



CONTROLLING COMP COSTS WITH FUNCTIONAL TESTING

Presented by

Larry Feeler
CEO/Physical Therapist
WorkSTEPS

Most employers understand that a key to controlling worker injuries is to hire employees with the physical abilities to perform the requirements of the job. However, with ADA compliance and the increasing threat of discrimination claims, employers are left wondering exactly what information they can legally obtain from a prospective employee and use to make a hiring decision. In construction, where the job often demands certain physical abilities, the legal issues are even more complicated. Does trying to obtain information about an applicant's physical capabilities expose employers to liability under the ADA? Add value to your services by learning ways to help your clients manage and avoid employment practices (discrimination) risks, while at the same time taking full advantage of their own rights in making informed hiring decisions.

Tuesday, November 14, 1:30–3:00 and 3:30–5:00 p.m.



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Larry Feeler
CEO/Physical Therapist
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Mr. Feeler is presenter for Workshop C, "Controlling Comp Costs with Functional Testing," on Tuesday. He is the chief executive officer and founder of WorkSTEPS, located in Las Colinas, Texas, one of the largest pre-employment testing companies in the United States. He graduated from the University of Texas Medical Branch in Galveston, Texas, in 1977 and is a Licensed Physical Therapist. He is recognized as one of the nation's leading authorities regarding job analysis and functional testing to appropriately match existing workers to their jobs, to expedite safe return to work for injured employees, and to detect fraud and abuse. The WorkSTEPS database literally overwhelms existing research with 40 measures on over 200,000 workers (as of August 2000) and creates the most reliable standard for comparison of employees. Mr. Feeler is a well-known guest lecturer and has authored in such texts as *Spine* and *State of the Art Reviews* as well as articles in the *Journal of Disability*, the *Back Letter*, *Compliance*, *Occupational Safety and Health*, and *Rehab Management*.

Notes

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CONTROLLING COMP COSTS WITH FUNCTIONAL TESTING

Larry Feeler
WorkSTEPS

I. Definition

System of ADA compliant employment tests designed to prevent injuries, control injury related costs, and combat fraudulent claims.

II. Testing

Customized to look at job specific strength requirements and most common medical risks such as cumulative traumas, backs and carpal tunnel syndromes.

III. Necessary Components

- A. Standardized testing on a national basis
- B. Create content valid essential functions
- C. Incorporate the most experienced industrial providers in the U.S.

IV. Types of Compensable Claims (1996)

- A. 97% of companies—Back injuries
- B. 81% of companies—Carpal tunnel syndrome
- C. 77% of companies—Repetitive motion

References: *Risk & Insurance*,[®] *Human Executive*[®] Magazines

V. Carpal Tunnel—Texas

- A. 1/3 of carpal tunnel cases occur in the first year of employment
- B. 15% occur in the first 3 months of employment
- C. 34 lost days/case

Reference: *Work Comp Advisor* (June 1998)

VI. Testing Successfully

- A. Identifies persons who have pre-existing cardiovascular, degenerative, or cumulative trauma disorders.
- B. Identifies persons who do not meet job related lift or aerobic requirements.
- C. Assists employers in appropriately matching current and new employees to "safe" job positions.
- D. Collects baseline data for comparison post injury.
- E. Documents pre-existing impairments that affect job performance.
- F. Has consistency checks that qualify legitimate injuries and disqualify fraudulent claims.
- G. Expedites rehabilitation and return to work post legitimate injury.
- H. Allows successful medico-legal intervention based upon objective scientific data.

VII. Legal Counsel

- A. Maintains ADA compliance
- B. Provides ongoing legal support
- C. Consistently studies ADA case law
- D. Establishes legally defensible policies and procedures to implement testing and to control post injury claims

VIII. Benefits

- A. Promotes “safe” job performance.
- B. Automatically compares test results to a national database.
- C. Returns employees to work sooner.
- D. Reduces turnover.
- E. Saves money!

IX. Company Profits Affected by

- A. Injury claims and health care costs
- B. Insurance premiums
- C. Worker’s compensation cost
- D. Claims management costs
- E. Disability settlements
- F. Legal cost to manage claims

X. University of Massachusetts Study

- A. 10% of existing employees in the workplace are not physically capable of performing their job
- B. 75% of workplace injuries occur among this same 10%

XI. Workers Compensation Assumes

- A. Workers are perfect when hired.
- B. Workers never age.
- C. Whatever happens to the worker, the employer caused.

All are true UNLESS you can prove otherwise.

XII. Americans with Disabilities Act (1990)

- A. Title I prohibits employment discrimination against qualified individuals with disabilities.
- B. Allows you to fail employees who can not safely perform essential job functions.

XIII. Pre-placement Tests Must Be

- A. Job related to the position in question.
- B. Consistent with business necessity.
- C. Required of all employees entering similar positions in the same geographic proximity.

XIV. Types of Tests Available

- A. Pre-offer agility (fireman)
- B. Post-offer (most leeway)
- C. Fit for duty (existing workers)
- D. Post-injury assessment (functional capacity evaluation)

XV. Title I—Post Offer Allows Employer To

- A. Fail employees who do not meet strength and or aerobic requirements for the job in question.

- B. Fail employees with a quantified medical condition that would make them unsafe for the position in question.

XVI. Test Components

- A. Ergonomic analysis:
 - 1. Weigh and measure objects.
 - 2. Document force requirements for hands, back, etc.
 - 3. Measure aerobic requirements/ repetitions.
 - 4. Document static and dynamic posture requirements.
 - 5. Create job specific tests (Content Validity).
- B. Musculoskeletal evaluation
- C. Cardiovascular assessment
- D. Static strength tests
- E. Dynamic strength tests
- F. Computerized extremity tests
- G. Job-specific tests
- H. Overuse syndromes--carpal tunnel tests
- I. Database comparison of information
 - 1. Norms
 - 2. Standard deviations from normal

XVII. Reason To Withdraw Offer

- A. Fail drug test.
- B. Lie on medical history (post offer).
- C. Can not lift enough weight to “safely” qualify.

- D. Fail any part of job specific tests.
- E. Attitude.
- F. At significant medical risk (post offer).
- G. History of multiple re-injuries in same line of work.

XVIII. WorkSTEPS® National Fail Rate—7%

XIX. Post Offer—Savings with Negligible Cost to Employer

- A. 10–15% do not return for drug or employment test.
- B. 15–28% require medical clearance (at their expense) to continue
 - 1. High blood pressure.
 - 2. Recent auto accident (must have physician release).
 - 3. Significant history (must have physician release).
 - 4. Did not ask for an accommodation before arriving for the test.
 - 5. Demonstrates serious medical or disease problems.

XX. National Council on Compensation Insurance (1994)

- A. One carpal tunnel surgery—\$29K
Indemnity—\$100K
- B. One back injury without surgery—\$24K
Indemnity—\$100K+
- C. One fraudulent claim—\$20-\$60K
Replacement—\$75K

XXI. Prevent One Carpal Tunnel, One Back and One Fraudulent Claim

- A. Saves \$84K in medical and \$275K in related costs.
- B. Buys 2,500 screens/year!

XXII. Current Database ...

- A. Houses over 200,000 tests (September 2000)
- B. Compares over 40 measures per applicant
- C. Is the largest industrial database in the U.S.
- D. Is content valid
- E. Returns comparative analysis in less than one minute!

XXIII. Creates Accountability!

XXIV. Gets Results!

XXV. Saves Significant Dollars (up to 80% of the previous year's medical expenses)!

XXVI. Testimonials

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COURT CASES

POST-OFFER

Stinson v West Suburban Hospital Medical Center
11 NDLR (N.D. III, 1998)

An applicant with back pain received an offer in house-keeping for the hospital but was unable to perform un-assisted lifting up to 45 pounds. Sued on grounds of discrimination.

