, authoritative guidance, and AMA interpretations and rationales for the use of the AMA *Guides to the Evaluation of Permanent Impairment.*

AMA AMERICAN MEDICAL ASSOCIATION

Comparative Analysis of AMA *Guides* Ratings by the Fourth, Fifth, and Sixth Editions*

By Christopher R. Brigham, MD, Craig Uejo, MD, MPH, Aimee McEntire, and Leslie Dilbeck

Background

The AMA *Guides to the Evaluation of Permanent Impairment* (*Guides*) is the recognized standard for quantifying the medical loss associated with an injury or illness. In December 2007, the American Medical Association published the most recent edition, the Sixth Edition.[1] The Fourth Edition[2] was published in 1993 and the Fifth Edition[3] in 2000. As with other areas of medicine, concepts and approaches are improved with time; for example, in medicine, some treatments are found to be ineffective and are dropped from practice and new approaches are adopted. This also occurs with the medical assessment of impairment. With the change in impairment methodology, there will also be changes in impairment values associated with specific conditions. As clinical medicine evolves and there is increased efficacy of treatment, it is hoped that improved outcomes will reduce impairment previously associated with injury and illness.

The Sixth Edition introduces a new approach to rating impairment. An innovative methodology is used to enhance the relevance of impairment ratings, improve internal consistency, promote greater precision, and simplify the rating process. The approach is based on an adaptation of the conceptual framework of the International Classification of Functioning, Disability, and Health,[4] although many of the fundamental principles underlying the *Guides* remain unchanged.

There have been challenges associated with the use of the *Guides*, including criticisms of the *Guides* itself,[5-12] Previous criticisms include the following:

- The method fails to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system.
- Impairment ratings do not adequately or accurately reflect loss of function.
- Numerical ratings are more the representation of "legal fiction than medical reality."

In response to these criticisms, the following changes were recommended with the Sixth Edition:

- Standardize assessment of activities of daily living limitations associated with physical impairments.
- Apply functional assessment tools to validate impairment rating scales.
- Include measures of functional loss in the impairment rating.
- Improve overall intrarater and interrater reliability and internal consistency.

Some changes in the Sixth Edition have impacted impairment ratings. For example, impairment ratings are now included for conditions that may result in functional loss, but previously did not result in ratable impairment (such as nonspecific spinal pain and certain soft-tissue conditions). Additional impairment is typically not provided for surgical interventions, reflecting an underlying concept that treatment is designed to improve function and decrease impairment, with a focus on final outcome. Impairments associated with some diagnoses (eg, total knee replacements, carpal tunnel release, and cervical spine fusion) were revised to more accurately reflect treatment outcomes.

The Sixth Edition states in Chapter 2, Practical Applications of the *Guides* "There is increased use of the *Guides* to translate objective clinical findings into a percentage of the whole person. Typically this number is used to measure the residual deficit, a loss—a number that is then converted to a monetary award to the injured party" (6th ed, 20). In that the *Guides* is used by many workers' compensation systems to define permanent disability awards, it is appropriate to determine whether changes in editions result in different impairment ratings and different permanent disability awards.

Study

To determine the impact of changes in editions, a study was performed to determine the impairment ratings resulting from use the Fourth, Fifth, and Sixth Editions for various conditions. Two hundred cases were assessed, and the clinical data were used to determine the resulting whole person permanent impairment according to each of these 3 editions. If the case reflected more than 1 diagnosis, each diagnosis was rated, and if both extremities were involved (eg, a bilateral carpal tunnel syndrome), each was rated as a separate diagnosis since each would be associated with a separate impairment. The cases analyzed were referred by 3 clients who refer all impairment ratings to determine their accuracy (2 based in California and 1 in Hawaii) in 2009 to Impairment Resources, LLC. It is probable that these cases reflect typical cases resulting in impairment rating, since the cases were not selectively referred, ie, the referring client did not refer the case because it was atypical or there was a concern about the rating.

