The ABC's of FCE's

Not all FCE's are alike. In fact, there are a myriad of systems, machines, and protocols available today. Unfortunately, when scrutinized, most of them do not hold up to peer reviewed published science, district, circuit, or Supreme Court decisions. If this is the case, why would you ever want one of your clients going through an FCE that can be easily and successfully challenged in court, potentially dangerous, and an enormous financial liability?

I find the reasons to be quite simple. About 99% of the time, I am only asked 2 questions; How much does the testing cost, and how fast can you get this done? In fact, I'm usually not asked anything, and adjusters blindly deny my request, and send them to, "One Call" or "Medrisk", not fully understanding the real potential danger in this. If these are your only true concerns, you may want to read, Indergard vs. Georiga Pacific (Ergoscience) and the CSX Transportation vs. EEOC (machine based FCE's) as well as many others, to see that a bad decision can cost dearly in settlements, fines, and legal fees due to FCE's that are not Title 1 ADA compliant, not based on peer-reviewed, published science, or follow case law. More recently, these awards are now getting into the millions. It's better to ask who is doing it, and how are they doing it?

So, how do I tell a good FCE from a bad FCE? Having a few simple questions ready can solve this problem for you. The best FCE's will be based on peer reviewed published science, and de facto case law. This is called a best practice, or evidence based approach, and will stand up to scrutiny and any legal challenge when done by an experienced, thinking evaluator.

Here is a simple list of questions you will want to ask your provider prior to scheduling;

1) How long do their FCE's take?

If they are 4 hours or less, they are flawed tests, unless the worker only works part time. There is no way to determine a workers ability to perform into the full Frequent physical demand levels (2.5-5.25 hours) or Constant physical demand levels (>5.25-7.5 Hours) as defined by the Department of Labor, or the ability to sustain any work over an 8 hour day in this format. This is also true for the 2 half day format as well. Testing should last 6-8 hours or until all questions of work tolerance have been fully answered in real time, many systems use extrapolation algorithms that have no scientific basis at all and do not hold up to the Federal Rules of Evidence.

2) Does your FCE include effort and reliability testing?

This should be very comprehensive, and not just, yes we use CV's (coefficient of variation) that have been proven invalid back in 2008 by Schectman. There are many peer reviewed protocols to use for effort and reliability, and if the provider cannot tell you what they are, this would be a red flag. Some systems use a, "Validity Profile" that combines effort and reliability together. This also has not stood up in court, as reliability and effort are separate issues ad should be treated so.

The problem is, the items in the profile are given equal weight ,even when the majority are not even peer reviewed, or scientific tests, making the data very weak if not useless. Without a robust, peer reviewed battery to achieve this goal, your likely to get a false positive disability determination, which is a very costly mistake. Here are some AMA Guidebook passages on the subjects of effort levels and subjectively credibility.

Reliability/Credibility Assessment Resources

AMA Guidebook, Disability Evaluation, 2nd Edition, 2003
Chapter 53, Introduction to Fitness for Duty, Page 719, "Patient Credibility Assessment"
Richard E. Johns Jr., MD, Alan L. Colledge, MD, Edward B. Holmes, MD

"Experienced clinicians are generally skilled at the art of distinguishing between real and fabricated allegations. The level of skill involved varies by practitioner. There is little if any training on the subject in standard American medical school curriculums."

"Social Security Administration rules state, "Under no circumstances may the existence of an impairment be established based on the basis of symptoms alone. Impairment cannot be established in the absence of objective medical abnormalities.

"Inconsistencies and conflicting statements make a significant contribution to the overall credibility assessment."

"Supporting evidence: A source that provides supporting evidence to substantiate the opinion about functional ability would be given more weight than one without support evidence."

"Specialty: The opinion of a specialist in the field may be given more weight than a generalist, even if the length of treatment was less."

Determination of Effort Level Resources

AMA Guidebook, Disability Evaluation, 2nd Edition, 2003
Chapter 55, The Functional Capacity Evaluation, Page 752, "Less than full effort performance."
Leonard N. Matheson, PhD

"Full effort is important for the reliability of score(s) and thereby a necessary underpinning of the validity of the assessment decision. It is imperative that the patient gives his or her best effort, and that less than full effort identified when it occurs. Failure to identify less than full effort performance may result in exaggeration of disability findings and false positive determination of disability.

AMA Guides to the Evaluation of Work Ability and Return to Work, 2011

> *Douglass P. Gross PhD, Michael F. Reneman PhD, Chapter 6 Pg. 91-92.Functional Capacity Evaluation in Return-to-Work Decision Making: Risk, Capacity, and Tolerance.*
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> ***'The only study published to date (2011) examining the association between setting (reason) and FCE performance found wide variability across settings and jurisdictions. Subjects in settings where FCE results were being explicitly being used to inform decisions regarding compensation claim status (and termination of wage replacement benefits depending on performance demonstrated during the FCE) performed too much lower levels than subjects in setting where such decisions were not being made.***
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> ***AMA Guidebook, Disability Evaluation, 2nd Edition, 2003***
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> *Tom C. Mayer, MD, Chapter 13, pg.134*
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> ***Because the financial award is intimately tied to the quantitative functional performance measurement, the claimant's motivational disincentives often will prevail over the need for maximum effort. It is a paradox that noncompliant and unmotivated evaluees often receive greater financial awards, regardless of the impairment methodology used. If the examinee demonstrates sub maximal effort, impairment higher than expected for the degree of pathology, or limited evidence for rehabilitation compliance, then he or she may not be at the state of maximum medical improvement.***

3) Does your testing utilize a standard protocol?

