

INTER-OFFICE MEMORANDUM

TO: ALL ATTORNEYS
FROM: W. Joseph Truce
DATE: June 23, 2006
RE: AMA GUIDES AND EXPERT WITNESSES

Senate Bill 899 brought about a major change in how we rate permanent disability.

Labor Code §4660(b)(1) provides in relevant part as follows:

“For purposes of this section, the ‘nature of the physical injury or disfigurement’ shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairment published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition) . . . ”

The premise of this rather dramatic change from the concept of rating an applicant’s disability on his “diminished capacity to compete in the open labor market” to rating an applicant by way of the **AMA Guides** was to “**promote objectivity**” in assigning injured employee’s factors of disability.

Those who promoted the **AMA Guides** assured that the disparity in opinions between applicants and defense doctors would disappear with the **AMA Guides** since the **guides** relied on objective factors of disability as opposed to “**subjectives.**”

My preliminary opinion at this time is that this “**assumption**” was sadly in error. On several cases competing advocate doctors, examining the same injured employee, have issued diametrically opposed reports as to a standard impairment rating pursuant to the **AMA Guides**.

Therefore, we will certainly need to advise our clients accordingly. In many cases we will need an expert witness to not only analyze medical reports with reference to the **AMA Guides** but also we will need to nominate expert witnesses that can testify competently on our behalf.

As we all know, we have used rating experts and/or expert witnesses in the past involving the old permanent disability schedule. Unfortunately few of these experts have developed an expertise in rating impairment under the **AMA Guides**. While I was at the RIMS Convention in Hawaii, I picked up the enclosed brochure from Brigham & Associates Incorporated. At my request, Leslie Dilbeck sent me the enclosed e-mail advising that she is available as an expert witness for \$150.00 per hour including travel time and expenses.

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RE: AMA GUIDES AND EXPERT WITNESSES

June 23, 2006

Page 2

In cases involving the AMA Guides we will probably want to list at least one expert witness on the guides on our Pre-Trial Conference Statement which is filed at the Mandatory Settlement Conference. The formal rating procedures under the AMA Guides should be a veritable train wreck and will probably drive me to the bar much earlier! When we submit a case for decision the workers' compensation judge must then issue instructions to the Disability Evaluation Unit and the rating specialist will then assign an impairment rating modified for age, occupation and diminished future earnings. By law the rating instructions by the judge should include the objective factors of permanent disability as indicated by the medical report on which the judge is relying as well as the proper method of rating. For example, in cases involving the spine, the question will always be whether or not we are to utilize the diagnosis related estimate (DRE) method or the range of motion (ROM) method. This is a decision which must be made by the judge (not the rater) in the rating instructions. I have already heard that some judges have thrown up their hands and indicate they will simply send the report to the Disability Evaluation Unit requesting the disability rating specialist to "rate the report." This, of course, is contrary to several decisions of the Court of Appeals as the Courts have said time and time again that the judges as the trier of fact must select the factors of disability for the rating specialist, not the other way around. Therefore I would anticipate that there is going to be a great deal of litigation over this particular issue.

However when the judge does issue proper instructions and we disagree with the interpretation of the rating specialist with respect to the AMA Guides we can then file for a cross examination of the rating specialist and in some cases to present rebuttal evidence, i.e., an expert on the AMA Guides.

 WJZ:ib

Attached:

Correspondence from Brigham & Associates
Email from Leslie Dilbeck

From: "Leslie Dilbeck" <leslie@brighamassociates.com>
To: <jtruce@kttl.com>
Subject: Brigham and Associates testimony fees

Hello. It was a pleasure meeting you and your colleagues at the RIMS conference. I trust you are having a great time in Kauai. I certainly look forward to working with you on future cases. My fees for live testimony are \$150 per hour including travel time.

If you have any further questions please do not hesitate to contact me.

Leslie Dilbeck, W.C.C.P., C.I.R.
Brigham & Associates, Inc.
Director of Impairment Services
(619) 299-7377

SERVICES

Impairment Rating Reviews

The *AMA Guides to the Evaluation of Permanent Impairment* are complex and recognizing errors in impairment ratings is difficult. Incorrect ratings are costly, we can help verify the accuracy of ratings.