Sixty-seven percent of the cases (134 cases) were from California, 28.5% (57 cases) were from Hawaii, and 4.5% (9 cases) were from Nevada. All cases had been originally rated by the Fifth Edition. Each case was independently analyzed by a professional rater experienced in the use of the Fourth, Fifth, and Sixth Editions, using the clinical data provided. Fourteen cases were excluded because the information was insufficient to permit a rating by the three editions, and these cases were replaced to provide a total sample of 200 cases. To ensure reliability, 15% (30) of these cases were blindly reviewed by an independent reviewer; all 30 ratings had interrater agreement within 1% whole person permanent impairment with the exception of one. In that case, there was a 5–percentage point difference between raters in whole person permanent impairment for the Fifth Edition rating because of differing interpretations of the appropriate spinal impairment (using the diagnosis-related estimates approach). There was agreement within 1% whole person permanent impairment for all Sixth Edition ratings.

Results

Two hundred seventy-nine diagnoses were associated with these cases; 48 of the cases had more than one ratable diagnosis. Forty-one percent of these diagnoses (114) involved surgery. The average age of the patients was 45.2 years (range, 22-79 years), and the majority were male (65%). The average time between the date of injury and date of the original impairment evaluation was 23 months (range, 3 months to 12 years).

Seventy-three percent of the Sixth Edition ratings (204 of 279) were based on the diagnosis-based impairment (DBI) approach (including entrapment), 22% of the ratings were based on range of motion (35% of the extremity cases), and 5% involved other approaches. Of the DBI ratings, most (81%) were class 1 (mild problem), with 6% class 0

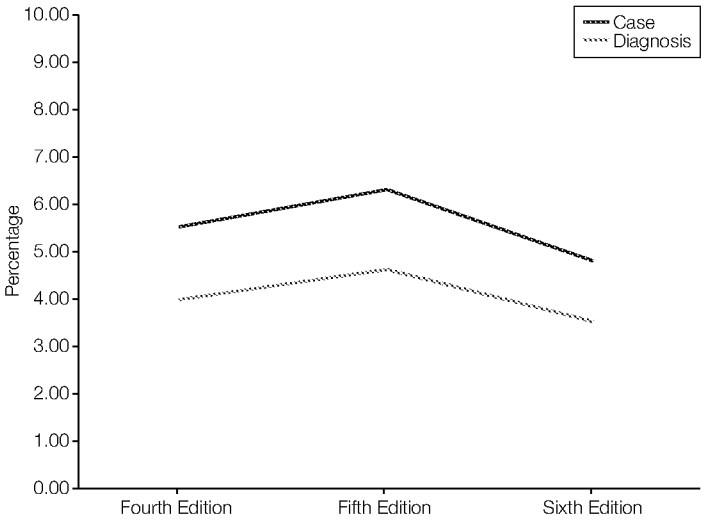
(no problem), 8% class 2 (moderate problem), 5% class 3 (severe problem) and 0% class 4 (very severe problem). The average ratable class was 1.2, with average grade modifiers for functional history adjustment of 1.2; physical examination adjustment, 0.6; and clinical studies, 0.8. Grade A was the most common assignment (34% of the time), followed by grade B (28%), grade C (21%), grade D (21%), and grade E (6%).

The average whole person permanent impairment (WPI) per case was 4.82% WPI per the Sixth Edition, 6.33% WPI per the Fifth Edition, and 5.5% WPI per the Fourth Edition. The overall average whole person permanent impairment for each diagnosis was 3.53% WPI per the Sixth Edition, 4.59% WPI per the Fifth Edition, and 4.00% WPI per the Fourth Edition. This is reflected in Figure 1. The difference between average whole person impairment ratings was tested using a paired sample t-test analysis, with an alpha level set at the .05 level of significance. This analysis revealed a statistically significant difference between average whole person impairment ratings when comparing the Sixth Edition with the Fifth Edition, but not when comparing the Sixth Edition results with those of the Fourth Edition.

With the Sixth Edition there were meaningful changes in impairment ratings as a result of not providing additional impairment for surgical (therapeutic) spine procedures, improved outcomes with surgical release for carpal tunnel syndrome, and improved outcomes with total knee and hip replacement. Excluding the cases that were not impacted by these changes, the overall average whole person permanent impairment for each diagnosis was 3.40% WPI per the Sixth Edition, 3.61% WPI per the Fifth Edition, and 3.16% WPI per the Fourth Edition.

Upper extremity impairments were most common, reflecting 45% of the ratable diagnoses, as shown in Table 1.