Ruling: In favor of employer since lifting up to 45 pounds was an essential job function.

LIGHT DUTY

Hendricks-Robinson v Excel
10 NDRL, 245 (C.D. III, August, 1997)

Excel made “massive” efforts to match injured workers to jobs they were safe to perform with medical restrictions. In 1991 a policy change resulted in injured employees being laid off if there were no vacant permanent positions for which they were qualified. The new policy reserved light duty for temporarily injured employees until they could return to their prior position. Four permanently restricted employees sued under the ADA when they were terminated.

Ruling: In favor of the employer that a return-to-work policy does not violate the ADA when it permits an employer to place injured employees on medical layoff if they have reached maximum medical improvement and can’t perform the essential functions of their job.

FIT FOR DUTY

Porter v U.S. Alumoweld Co.
Fourth Circuit Court of Appeals
CA4, 1997, case 537

Employer requests Fit For Duty test “at employee’s expense” after the employee had back surgery and was released by his M.D. who stated that he was “able to return to work safely without any limitations.” Employee didn’t have the examination and was terminated. He then sued under ADA and FMLA.

Ruling: In favor of the employer since “A simple statement of an employee’s ability to return to work does

not obviate the need to comply with ADA. Because the job required lifting and pulling and because he had a history of back problems, the exam was job related and consistent with business necessity.”

POST OFFER

Bolton v Scrivner, Inc.
36 F. 3d, 939, 10th Cir. 1994

An employee suffered an injury and had a disability that prevented him from returning to work at his regular job and he was terminated. The employee felt he was disabled under the ADA since the inability to work substantially restricted a major life activity.

Ruling: In favor of the employer since the inability to work requires a plaintiff to show that their function significantly restricted them from performing a broad range of jobs in various classes. “The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working.”

FIT FOR DUTY

Castro v Fiberglass, Inc.
13 NDRL (Kansas 1998)

Assembly line worker developed carpal tunnel and tenosynovitis and was transferred to light duty temporarily and then terminated.

Ruling: In favor of employer since employee was unable to perform essential functions with or without reasonable accommodation.

FIT FOR DUTY

Hill v Harper
13 NDRL (Virginia 1998)

Sheriff deputy with circulatory problem quit and sued after light duty was abolished and he was required to rotate shifts and perform varying degrees of physical activity.

Ruling: Employer not required to accommodate employee since requirements were the essential job functions.

POST OFFER

*Lanning v South Eastern Pennsylvania Transit
Authority (Septa)
(Septa) 1998*

A transit security officer sued that he was discriminated against when he failed a fitness test that required a 1.5 mile run and strength measures to grip, trunk, and etc. He argued the validity of such test being job related.

Ruling: In favor of the employer that such tests were predictive of successful job performance and were valid without a formal validation study.

Note: U.S. District Court also clearly upheld job simulation tests as a better indicator of success on the job than a fitness test regardless of “adverse impact” against females in the job.

FIT FOR DUTY

*Taylor v Mannesman Dematic Rapistan
WCC No. 588-Q*

Employee had “fit for duty” test one week post injury that showed little difference in WorkSTEPS baseline test, and MD released him to return to work. He refused RTW, was terminated, and sued for back wages and medical under workers’ comp. The patient’s court appointed doctor ruled in his favor until results of another “fit for duty” 6 months post injury revealed severe functional deficits.

Ruling: The doctor reversed her decision entirely and negated the compensation claim since whatever caused his condition to deteriorate happened after he was terminated and therefore was not work related.

Note: Court appointed doctor stated that “The employer’s effort to obtain the testing on Mr. Taylor and other employees was truly a benefit to the court and to the medical profession, and that she was convinced after reviewing the objective data presented by the WorkSTEPS Provider that Mr. Taylor’s condition was not job related.”

Functional Testing

... is a "System" of employment tests designed to scientifically prevent injuries, control injury costs, and stop fraudulent claims.

OSHA OPENING STATEMENT 3/13/2000 by Marthe Kent

- Clearer screening mechanisms to insure ergonomic injuries are truly work-related

ANSWER ...

- Identifying problems before the employee is hired
- Adapting employees job demands to their function
- Requiring honest/responsibility/accountability for everybody involved
- Gradual implementation based upon incidence of injury compared to the industry average
- Gradual reduction in industrial average criteria

OSHA AND Our Company HAVE SIMILAR GOALS

- Prevent work-related MSDs
- Help employees maintain health/livelihood
- Help employers maintain productivity/profits
- Provide objective solutions to job-related problems

Not Far Enough

- Multifaceted problem addressed with a single approach remedy (ergonomics)
- Single focus accountability (employer)
- Open medical (too broad)

ACES Technologies

- Reports 60% of injuries would be impacted by ergonomics
- 40% require employer changes
- 60% require employee changes

American College of Occupational & Environmental Medicine (ACOEM)

- Defined 5 areas to improve safety and reduce hazards:
 1. Workplace
 2. Exposures
 3. Environment
 4. Lifestyle (Personal Responsibility)
 5. Prevention (Personal Responsibility)
- Need to build incentives that include personal responsibility

Personal Responsibility

- Less responsibility for employer and more accountability for employee if a violation of corporate policy results in injury
- Incentives to promote awareness/safety

Does Not Address Management of ...

- Fraudulent claims by employees and/or medical providers
- Falsification of information during application process
- Employees who have complicated medical history/significant family history, unhealthy lifestyles, predispositions for work-related MSDs, etc.
- Layoffs, union strikes, or business downturns that suddenly produce MSDs

- Workers hired with existing MSDs
- Signs and symptoms and/or management of questionable injuries or complicated cases
- *Individualized* evaluations to match ergonomics and job capabilities

No Consideration for ...

- Body size, age, gender
- Pre-existing physical conditions/genetics
- Physical demand classification
- Lifestyle/personality
- Insidious onset vs. single episode
 - 56% of work-related back injured patients (Bergquist-ullman Larsson)

Standard Assumes

- All MSDs can be controlled by ergonomics
- All symptoms/diagnoses are consistent
- All individuals respond to work stresses the same
- All employees are honest
- All HCPs are honest
- All MSDs are the employer's responsibility
- All complaints, negotiations, costs and RTW will be reasonable

... Further Assumes

- Employees are perfect when hired
- They never grow old
- Whatever happens to them is caused by the workplace

Model ...

- Computerized and refined over the last 14 years
- Implemented successfully in over 1,000 companies
- Largest industrial database in the United States
- 40 measures on over 200,000 industrial applicants
- Computerized post injury comparison to pre-injury status

INCLUDES ...