We will promptly provide you with a detailed Physician's report including:

- An impartial review and critique of the original rating,
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Wide range of services including but not limited to process improvement & refinement in clinical settings, claims issues surrounding *AMA Guides*, integration of *AMA Guides* into software solutions.

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All medical records received are scanned upon receipt. We will then prepare and organize a chronological medical abstract summary. You will receive an abstract that contains the actual content from the medical records including a very useful keywo. index.

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OUR MISSION

to be the international leader in the field of permanent disability impairment evaluation and AMA Guides

values are integrity, accuracy and service

the assessment of causation, impairment, and the assessment of care. Our clients are attorneys (defense and plaintiffs), insurers and others in the fields of workers' compensation, personal injury, automobile casualty, and Harbor Workers' Act, and disability.

physicians (allopathic, osteopathic, chiropractic, naturopathic) and consultants are highly qualified in assessing disability issues.

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following are examples of issues that we can address:

Diagnosis - Careful assessment of clinical issues.

Permanent Impairment - correctly apply the criteria in the AMA Guides.

Classification and Apportionment Analysis - determine if permanent problems are related to an injury and apportion liability.

Psychological Case Review - we will review cases to determine the extent of psychological impairment.

Appropriateness of Care - determine appropriateness of medical, surgical, chiropractic, physical therapy and psychological care.

Permanent Disability Rating - application of Guides to California Permanent Disability Rating schedule.

BRIGHAM & ASSOCIATES, INC.

Brigham & Associates provides you with the resources you need to evaluate and manage ratings per the AMA Guides to the Evaluation of Permanent Impairment.

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- Seminars on the Guides - On-site training for your staff meeting your objectives.
- AMA Guides Skills Assessment & Certified Impairment Rater™ Exam
- Publications - AMA Press Books, Reference Charts, Monographs, Quick References, and templates.
- DVDs & CDs on the Guides
- On-site training & Consultation Services

- Guides IQ™ - Streaming educational media available online - high quality, over 50 modules, instantly available on annual subscription basis.
- Evaluation Tools - Software, inclinometers and other examination instruments
- Professional Speaking Services

Christopher R. Brigham, MD, MMS, FAADER, FACOEM, CIME.



Dr. Brigham is regarded as the nation's leading expert on the Guides. He is the Editor of the Guides Newsletter, Primary Editor of the Guides Casebook, co-author of the text Understanding the AMA Guides in Workers Compensation, and has authored hundreds of publications. Dr. Brigham is a highly regarded professional speaker and consultant. He is Board-Certified in Occupational Medicine (ABPM), Founding Director of the American Board of Independent Medical Examiners (ABIME), a Certified Independent Medical Examiner (CIME), a Certified Impairment Rater (CIR), a Fellow of the American Academy of Disability Evaluating Physicians (FAADER), and a Fellow of the American College of Occupational Environmental Medicine (FACOEM).

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COST BENEFIT ANALYSIS FOR BRIGHAM & ASSOCIATES IMPAIRMENT SERVICES

- ❖ We looked at 403 California cases from January 1, 2005 through September 24, 2005. 74% of those cases were incorrect impairment ratings.
- ❖ The average original impairment rating was 11.9% WPI. The average correct impairment rating was 4.8% WPI. Although some ratings were lower than appropriate, most were much higher than appropriate.
- ❖ The average permanent disability number is 1.6 times the impairment standard; therefore, original rating 11.9% WPI X 1.6 = 19% PD vs. re-rate 4.8% WPI X 1.6 = 8% (ie. Reduction of 11% in PD).
- ❖ At the maximum rate the 19% PD benefit award is \$15,510. At the maximum rate the 8% PD benefit award is \$5280. The cost savings on the permanent disability rating is \$10,230.
(assuming a January 1, 2005 date of injury)
- ❖ Our average charge for these cases was \$400, often less.

Most of our clients provide the physician whose report is being critiqued, a copy of our impairment rating analysis/critique. More often than not the physician agrees with our analysis/critique and corrects his/her original rating.

The average cost savings per case was \$9830 after deducting our fees. A twenty five fold return on this investment.

BRIGHAM & ASSOCIATES, INC.

As always integrity and excellence are core values for our organization. Our conclusions are always based on the specifics of the case and appropriate use of the Guides.

BRIGHAM & ASSOCIATES, INC.