Figure 1. Comparison of Average Whole Person Permanent Impairment Ratings by Edition



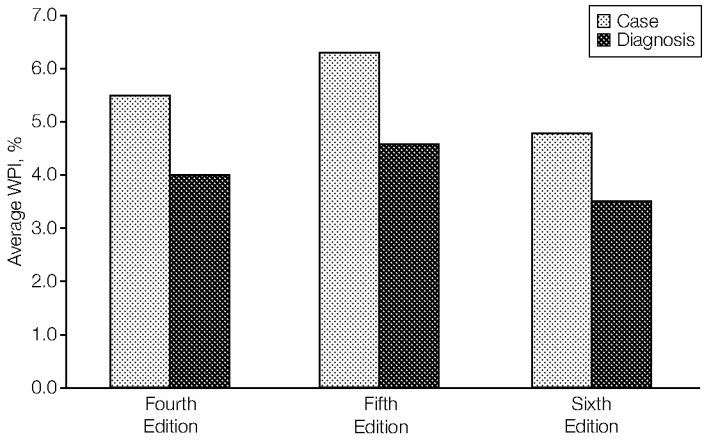
The average WPI ratings for cases and diagnoses are given in Figure 2.

The difference between impairment ratings for diagnoses, grouped as nonsurgical and surgical, was tested using a paired sample *t*-test analysis, with an alpha level set at the .05 level of significance. There was no meaningful difference in the rating values seen for the 165 nonsurgical diagnoses with the Sixth Edition compared with the Fourth Edition (both averaging 2.9% WPI) nor with the Fifth Edition (averaging 3.2% WPI). The most meaningful differences were observed with surgical diagnoses, with the Sixth Edition averaging 4.5% WPI, the Fifth Edition 6.6% WPI, and the Fourth Edition 5.6% WPI. This analysis revealed a statistically significant difference between impairment ratings for surgical diagnoses

Table 1. Comparison of Average Whole Person Permanent Impairment Ratings by Sixth Edition Chapters

Chapter	Title	WPI, %			No. (%) of Diagnoses
		Fourth Edition	Fifth Edition	Sixth Edition	
6	The Digestive System	2.0	2.0	3.0	1 (0.4)
5	The Pulmonary System	25.0	25.0	24.0	1 (0.4)
7	The Urinary and Reproductive Systems	5.0	5.0	5.0	1 (0.4)
12	The Visual System	5.0	5.0	5.0	1 (0.4)
4	The Cardiovascular System	4.0	4.0	3.0	2 (0.7)
11	Ear, Nose, Throat, and Related Structures	1.5	1.5	1.5	2 (0.7)
8	The Skin	1.0	1.0	1.0	2 (0.7)
16	The Lower Extremities	4.0	4.0	3.2	57 (20.4)
17	The Spine and Pelvis	5.2	6.7	4.1	86 (30.8)
15	The Upper Extremities	3.1	3.4	3.2	126 (45.2)
	Total				279 (100.0)

Figure 2. Comparison of Average Whole Person Permanent Impairment Ratings by Edition



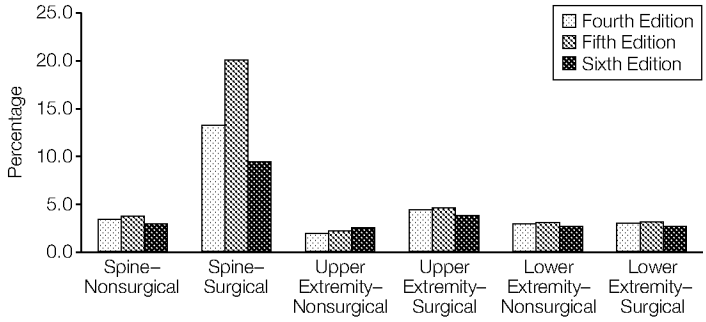
when comparing the Sixth Edition with the Fifth Edition, but not when comparing the Sixth Edition results with those of the Fourth Edition. This finding was expected, given that the Sixth Edition typically does not give additional impairment for surgical (therapeutic) interventions. The most meaningful change in impairment values was for spine-related diagnoses, particularly those that resulted in surgery; the results for musculoskeletal impairments are given in Table 2 and Figure 3.