Test Components

- Ergonomic Analysis
- Musculoskeletal Evaluation
- Cardiovascular Assessment
- Static Strength Evaluation
- Overuse Syndrome Profile
- Dynamic Strength Evaluation
- Isokinetic/Isodynamic Evaluation
- Job Specific Component

Musculoskeletal Evaluation

- Posture
- Range of Motion
- Flexibility
- Joint Integrity
- Strength
- Palpation

Cardiovascular Assessment

- Risk Profile
- Blood Pressure
- Heart Rate
- Recovery Rate

Static (Isometric) Strength Evaluation

- Back
- Lower Extremities
- Upper Extremities

Isokinetic/Isodynamic Assessment

- Back
- Lower Extremities
- Upper Extremities

Dynamic (Isotonic) Strength Testing

- Back
- Lower Extremities
- Upper Extremities

JOB SPECIFIC COMPONENT**Program Successfully**

- Identifies persons who have pre-existing cardiovascular, degenerative, or cumulative trauma disorders
- Identifies persons who do not meet job-specific strength and/or aerobic requirements
- Assists employers in appropriately matching current and new employees to safe/appropriate job positions
- Collects baseline physical measurements for comparative analysis post injury or trauma
- Allows determination of objective physical/functional loss
- Qualifies legitimate injuries and disqualifies fraudulent injuries
- Expedites rehabilitation and return-to-work post legitimate injury

- Allows successful medico-legal intervention comparing an employee's pre-injury and post-injury status

Shared Responsibility and

- Employer and Employee
- Health Care Provider (HCP)
- Appropriately match existing workers and new hires to their job demands
- Do not place individuals who are already at significant medical risk to perform job functions
 - a. Bank teller with carpal tunnel
 - b. Construction worker with dangerous heart rate

“Texas Workers Compensation Advisor” June 1998

- Carpal Tunnel ...
 - 1/3 of cases occur in 1st year of employment
 - 15% of cases occur in 1st 3 months of employment
 - 34 lost workdays per claim

MSD SIGNS

- 1) Decreased ROM
- 2) Deformity
- 3) Decreased Grip
- 4) Loss of Function

MSD SYMPTOMS

- 1) Numbness
- 2) Burning
- 3) Pain
- 4) Tingling
- 5) Cramping
- 6) Stiffness

Subjective vs. True Clinical Correlation

FIT FOR DUTY

Purpose of Fit for Duty Tests:

- Documentation of baseline pre-injury status
- Classification according to risk with specific prevention protocols
- Recommend work conditioning
- Accommodate employees
- Discover disease process

Residual Job Functions

Testimonials!

State School

	1996	1997
Total Cost	\$2,281,265.57	\$1,435,767.35
Lifting Costs	242,206.07	40,157.08
Total Claims	344	79
Lifting Claims	75	11
As of 2/1/98, the State School reported at the end of 1997, they saved over \$1,000,000.00 with our help.		

Improvement Below Industry Average vs. Total Elimination

Win-Win

- “What an amazing turn-around! We experienced a 79% reduction in recordable injuries for construction employees from 1996 to 1997. In 1997, we experienced zero soft tissue injuries using the functional testing process. Since implementation in 1996, to present, our recordable incident rate has remained below 1.0.”

- “We were one of the first companies to contract for functional employment testing. After implementing this program, we estimate that over a three-year period, we experienced a 75% reduction in lost time accident rates.”
- “Our company is a commercial general building contractor. In the twelve-month period after implementing your testing program, our WC modifier was lowered by 21%. Please congratulate your staff and feel free to use us as a reference at any time.”
- “As an integral part of our work site’s health and safety program, this functional testing program has improved our placement process and added a higher dimension of safety and employee retention.”
- “Since utilizing the functional testing process, workers compensation claims for employees who were tested have reduced to zero.”

Objective Third-Party Intervention

- Consistent pre- and post-injury data comparison
- Education of employee, employer, HCP, and ergonomist of each other’s role in successful elimination of injuries
- Categorize employers according to risk and allow 12 months to reduce injuries to accountability standard.
- Fairness to “best practices” and incentives to those behind in the learning curve.
- Monitor pass/fail match to jobs, ergonomic success, and medical risk as it relates to job function

Checks and balances as well as equal commitment from ALL:

Employer, employee, HCP, ergonomic management team, OSHA

ARE YOU IN ALIGNMENT?¹

**By Larry Feeler, PT
President/CEO
WorkSTEPS®**

The booming economy has offered renewed hope and opportunity for our Nation's workers. However, it has presented many new challenges for employers. Escalating incidences and costs of injuries, increased obesity, an aging workforce, fewer applicants and federal mandates are making it difficult for both employers and employees to capitalize on the prosperity that should be created by our current economic growth.

One in every three American workers will suffer a work related musculoskeletal disorder (MSD) this year costing employers an estimated twenty billion dollars. Many companies have developed "best practice" methods to help prevent injuries, but can't do enough to be competitive on a national basis. Human resource and safety personnel, the ergonomist, medical providers, insurance carriers, case managers and company management all contribute their individual parts to help out. Unfortunately, each source tends to approach the problem from their own perspective and as a result the overall success is fragmented and less efficient. Is there a missing link that could align all injury management services together in a successful partnership that exceeds everyone's expectations?

Eighteen years ago, I began to answer that question for my father's pipeline construction company. Each year, the product has been adapted and refined to the point where it can now literally be the catalyst for occupational medicine professionals who want the ability to create accountability for all "partners" involved in injury prevention and management. Functional employment testing is the answer. The reason – It Works!

There is no other method available that incorporates baseline ergonomic, medical, and functional measures that can be replicated any time throughout employment and/or the injury management process. By testing new hires for job specific strengths and motion as well as common musculoskeletal and neurological symptoms that would prevent safely performing job functions, the functional test itself becomes the first line of defense to prevent hiring your next claimant. Without question, when an employee is placed in a position where the physical demands exceed their capability, they will suffer an injury. Likewise it would be senseless to hire a bank teller with carpal tunnel symptoms. Certainly such methods are fair not only to the employer, but to the employee who doesn't needlessly injure themselves and who may be able to get well or increase their capability to a safe level through early detection and/or intervention. The employee also has the option of taking another job for which they are capable and are not at significant medical risk.

It has been stated that such tests are overkill and that the physician physical is adequate for any gross abnormality. But this is simply not true and is just another example of fragmentation versus alignment. I have personally worked with a board certified Occupational Medicine doctor who performs physician physicals to detect glaucoma, hernias, high blood pressure, and etc. He has been eager to study our job analysis information for his employer companies and to understand the value of baseline information to honestly control future injuries. He understands that we are not in competition with him, but supplement his gross overview with medical and functional measures specific to each individual and their job according to the ergonomic analysis. If a problem is found during functional testing the applicant has the right to clear the medical risk with the physician of their choice. But many applicants choose to go back to the Occupational medicine doctor since he is readily available and understands what their specific job entails.

Functional "fit for duty" tests are also available for existing employees under several different scenarios of the Americans with Disabilities Act (ADA). Such testing may be voluntary as a part of a "health screening" provided by the employer, but is typically "triggered by some evidence of problems related to job performance or safety, or...to deter-

¹As published in Ryan & Associates, October 2000, A National Occupational Health and Medicine Newsletter. Used with permission.

mine whether individuals in physically demanding jobs continue to be fit for duty.”² These tests must be job related and consistent with business necessity so only those measures that are applicable to the employees safe job performance can be measured. But these applicable measures still include the same musculoskeletal, neurological, postural, lifting and essential function measures utilized for newhires. The data collected is instantly compared to the largest industrial database in the United States as well as the companies individual statistics to verify the exact status of each worker to eliminate risks before an injury occurs and insure continued safe job performance.

The ADA also allows employers to require functional testing that is job related and consistent with business necessity after an injury occurs. Consistency checks are built into the baseline test so that a determination can be made as to the validity and severity of symptoms as they relate to the diagnosis. A comparison to the baseline information previously collected allows for a scientific determination of all functions affected by the specific injury. Think about the value of knowing the exact difference in spine or joint function after an injury occurs and knowing whether the symptoms are consistent with a real injury or are inconsistent and exaggerated. This creates accountability not only to the employee but also to the medical provider and prevents fraudulent claims and unnecessary medical tests, surgery and/or treatment. This product is clearly recommended to employers who have fragmented care since it is available through federal law regardless of the workers’ compensation process and disability management systems. On the other hand, if an employer is self-insured or has a good working relationship with a physician gate keeper, the insurance carrier, and the disabilities management team, a medical functional capacity evaluation (FCE) is available that includes the same baseline data collection as the test for newhires but includes more consistency checks, medical narratives and explanation, symptom magnification tests if indicated, more job function tests and specific recommendations to accommodate “temporarily” injured employees.