By a standard protocol, I mean specifically the same test is given to the worker regardless of the injury or job. They would start with test A, then go to test B, etc. This is what most systems do, and this was exposed in, ***Indergard vs. Georgia Pacific*** and resulted in a 250K fine. Each test needs to be related to or consistent with business necessity, as mandated in Title 1 of the ADAA. For example, having a worker failed for a lift from floor to overhead, or running on a treadmill, when they do not do this at work, will certainly get the test thrown out in court or worse, a possible EEOC claim.

Another scenario is the test can be ignored by the court, if another provider performed a full day of testing that was designed and administered to address the actual physical demands of the job or, “job calibrated”. The testing should be done based specifically on the actual physical demand of the job as they relate to the injury. You should question any testing that is filled with scores of ROM measurements, manual muscle testing measurements, special tests, etc. These are all impairment based tests and have nothing to do with meeting work demands or Disability Evaluation. There are numerous passages in the AMA Guidebooks on this subject.

4) Does your testing utilize an iso-based machine such as Biodex, CRTS, Hanoun, Ergos, BTE, Cybex, J-Tech, etc.?

If so, these have also been shown in the peer-reviewed literature to be invalid systems that also tend to use a standardized protocols regardless of injury or job. Secondly, they have been and continue to result in many lawsuits with workers becoming injured on them. The reason being, is that when you are asked to push, pull and lift multiple time at various heights and angles on an isometric, isotonic or isokinetic machine, the forces exerted can easily far exceed the job demand. For example, a worker may only be required to lift 20 pounds at work, however when lifting or producing forces isometrically, they may exert forces of say, 150 ft/pounds repetitively, and injure themselves. The provider, carrier and employer will need to explain why they were having the worker exert such forces when the job only requires 20 pounds to perform. You can see the potential for injury and litigation to this type of testing exposing you and your clients financially. Another common issue with machine based FCE's is that providers are trained simply as technicians to operate the machine that in turn generates a report with no real knowledge as to any scientific literature or case law, if any, is behind the protocol or report. (See the CSX 3.2 million fine recently handed down)

These are the best and quickest questions to ask your provider. If in doubt, ask to see a report they have done in the past. Other things you can look for is if they are they formally certified, how many FCE's have they done, are they an Expert Witness, and have they ever successfully defended their tests in court? One of the worst mistakes to make is to simply allow third parties to schedule these such as One or Med Risk. They will only find the cheapest provider period regardless of the format. The also rarely provided medical records, or job descriptions, that is certainly a form of negligence to perform a test in this manner. Remember, 99% of the time it is how, “much and how fast” or we sent it to “One Call”, when you should think how many millions will it cost my company, and client, if it’s done wrong?

Another common mistake I have been seeing is letting the treating physician, QME or AME arrive at all of the work related limitations, restrictions, etc. based on impairment or subjective information alone. The AMA Guidebooks are very clear they are not to this, but to defer to outside, “disability based tests”, such as work related FCE. Here are some powerful passages.

Courts around the U.S. are delving into the inability of a physician to determine work disability from an impairment rating. In recent cases, they have discussed the separation of impairment from disability, stating that an impairment rating alone cannot be used to determine work-ability. The new Americans with Disabilities Act as Amended (ADAAA) makes it clear that there is no link and the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition also clearly delineate their thinking on this subject:

Chapter 14, page 356, paragraph 6: ***"Impairment scores do not, in themselves, indicate whether a patient can work or not. This is an independent assessment that must be made during the evaluation."***

Chapter 14, page 352, paragraph 2: *"Reliable collateral information concerning the individual's behavior while performing activities of daily living (ADLs) may be drawn from medical and nonmedical sources. Records from hospitalization, outpatient treatment, day hospital, rehabilitation evaluations,* ***work evaluations and disability assessments are useful in assessing the status of the patient.*** *Helpful nonmedical sources may include records from vocational assessment, sheltered workshops, or day care centers."*

Chapter 1, page 6, paragraph 2: ***"The guides is not intended to be used for direct estimates of work participation restrictions. Impairment percentages derived according to the Guides' criteria do not directly measure work participation restrictions."***

Chapter 1, page 6, paragraph 3: ***"In disability evaluation, the impairment rating is one of several determinants of disablement. Impairment rating is the determinant most amenable to physician assessment; it must be further integrated with contextual information typically provided by non-physician sources regarding psychological, social, vocational, and avocational issues."***

Guidelines to the Evaluation of Permanent Impairment (2nd Edition)

"In general, it is not possible for a physician, using medical information alone, to make reliable predictions about the ability of an individual to perform tasks or to meet functional demands…when functional ability is assessed by a standardized non-medical procedure in ….an occupational setting, the physician may have confidence in the determination. "

In closing, it is also prudent to avoid scheduling an FCE to be done by the treating physician or in the same office where therapy is done. This will eliminate any conflict of interest, bias or self serving motives such as stating the worker needs further treatment, work conditioning, or functional restoration of which the evaluator can then provide in house. These practices are not ethical and now also unlawful under SB863. This law makes the self/cross-referral or profiteering of any ancillary service while being the primary treating physician or related to the physician in any way, illegal, and a misdemeanor.

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