Twenty-one percent (58) of the 279 diagnosis-based ratings resulted in no ratable impairment per the Fifth Edition; however, of these 0 ratings, 41 (71%) had ratable impairment by the Sixth Edition, with the average impairment

Table 2. Comparison of Average Whole Person Permanent Impairment Musculoskeletal Ratings by Category, Nonsurgical vs Surgical Intervention, and Edition

Category	No.	WPI, %		
		Fourth Edition	Fifth Edition	Sixth Edition
All				
Spine	86	5.2%	6.7%	4.1%
Upper extremity	126	3.1%	3.4%	3.2%
Lower extremity	57	4.0%	4.0%	3.2%
Nonsurgical				
Spine	71	3.5%	3.8%	3.0%
Upper extremity	66	2.0%	2.2%	2.6%
Lower extremity	20	3.0%	3.2%	2.7%
Surgical				
Spine	15	13.3%	20.1%	9.5%
Upper extremity	60	4.4%	4.7%	3.8%
Lower extremity	37	4.6%	4.5%	3.4%

Figure 3. Comparison of Average Whole Person Permanent Impairment Ratings by Category, Nonsurgical vs Surgical Intervention, and Edition



being 1% WPI (66% of these cases involved nonspecific ment by the Sixth Edition, with the average impairment spinal pain and most of the other cases involved soft-tissue injury). Twenty-seven percent (76) of the ratings that resulted in no ratable impairment by the Fourth Edition resulted in an average of 1% WPI when rated with the Sixth Edition.

In analyzing impairments categorized by the value obtained by rating with the Fourth and Fifth Editions, the most meaningful differences were seen with higher-rated impairments. Of the Fifth Edition ratings, 68% (189 diagnoses) were within the range of 1% to 9% WPI. For these cases, the average rating by the Sixth Edition was 3.2% WPI, the Fifth Edition 3.8% WPI, and the Fourth Edition 3.4% WPI. For impairments of 10% WPI and greater by the Fifth Edition, the average rating by the Sixth Edition was 10.2% WPI, the Fifth Edition 16.8% WPI, and the Fourth Edition 14.1% WPI.

Figure 4. Comparison of Average Whole Person Permanent Impairment Ratings Based on Fourth Edition Rating Categorization

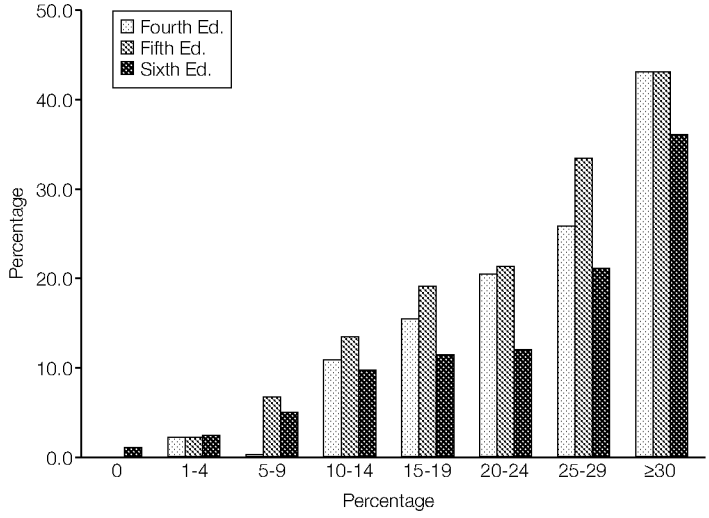
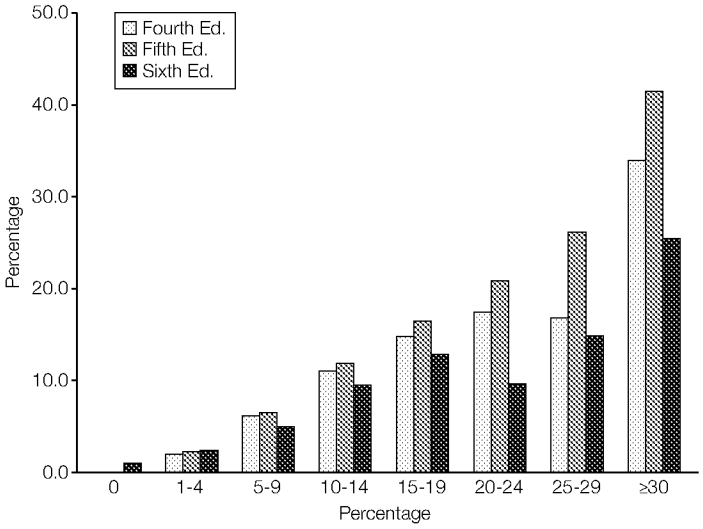