This functional test system has been supported by legal counsel for over ten years with development of policies and procedures based upon case history that provide the groundwork for success. The tests themselves are only a small part of the entire product, but hopefully one can readily see the value of this missing link to every part of a comprehensive injury management system. To initiate solid programming employers must insist that the product be administered by licensed medical personnel, that it be in compliance with many federal statutes, that the information is validated by database comparison with adequate geographic and job distribution, and that it have a legal history that can support its compliance claims.

As you study this correspondence, please understand that this system is sophisticated and difficult to replicate. It was created to prevent injuries and accomplish safety in the workplace and has a track record of doing just that better than any individual product in todays market.

If you are willing to forget any bias from a specific vantage point, to judge functional testing by investigating its complexity, to discuss specific needs and strategies with experienced experts, and to align yourself with a team of partners dedicated to a common cause, functional testing will make you invaluable to companies and their employees that you protect. Such services, combined with the positive relationships created in a network where all specialties from safety training to case closure are in congruence, create a tremendous opportunity for dedicated medical professionals in a delicate market where future business needs to be solidified. Look around you and see how many companies could benefit from these services. Are you in Alignment?

²Equal Employment Opportunity Commission. Technical Assistance Manual for the Americans with Disabilities Act. Warren Gorham Lamont; 1990: VI-12.

Summary Brief:

OSHA Proposed Ergonomic Standard

Presented By:
Larry Feeler, P.T.
President / C.E.O.
WorkSTEPS, Inc.

Revised Summary Brief With New Documentary Evidence

Presented To OSHA On June 26, 2000

I am writing in reference to the Occupational Safety and Health Administration's ("OSHA") Proposed Ergonomic Standard ("Standard"). I am a physical therapist with over 20 years of experience treating primarily industrial clients who suffer work related injuries including musculoskeletal disorders ("MSDs"). I am recognized as a specialist and authority in the field of work injury prevention and management. I am president and chief executive officer of one of the fastest growing industrial medicine networks in the nation. I have personally performed hundreds of job analysis, hundreds of safety training classes, have authored numerous articles/chapters, and continue ongoing statistical research regarding ergonomics and workplace injury prevention. I am also a certified claims reviewer for the Texas Physical Therapy Association, evaluating cost and effectiveness of physical modalities and procedures provided by doctors, chiropractors, physical therapists and ancillary personnel. It is this vast experience and my long-term commitment to safety in the workplace that motivates me to submit these comments regarding the Standard.

In the early 1980's, my father's construction company suffered a rash of workers' compensation claims and his experience modifier was so high he paid the first fifty thousand dollars per claim out of pocket. At the same time, I was working as a staff therapist at the county hospital and realized that there were no cost controls for compensable claims and no accountability requirements. Many of the workers' claimed injuries in the first week of employment or just before the job was to be finished, and seemingly incidental injuries turned into settlements instead of a return-to-work.

By 1986, I developed the WorkSTEPS Model in order to meet a critical need – to establish a medically safe, legally compliant, scientific and objective method of matching workers to the essential functions of their jobs. I knew if successful, the process would significantly reduce injuries and their related costs, and return legitimately injured employees to work sooner.

This model was designed to accomplish similar goals to those of the Standard. Since that time, the model has been refined, computerized and implemented in hundreds of companies throughout the United States.

The data collected over the last ten years has been used to develop the largest pre-injury industrial database in the United States, with over 40 measurements on 160,000 industrial employees. The database also houses thousands of standardized post injury functional capacity evaluations and fit-for-duty examinations.

While there is an abundance of scientific evidence to support the claim that ergonomics in the workplace can reduce MSDs, there is no evidence to determine what specifically causes an individual to become injured. Furthermore, medical experts and/or ergonomists do not agree nor does the research support agreement about all of the causes and remedies to alleviate MSDs. As an example, there are inferences in the Standard that “awkward postures” need to be alleviated and that simultaneous bends and twists of the spine cause increased disc pressure. However, the Standard does not specifically say do not bend your spine during work activities because there is substantial evidence that the back is structurally stronger in a bent posture. In fact, the National Institute of Occupational Safety and Health (NIOSH) summarized “a wealth of research” and stated that “instructions as to specific lifting postures used for a load on the floor be avoided until further research defines the complexities of floor lifting.” An issue as simple as bending to lift cannot even be resolved scientifically! Stover Snook, one of the United States’ most experienced researchers in ergonomics, reports that **genetics and age** are more important in spine disc degeneration than the type of physical activity one performs! Even so, the new standard is so broad in scope that the employer is responsible no matter what causes any employee to suffer a MSD.

There is minimal or no consideration for anthropometry, gender, age, pre-existing genetics, medical history or injury history, degenerative changes, psychology, disgruntlement, anger, mental stress, lifestyle or general condition. In its current form, this Standard requires employers to accept that all employees are perfect when hired, that they never grow old, and that all MSDs are caused by an unsafe workplace. The employer is not responsible for these factors and should not be held accountable for them without clear evidence implicating the workplace.

It is my position that the Standard is unfair to almost every employer. It is especially undeserving to thousands of companies who have spent a great deal of time and money to create “best practices” policies to lower MSDs without government intervention, and have worked millions of man-hours without a lost time accident. Companies in this condition would be encumbered with the Standard the first time a MSD occurs, or may even have blanket requirements because they are in manufacturing or material handling jobs. Such companies could spend countless more dollars to become compliant with the Standard, only to find themselves in a system that rewards common complaints and is relentless in its management, both financially and administratively.

Even though it is not OSHA’s intent, there is no doubt that a few disconcerting employees involved in the management and implementation of the “Standard” could open the door for lengthy negotiations, costly unproven renovations, special interest considerations, reporting and treatment for all pain complaints, and the threat of litigation or fines if **everyone** is not satisfied with **each** result in the **entire** evolving process.

For the record, I would like to address the following Sections of the Proposed Ergonomic Standard:

1. SECTION 1910.905—WHAT ARE THE ELEMENTS OF A COMPLETE ERGONOMICS PROGRAM?

In the Standard, a full ergonomics program consists of six program elements. The biggest problem with this section is that the employers’ responsibilities appear limitless in both scope and financial obligation regarding each of the parameters listed. Furthermore, there is no consideration for employers to deal with the following:

- Fraudulent claims by employees and/or medical providers.
- Employees, who have previous medical problems, complicated family history, general de-conditioning, aging, etc.

- Any lay-offs, union strikes, or business downturns that may suddenly produce a large number of MSDs
- The Standard omits baseline impairment measurements and functional measurements before employment that would help to negate non-work-related injury claims or fraudulent claims post injury.
- There is no definitive transitional return-to-work that does not pose an undue hardship on the employer, once it has been determined that an employee will not be able to return to effective function within a reasonable time frame.
- There is no proof that MSDs can effectively be eliminated through utilization of the proposed standard. In fact, the qualifications of an OSHA recordable MSD are so general that they are all-encompassing.
- There is no remedy for employers, large or small, to deal with costs that will exceed the projected calculations.

The elements of the ergonomic proposal can not define the causes of a single event injury or repetitive trauma they purport to address. Even sophisticated magnetic imaging (MRI) reveals that over 20% of the normal population and 75% of normals over age 60 have herniated discs and other problems commonly found when “pain” develops in injured workers. 56% of work-injured patients acknowledge gradual changes rather than a single event as the cause for low back pain. The Standard cannot predict how many repetitions, what specific weight, what exact work position or what non-occupational contributions will cause a particular MSD on an entire class of workers much less on an individual basis.

2. SECTION 1910.906—HOW DOES THE STANDARD APPLY TO MANUFACTURING AND MATERIAL HANDLING JOBS?

Fortunately, 36 % of manufacturing companies and 54% of health and business service companies have allotted significant resources to lost time prevention services. One construction company that uses the Model I will describe did not have one soft tissue MSD the entire year of 1997. This company spent one million dollars over a two-and-one-half year period and saved 30 million dollars in injury costs and claims! Regardless of their efforts, as soon as one MSD occurs, they will be responsible for full implementation of the program.

This Standard should deal with employers, who have significant injury problems without documented evidence of intervention. There should actually be leeway for those who have shown significant reduction in injuries, as long as they are continuing to improve. These proposed ergonomic solutions are so complex that a company cannot be expected to be in full compliance, or have a significant work-injury reduction, without a minimum of a two to three year grace period showing significant, gradual improvement, versus instant overall achievement.

3. SECTION 1910.907—HOW DOES THIS STANDARD APPLY TO OTHER JOBS IN GENERAL INDUSTRY?

This section calls for immediate compliance “when a covered MSD is reported”, and is obviously all-inclusive. I have 40 employees in my physical therapy clinic. I have not had a work-related MSD claim in over 10 years. I attribute this to the use of post offer employment physicals, micro-breaks for secretaries, as well as education and incentives to exercise through break periods. I have 13 secretarial and transcription personnel who still would rank neck/shoulder tension as a common complaint. If one employee claimed a MSD related to the generic signs and symptoms, it would be easy to see how an epidemic could occur. My facility could go from no injury claims for this problem in 10 years to multiple

claims in a few months. If I had a disgruntled employee or an overzealous health care professional, my costs would get out of hand as soon as my next experience modifier was calculated. Furthermore, this would require that I hire at least one additional employee to manage the responsibilities designed in this Standard.

It would cost thousands of dollars to ergonomically retrofit each secretarial station in order to accommodate the number of employees I employ. Additionally, the ergonomically perfect station won't resolve the fact that some of these employees sit on the Internet for four to five hours each evening, live a sedentary lifestyle, and have pre-dispositions to MSDs like poor posture, pregnancy, and/or fluid retention that are out of my control.

This simple example shows how an employer with a minor MSD problem could be devastated by a single, non-organic symptom. Statements like "you must not have policies or practices that discourage employees from participating in a program or from reporting MSDs signs or symptoms" are all encompassing. Some employees on management teams will be unreasonable with recommendations.

4. SECTION 1910.918—WHAT MUST I DO TO ANALYZE A PROBLEM JOB?

I believe this section is over-burdensome to the employer by allowing all employees in the problem job to give input to interventions that are financially impossible to initiate and yet, if not considered, may create legal or litigious liability. Ergonomics itself is an expensive venture. To evaluate one secretarial station would cost a minimum of \$125.00 to \$500.00, depending upon the qualifications of the evaluator. Renovation or implementation typically cost thousands of dollars to make each station ergonomically correct. Furthermore, there is little evidence to prove that the perfect workstation does limit injuries.

A recent study by ACES Technologies found that ergonomic changes in the workplace would affect 60 percent of all injuries. However, it is also reported that around 40 percent of the proposed remedies required changes by the employer, while 60 percent required changes by individual employees.

The American College of Occupational and Environmental Medicine (ACOEM) was designed to specifically target areas to improve health and safety for workers and to eliminate workplace hazards. Of the five areas studied (lifestyle, prevention, the workplace, exposures, and the environment), lifestyle and prevention were recognized as personal responsibilities. The ACOEM recommends that employers encourage certain types of health conscious and safety behaviors and that employees participate. One way this has been done successfully is through safety incentive programs. Human beings tend to respond extremely well to rewards for taking a personal role in increasing productivity, minimizing waste, and taking responsibility to promote safety in the workplace. There is no reason to believe that such incentives would not work equally well under the Standard. However, the policy to encourage reporting and participation and provide those in authority with resources, information and training, without limits or controls, could negate these incentives and be extremely costly for most companies who have not experienced any claims but suddenly have one MSD!

The quick fix solution is appropriate, but would be negated if a second injury occurred any time in the next three years in the same job description. Is that a fair standard for employers, regardless of the number of workers they employ? Moreover, is it possible that if the employees are held accountable to these standards, they might retaliate by fighting changes, making waves about unrelated issues, and seeking legal intervention?

As far as my review of the article was concerned, it made no mention about the high incidence of back injury patients who were depressed, burned out, stressed, or just didn't like the supervisor or the employees they worked with. This plan should provide a remedy for such situations and an exemption to

employers who have reasonably lowered the incidence of MSDs using their own plan and who continue to show improvement to tolerable levels – but not zero claims.

5. SECTION 1910.908—HOW DOES THE STANDARD APPLY IF I ALREADY HAVE AN ERGONOMICS PROGRAM?

No existing ergonomics program will be sufficient unless it virtually eliminates MSDs. In order to accomplish this, it is felt that the employer must do preventive care on the front end and then match new hires to their functional job requirements. It is my experience that employees with a level of reserve of approximately 25 percent more than what is required on the job are at minimal risk of injury. It is felt that, if an employee is placed without symptoms and can be annually reviewed to make sure there is no organic pathology, the employer could actually be protected from an injury claim through early detection and intervention. With the current system, the employer is reactive to a Workers' Compensation claim and now will be subject to regulatory interaction by OSHA, as soon as a MSD occurs.

Some jobs are too physical to avoid MSDs without undue hardship to the employer. Ergonomic interventions have decreased workloads, but in some occupations, such as drilling contractors or firemen, it is impossible to remove all physical activities. Therefore, it would be smarter to match the range of motion and strength of the individual to the task, as well as to implement education about forces and posture to aid in the prevention of injuries.

Periodic intervention or follow-up testing would be necessary to insure that early detection is always possible. Throughout the Standard, generalized statements appear to be a catchall for those in management that will be over-burdening and extremely expensive.

6. SECTION 6—GENERAL STATEMENTS THAT APPARENTLY CAUSE INCREASED EMPLOYER LIABILITY.

Throughout the Standard, generalized statements appear to be a catchall for those in management that will be over-burdening and extremely expensive. Therefore, I would like to summarize some of those statements.

- **Section 1910.911.** *“The employer must have ways to report MSD signs and symptoms, get responses to reports, and be involved in developing, implementing, and evaluating each element of your program. You must not have policies or practices that discourage employees from participating in the program or from reporting MSD signs or symptoms.”*
- **Section 1910-917.** *“You must eliminate the MSD hazards, reduce them to the extent feasible, or materially reduce them, using the incremental abatement process in this standard.”*
- **Section 1910.926.** *“You must give employees an opportunity to ask questions and receive answers.”*
- **Section 1910.929.** *“You must provide employees with temporary work restrictions and the work restriction protection this Standard requires.”*
- **Section 1910.930.** *“When necessary, provide employees with prompt access to a health care professional (HCP) for evaluation, management, and follow-up.”*
- **Section 1910.939.** *“You have to keep records if you have 10 or more employees (including part time employees provided through personnel services) on any one day during the preceding calendar year.”*

7. SECTION 1910.942—WHEN DO I HAVE TO BE IN COMPLIANCE WITH THIS STANDARD?

The employer has only one year to be in compliance if they do not have any MSDs, two years to have job analysis and interim controls, and three years to have permanent controls. However, if an MSD occurs, under 1910.943, the company has only one year to have permanent controls and a program evaluation accomplished. This is extremely over-burdensome, especially for companies who have had minimal intervention and are unable to use their current services.