Figure 5. Comparison of Average Whole Person Permanent Impairment Ratings Based on Fifth Edition Rating Categorization



The relative changes in impairment values per case based on categorization by the Fourth and Fifth Edition ratings are illustrated in Figures 4 and 5.

In analyzing the differences for musculoskeletal disorders, the most meaningful changes were for the spine, as reflected in Table 3. There was slight increase in ratings for the shoulder, wrist, and ankle/foot. (Table 3 includes only regions where there were 5 or more ratable diagnoses.) The differences for musculoskeletal regions are illustrated in Figures 6, 7, and 8.

The most common diagnosis (based on assignment by International Classification of Diseases, Ninth Revision [ICD-9]) was shoulder region disease not elsewhere classified (NEC) (726.2), followed by backache not otherwise specified (NOS) (847.2) and carpal tunnel syndrome (354). The impairment values associated with these diagnoses are shown in Table 4.

Figure 6. WPI Comparison for Upper Extremity Diagnoses

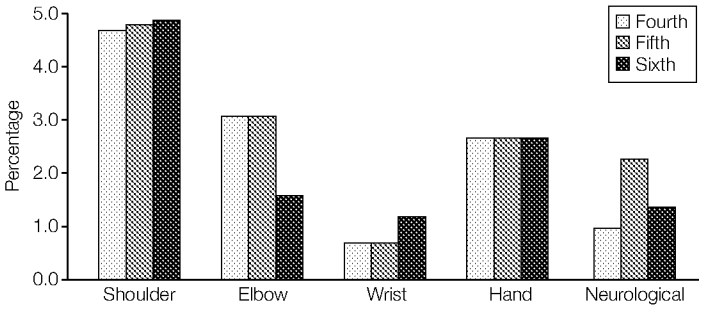


Figure 7. WPI Comparison for Lower Extremity Diagnoses

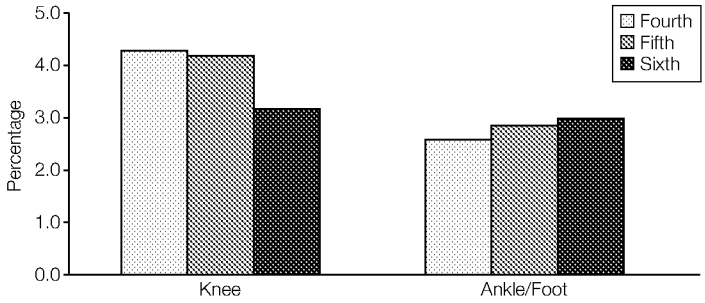
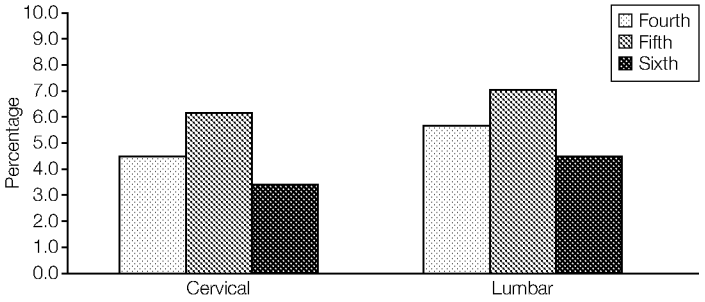


Figure 8. WPI Comparison for Spine Diagnoses



Summary

There is a statistically significant difference between average whole person impairment ratings when comparing the Sixth Edition with the Fifth Edition, but not when comparing the Sixth Edition results with those of the Fourth Edition. Average values had increased from the Fourth Edition to the Fifth Edition, yet without clear scientific rationale. The average impairment rating in this sample of cases, per the Sixth Edition, was 4.82% WPI, with an average impairment rating per diagnosis of 3.53% WPI. The impact for a patient based on his or her actual diagnostic impairment is small, with a greater difference seen for the Fifth Edition (4.59% WPI, a 1.06–percentage point WPI decrease) than the Fourth Edition (4.00%, a 0.47–percentage point WPI decrease). Many of the more meaningful changes were for spine-related diagnoses that resulted in surgery, reflecting the Sixth Edition approach, which bases impairment ratings on the condition and outcome rather than therapeutic interventions including surgery. However, with the Sixth Edition, a substantial percentage of cases that were rated as zero impairment in previous editions will have some ratable impairment.