8. SECTION 1910.932—WHAT MUST THE HEALTH CARE PROFESSIONALS (HCP's) WRITTEN OPINION CONTAIN?

Currently, the Paperwork Reduction Act for health care professionals has caused me to hire at least two office personnel for each licensed medical person, in order to manage claims and insure appropriate and timely treatments. It is a requirement to include specific data on a variety of impairment reports, functional reports, and progress reports. This Section requires different information to be included without mandating that the health care professional has interacted with the company and knows what the job position entails. There is no requirement for a residual functional capacity to find out what activities the client could perform beyond lifting. Also, there is no functional capacity requirement to find out exactly what the client can do (in regard to lifting and other essential job functions) in order to return to work.

One of the problems in the current system is that health care professionals grab numbers out of the air and return people to work with light duty when, in fact, many are capable of safely performing residual functions and even lifting functions that are in excess of their restrictions. Wouldn't it make sense to require that DOT functions be accurately measured and matched to the individual's job demands?

In this Section, the medical provider must also provide the employees with temporary work restrictions and work restriction protection that the Standard requires. There is no consideration for fraud (reported at 5 to 6 billion per year), psychological involvement, non-occupational causes, symptom magnification for secondary gain, inappropriate illness behavior, or lack of validity in objective scientific testing regarding a specific diagnosis.

9. SECTION 1910.945—DEFINITIONS

MSD Signs Include:

- Decreased Range of Motion
- Deformity
- Decreased Grip
- Loss of Function

The problem here is that there is no differentiation as to whether or not the decrease in these parameters is associated with true organic symptoms. For example, if an employee suffers a back injury and demonstrates decreased grip strength, that would actually be a sign of symptom magnification or overreaction to symptoms, since grip strength cannot be affected by a back injury. Furthermore, the right shoulder, on a right-handed individual, has decreased range of motion, compared to the non-dominant left side, simply because of greater use. This would be a MSD sign, even though it is normal for right-handed individuals. There are countless other examples that are normal for a certain individual, but that would be considered a MSD sign according to this guideline.

Symptoms include:

- Numbness
- Burning
- Pain
- Tingling
- Cramping
- Stiffness

All of the symptoms that are included in this list are subjective in nature and cannot be measured. There is no mention of a requirement for true organic symptoms that would be associated with legitimate MSD injuries. Taber's Cyclopedic Dictionary defines medical diagnosis as; the use of scientific and skillful methods to establish the cause and nature of a person's illness; laboratory data, and special tests. The signs and symptoms proposed in the Standard are so generic and so broad that they allow anyone, including employees, to diagnose themselves as having a covered MSD. By simply allowing pain to be a symptom, any individual would qualify within the auspices of this Standard.

This Section of the Standard does not require the Health Care Professional ("HCP") to have any specific qualifications. It does specify that they be "legally permitted by their scope of practice (e.g. licensed, registered, or certified) to independently provide or be delegated the responsibility to provide some or all of the MSD requirements of this Standard." This would include obvious appropriate professionals such as physicians, D.O.s, chiropractors, physical therapists, and occupational therapists as well as physicians assistants, and nurses. However, since problems are not "diagnosed" but defined by symptoms, this would mean that any HCP that is eligible to treat under the laws in the state can make opinions and restrictions that must be followed. In addition to athletic trainers and EMT's this would also include more alternative and esoteric professions such as allopaths, naturopaths, kinesiotherapists and massage therapists. This Standard would allow any HCP without regard to qualifications, to be made an expert in any industrial field with the stroke of a pen. Recommendations and opinions must be followed even if the employer has an awesome modified duty program. The employee can still be taken off work without regard to the effectiveness or completeness of the company's injury management programs. In my experience, this would be a disaster to cost effectiveness in managing work-related injury claims.

Another problem that I have experienced is that some medical practitioners tend to make the employee dependent on them for their medical care and provide the same treatments over and over for months, while willingly justifying those treatments in the medical record.

If this Standard is to be implemented successfully, there will need to be guidelines regarding what type of practitioners may see certain diagnoses, and there must be a requirement that functional measures have to be taken following recognized scientific protocols to insure that each individual is looked at according to their specific job requirements. A residual Functional Capacity Evaluation that looked at all the Dictionary of Occupational Titles (DOT) requirements as they relate to the individual job in question, and that was supervised directly by licensed medical personnel would, more than likely, suffice to meet this requirement.

Over the last few years, the gap between medical care and occupational return-to-work has closed considerably by involving the insurance company, the employer, the medical provider, and the employee favorably in that process. If the employee does not comply with the treatment and/or does not continue to

progress to full return-to-work within a reasonable period, the employer has no options for remedy under the current draft. The proposed Standard maintains protection for the injured worker, indefinitely, or until all intervention strategies are exhausted without regard to substantial evidence that indicates that the employee does not wish to return to work.

10. SECTION 1910.932—WHAT MUST THE HCP’S WRITTEN OPINION CONTAIN?

It is noted that if the employer provided temporary work restrictions, salary protection is automatically triggered. Work restriction protection = Salary+Benefits+Rights.

- a) 100% pay and benefits for employees on light duty
- b) 90% pay and 100% benefits for employees who must be removed from work

(Costs offset by workers’ comp or similar benefits)

This protection must be maintained until (1910.934) which describes when these benefits cease:

- a) The employee returns to full duty.
- b) The hazards are materially reduced so that no risk is posed during the recovery period.
- c) Six (6) months have passed.

Because of the ease of filing a subjective complaint, and the prospect of minimal or no wage loss while not working, it should be anticipated that this component will commonly result in six (6) months paid time off and will also be widely used as a solution for other grievances as well. A system of accountability and specific justifications is mandatory on a case by case basis to prevent an “epidemic” of injuries.

11. HEALTH EFFECTS SECTION, DOCKET S-777, EXHIBIT 27.1

This section focuses on research that substantiates ergonomic intervention, but then “concentrates on external stressors.” Personal factors such as “anthropometry”, “age”, “gender”, “physical condition”, and “general health care” are not clearly defined external stressors for immediate intervention even though they are universally agreed upon signs of aging and the natural degeneration process. Nonetheless, those in high-risk categories are equally covered under this act.

It is estimated that 250,000 to 650,000 Americans who had paralytic poliomyelitis 30, 40, and even 70 years ago are now experiencing some of their old symptoms in what is known as post-polio syndrome. In the journal article reference, they complain of “increasing muscle weakness, joint and muscle pain, fatigue, breathing difficulties, loss of stamina, low back pain, and intolerance to cold.” In at least 1 out of 25 survivors, the symptoms are disabling. Yet, if these complaints occur while on the job, they would accurately be construed as MSDs according to the guidelines of this Standard.

It is felt, that if employers are to follow ADA guidelines and are willing to accommodate individuals with disabilities or hire people with known medical histories, they should be given some consideration if a musculoskeletal disorder develops. The worker could be accommodated and returned to work with modified duty on a permanent basis, or the employer could be exempt from a recordable MSD, based on the severity of the pre-existing objective scientific evidence.

Closing Statement And Introduction Of The Functional Testing Model

I have outlined the elements of the Standard that I believe will hinder OSHA's mission regarding the management and reduction of work related musculoskeletal disorder.

I would now like to present the following Model for your consideration:

The Model

Statistics prove that the best way to treat any injury or illness is to prevent it from ever occurring. However, there are many debates about what interventions are the most effective and which ones achieve the highest measures of success. It has been my experience as a recognized expert in the field of occupational and industrial medicine, that the single highest degree of injury reductions are accomplished through functional testing. Functional testing is a bio-ergonomic intervention that measures human strength and performance, and appropriately matches them to the physical demands of the job. The WorkSTEPS Functional Test Model (“Model”) has proven to reduce work-related MSDs by an average of 50% in its first year of implementation when used as a first line of defense in the prevention of MSDs. Functional testing combined with other injury management programming such as conditioning, ergonomics, etc., can help achieve reductions which are even more significant.

This WorkSTEPS Model (“Model”) was developed in clinical setting, by occupational clinicians over 15 years ago. It was founded to meet a critical need – to create a medically safe, legally compliant, scientific and objective means of matching a worker’s functional capabilities with the essential functions of the job. It was developed as a tool that employers could use to help insure that a worker was safely and appropriately matched to the physical demands of the job.

The Model establishes safety as a mission with shared responsibility between employers, employees, and the health care clinician consulting them. It also supplies a system of checks and balances that measures accountability for all parties concerning their respective roles.

The Model is being provided to employers through a national network of occupational health care clinicians (doctors, physical therapists, and occupational therapists). These clinicians provide employers with one the most comprehensive, state-of-the-art, and legally compliant functional testing models available. Licensed clinicians perform the protocols, procedures and processes outlined in the Model in a clinical or on-site setting. These clinicians and their aides receive annual training and refresher course work on proper protocols, and procedures as well as updates on changes in regulations and compliance factors.

The Model has gained wide acceptance in the business community due to the rising costs associated with workers’ compensation and increased federal regulations being imposed on employers by the Occupational Health and Safety Administration and the Equal Employment Opportunity Commission. The Model helps employers stay compliant with federal hiring practices and the Americans’ With Disabilities Act. The Model utilizes appropriately designed and administered tests, historical pre- and post-injury data, and evaluations relevant to physical performance to help mitigate the incidence and costs of injury and provide better data to its employers to assist in resolution of claims.

The Model is currently utilized in 35 states and has proven invaluable to both large and small employers in their ongoing efforts to reduce workplace injury incidence and their related costs. This Model is appropriate for use in all industries as it addresses common musculoskeletal problems that encompass heavy labor to high tech, repetitive motion injuries. Many employers using the Model have been recognized both nationally and regionally for exemplary accomplishments in safety and prevention programming. The employer/occupational medicine partnership created through this Model has resulted in hundreds of safer, more productive workplaces.

The Model being presented compliments the Occupational Health and Safety Administration’s (“OSHA”), Proposed Ergonomic Standard (“Standard”), but limits the scope to reasonable parameters that are economically feasible and objectively attainable. Most testimonials in the literature reported by OSHA and documented by companies like mine, define job specific interventions, reasonably implemented (time and cost), with an expected outcome specific to a calculated need. The Model addresses most of the issues in the OSHA Standard but can be implemented and monitored with minimal additional cost to the employer and limited additional manpower.

The Model is affordable, and viewed by most employers as an investment as opposed to an expense. The entire process can be accomplished for less than 1,000 dollars per job and an investment of 150 dollars per year per employee not including expenses related to injuries. A recent study conducted for one of our national clients by a national, independent injury management consulting group calculated that the employer saved \$30.00 for every \$1.00 invested in functional testing. To date that employer has spent approximately \$1,000,000 on testing and the return on investment was calculated at \$3,000,000. I have enclosed *An Outcome Study By A National Construction Company*¹ for your review.

The Model has been refined, computerized, and studied for over ten years. It is valid and reproducible (publication pending). Employers using this Model have experienced tremendous success in reducing MSDs and their related costs. Although it does not completely alleviate MSDs they are reduced an average of 50% during the first year's implementation, with an average reduction of 75% by the end of year 3. I have included a report entitled *Testimonials and Outcome Statistics Documenting First Year Injury Reductions When Using Functional Testing*², to substantiate this statistic. This report was developed from testimonials and outcome studies provided by employers using testing services provided for in the Model.

Employers who utilized the Model in conjunction with other injury management programming and ergonomic technologies are achieving reductions of up to 75% during first year's implementation, with some having achieved reductions of as high as 89%. I have included a study *Calculated Percentage Of Reductions Of Musculoskeletal Injuries When Utilizing Functional Testing*³ for review.

The Calculated percentage of MSD injury reduction was computed by dividing the total incidence of occupational illness and injury rate per 100 workers by the WorkSTEPS fail rate per 100 workers. Industries in this study were profiled by S.I.C. Code category and size. Companies included in the study were companies who had administered a minimum of 500 to a maximum of 10,000 functional tests including light, medium, heavy and very heavy physical demand levels. Both male and female candidates between the ages of 18 to 65 were included in the profile. The U.S. Census Bureau provided the mean average per 100 workers for total occupational illnesses and injuries for 1998. The average fail rate per 100 workers was provided by statistics compiled from the WorkSTEPS Industrial Database. The fail rate is comprised of individuals who are unable to perform the essential function tasks for the positions they are applying or who failed due to a significant medical risk that affected job performance. The functional test passes or fails on performance of essential functions and the clinical portion of the test detects significant health problems that are referred to a physician for final clearance or rejection for the job offer (the test detects other health problems but refers to a physician for additional evaluation).

The "calculated % of reduction of MSDs" is based on the assumption that the percent of actual fails per industry were not hired or were placed in alternative positions they were safely qualified to perform thereby reducing the national injury rate by the Model's current fail rate for that same type of industry.

In addition to reducing new injuries and their related costs, employers are experiencing reduced modifier rates, reductions in lost time, increased worker productivity, decreased turnover, and diminished incidences of fraud and abuse. I have enclosed for review a report on *Benefits of Implementing Functional Testing*⁴ based on testimonials supplied to us by employers using the Model.

The Model establishes functional testing as the foundation for hiring, health maintenance, rehabilitation, and return-to-work programming. I enclose for review; *A Flow Chart for Functional Testing Utilized in Pre-Placement Post Offer Testing for New Hires, A Flow Chart for Function Testing Utilized in Injury Management and A Flow Chart Which Identifies The Role Functional Testing Plays In Work Injury Prevention And Management*

¹Outcome Study By National Construction Client Using WorkSTEPS Functional Testing

²Testimonials And Outcome Statistics Documenting First Year Injury Reductions When Utilizing Functional Testing

³Calculated % Of Reductions In MSD When Utilizing Functional Testing

⁴Benefits Of Implementing Functional Testing

Programs⁵. The Model provides employers with guidance, information and protocols on how to incorporate functional testing into their existing policies and procedures. It also provides guidance on how to educate employees about its values and benefits.

The Model is comprehensive in nature and combines an ergonomic, a functional, and a medical model. Medical and functional (job specific) tests are based upon actual job demands and the common medical complaints associated with the position in question. Tests include pre and post offer tests for new hires, fit for duty tests for existing workers, upper extremity and carpal tunnel testing for jobs requiring hand repetitive motion and functional capacity evaluations for employees who have been injured on the job. Baseline health information collected in the pre and post offer test is invaluable to both employers and employees in the maintenance, treatment, and return-to-work of employees. Matching workers to the job instead of matching jobs to the worker is a more objective, economical, and safer way of approaching injury reduction programming.