The observed modest changes in values with the Sixth Edition were expected and primarily due to the recognition that (1) surgery and all therapeutic endeavors should improve function and therefore should not routinely increase impairment, (2) there are improved functional outcomes for

Table 3. Comparison of Average Whole Person Permanent Impairment Ratings by Region and Edition

Problem	No. of Diagnoses	WPI, %			Difference, Sixth vs Fifth Edition, Percentage Points
		Fourth Edition	Fifth Edition	Sixth Edition	
Upper extremity–shoulder	48	4.7	4.8	4.9	+0.1
Upper extremity–elbow	7	3.1	3.1	1.6	-1.5
Upper extremity–wrist	6	0.7	0.7	1.2	+0.5
Upper extremity–hand	30	2.7	2.7	2.7	0
Upper extremity–neurological	26	1.0	2.3	1.4	-0.9
Lower extremity–knee	31	4.3	4.2	3.2	-1.0
Lower extremity–ankle/foot	13	2.6	2.9	3.0	+0.1
Spine–cervical	33	4.5	6.2	3.4	-2.8
Spine–lumbar	50	5.7	7.1	4.5	-2.6

Table 4. Comparison of Whole Person Permanent Impairment Ratings for Common Diagnoses

Diagnosis	ICD-9 Code	WPI, %			No. (%) of Diagnoses
		Fourth Edition	Fifth Edition	Sixth Edition	
Shoulder region NOS	726.2	4.6	4.6	4.8	36 (12.9)
Backache NOS	724.5	2.9	3.6	2.0	29 (10.4)
Carpal tunnel syndrome	354.0	0.9	2.4	1.3	22 (7.9)
Derangement meniscus NEC	717.5	2.1	2.1	1.8	18 (6.5)
Cervicalgia	723.1	0.9	1.1	0.7	17 (6.1)
Disc disease NEC/NOS–lumbar	722.93	9.4	11.3	7.6	16 (5.7)
Sprain of hand NOS	842.10	1.8	1.8	1.8	13 (4.7)
Disc disease NEC/NOS–cervical	722.91	7.1	9.3	5.8	12 (4.3)
Osteoarthrosis, Unspecified–leg	715.96	4.9	4.9	3.6	7 (2.5)
Rotator cuff syndrome NOS	726.10	7.8	7.8	6.7	6 (2.2)
Sprain of ankle NOS	845.00	1.8	2.5	2.3	6 (2.2)
Finger injury NOS	959.5	2.0	2.2	1.8	6 (2.2)
Internal derangement knee NOS	717.9	3.2	3.2	3.0	5 (1.8)
Fracture ankle NOS–closed	824.8	3.8	3.8	4.0	5 (1.8)
Trigger finger	727.03	2.5	2.5	2.0	4 (1.4)
Fracture forearm NOS–closed	813.80	5.8	5.8	4.8	4 (1.4)
Sprain elbow/forearm NOS	841.9	1.5	1.5	1.0	4 (1.4)
Ulnar nerve lesion	354.2	2.0	2.0	2.0	3 (1.1)
Biceps tendon rupture	727.62	1.3	2.0	2.3	3 (1.1)
Fracture lumbar vertebra	805.4	10.0	12.3	9.7	3 (1.1)
Joint replaced knee	V43.65	20.0	20.0	13.3	3 (1.1)

carpal tunnel syndrome and total joint replacement, and (3) certain common conditions that resulted in functional deficits but no ratable impairment in previous editions should be ratable. Excellent interrater reliability with Sixth Edition ratings was demonstrated; this is consistent with one of the goals of the Sixth Edition, to improve the validity and reliability of impairment ratings.

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