The Model is currently utilized by approximately one thousand companies spanning 35 states with a national fail rate of 7-10%. The Model has been established since 1986 and conforms fully to the Equal Employment Opportunity Commission (EEOC) guidelines for application in regard to the Americans with Disabilities Act (ADA) and provides ongoing legal support to clinicians and employers utilizing the Model. I have enclosed a segment of ***Case Law Summary***⁶ that supports the implementation and use of functional testing in regard to hiring and appropriate, safe return to work.

CONCLUSION:

Since its inception, this Model has significantly prevented and reduced workplace injuries and has effectively and safely been utilized to return injured workers to gainful employment in a timely manner. There is no greater benefit to safety than individualized assessment of work capability for new hires, periodic evaluation for existing workers', and post injury testing. By combining the ergonomic model with a functional and a medical model, the ability to accommodate, effectively treat, create accountability and base decisions on objective information are significantly enhanced.

Our history proves that injuries are reduced by 50% the first year and 75% by three years of implementation. If a company utilizes this Model or any other available method to accomplish such success, the proposed Ergonomic Standard should allow an exemption for that employer. Such a system would motivate employers to seek out successful interventions to eliminate every musculoskeletal injury and reserve enforcement to those employers who did not attempt or were unsuccessful in doing so. Finally this Model allows for a scientific method of checks and balances that creates accountability for the employee, the employer, the ergonomist, and the healthcare professional to eliminate abuse and be equally fair to all parties concerned.

⁵A Flow Chart For Functional Testing Utilized In Pre-Placement/Post Offer Testing For New Hires and A Flow Chart For Functional Testing Utilized In Injury Management

⁶Flow Chart Of How Functional Testing Effects Other Components Of Prevention And Injury Management

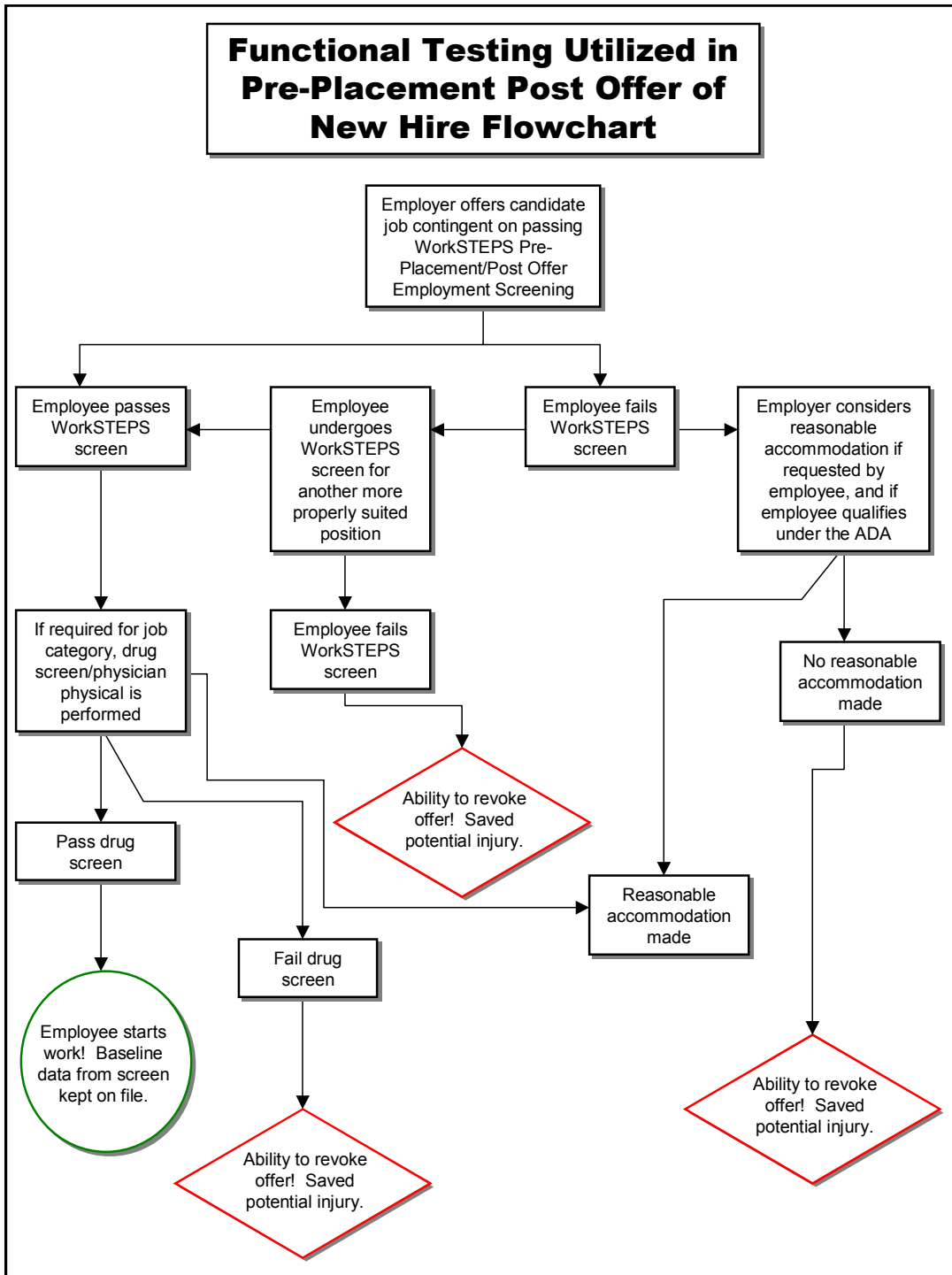
FIRST YEAR INJURY REDUCTION STATISTICS FOR NATIONAL, REGIONAL, STATE, AND LOCAL EMPLOYERS UTLIZING THE WORKSTEPS FUNCTIONAL EMPLOYMENT TESTING PROGRAM

TYPE OF INDUSTRY	SIZE OF INDUSTRY AND SIC CODE	ESTIMATED % OF INJURY REDUCTION DURING FIRST YEAR OF IMPLEMENTATION
Construction— Heavy Construction Except Building	National / 16	79%
Manufacturer— Office Furniture And Fixtures	National / 252	36%
Mining— Oil and Gas Extraction—Offshore Drilling	International / 13	33%
Transportation— Transportation / Warehouse	National / 142	40%
Mining— Oil and Gas Extraction—Well Servicing Company	State / 138	67.4% (back injuries only)
Education— State School	State / 82	85.3%
Manufacturer— Motor Vehicle Parts & Accessories	Regional / 3714	31%
Health Services— Nursing Homes	State / 805	67%
Manufacturing— Ship Building	State / 373	37% (back injuries only)
Health Services— Hospital	State / 806	63%
Manufacturer— Plastic Materials & Resin	National / 3089	44%

- The statistics reported in this study were provided by risk, human resource, and safety professionals employed by the reporting industry, not WorkSTEPS representatives.
- The reporting industries averages are based on a minimum of 500 to a maximum of 10,000 tests.
- The average reduction in injury statistic is based on first year implementation. Second and third year average reductions range from 10% to 20%.

WorkSTEPS does not promote its product based on name recognition of the clients we serve. WorkSTEPS represents that all statistics utilized in this study are on file at the WorkSTEPS Corporate Office located in Las Colinas, TX. Should you desire to speak with a representative from an industry utilizing the WorkSTEPS Program, please contact WorkSTEPS at 800-549-4502 and we'll be glad to put you in touch with an industry representative who has given us permission to utilize them as a reference.

Functional Testing Utilized in Pre-Placement Post Offer of New Hire Flowchart



Functional Testing Utilized in Injury Management