Fees

Our Fee and Payment Policies are designed to reflect our goal to provide exceptional value to our clients. Our fees for consultation and deposition / testimony are based on the time involved or reserved. The fees for our impairment consultation and review services are based on the complexity of the case.

Impairment Rating Review and Consultation Fees

We are both efficient and thorough in reviewing medical records and preparing our reports, therefore obtaining the best value for our clients. To simplify our fee structure and to provide you with an advance estimate of the costs we use a structured approach based on complexity. If the review is limited to that of a rating report and the report is correct, the cost is only \$95.00.

If the report reviewed is erroneous, the fees for our review are based on four factors that correlate with the complexity and time involved in the review process and preparation of the report:

1. **Records Provided** (Please provide us with the rating report and, if necessary, additional pertinent records, such as consultation reports, initial injury report, and current medical reports. Unless the case is of unusual complexity or there are questions concerning causation or reliability of examination findings, it is often not necessary to provide the entire file.)
2. **Impairment Complexity** (Determination of hand ratings and spine ratings involving the Range of Motion Method are more complex and time-consuming)
3. **Regions Rated** (The more areas rated, the more complex the rating. Musculoskeletal regions include: cervical spine, thoracic spine, lumbar spine, shoulder, elbow, wrist, hand, hip, knee, and ankle/foot.)
4. **Length of our report** (Our reports are thorough, with supportable conclusions. The longer the report, the more time involved.)

FEE SCHEDULE ON REVERSE SIDE

FEE SCHEDULE

The basis for determining the complexity of a case is based on a point system:

Case Parameters	0	1	2	3
Records Provided	Report to Critique or < 15 pages	15-50 pages	50-150 pages	> 150 pages
Impairment Complexity	Routine	Hand-Routine; Spine-Range of Motion Method	Vision	
Number of Regions Rated	1	2-3	4-5	>6
Our Report Length	3 pages	4 – 6 pages	7 – 10 pages	>10 pages

Level	Complexity	Points	Price	Example
0	(Critiqued Report Correct)	n/a	\$95.00	Review of a rating that was correct with brief letter prepared. (Total numbers of pages reviewed <15)
1	Low	0	\$195.00	Routine review of impairment report involving a single region with detailed written critique (no additional points)
2	Moderate	1-2	\$295.00	Review of impairment report involving two regions, a more complex rating (hand or spine range of motion), and/or review of additional medical records. (total 1 to 2 complexity points)
3	Moderate High	3-4	\$495.00	Review of 100 pages of records, 2 regions, and 6 page report (total of 4 complexity points)
4	High	5-6	\$795.00	Review of 125 pages of records, 3 regions, and 10 page report (total of 5 complexity points)
5	Very High	>6	case dependent	Review of 200 pages of records, spine range of motion assessment, 3 regions, and 10 page report (total of 7 complexity points)



P.O. Box 270759, San Diego, CA 92127 (858) 385-4040 FAX (858) 437-6903

September 15, 2005

Brigham & Associates, Inc.
2655 Camino Del Rio South, Suite 211
San Diego, CA 92108
Attn: Mindy Brigham

Dear Ms. Brigham:


I would like to thank you for the services you have been providing my organization. As a workers' compensation claims adjuster in California I have felt the challenges of the recent Workers' Compensation Reform as I do my day-to-day tasks on my claims desk. One area of great challenge has been determining the impairment ratings based on final reports from physicians. Some physicians are not doing impairment ratings in their reports, and there are others who are making attempts at providing impairment ratings. Both scenarios create a challenge for me as I am required to pay benefits based on the final reports impairment findings.

I have been using your services for critiquing and analyzing medical reports to determine a claimant's level of impairment. I have found the quality and credibility of your reports beneficial in moving my cases forward. On cases in which the physician has not done an impairment rating I am able to obtain an analysis from your organization and then provide that to the physician on my case. In turn the physician reviews your report and provides his/her opinion based on your findings. I have found more often than not the physician agrees with your opinion as they recognize your organization as experts in the impairment rating field. There are cases in which impairment ratings have been attempted by the reporting physician but are not well documented. You have provided me with critiques on those cases which have often times disagreed with the impairment rating of the reporting physician. In turn I have sent your critique to the physician whose report is being critiqued for comment. Again, more often than not they agree with your critique. I believe the doctors in California recognize the complexity of the usage of the 5th Edition, AMA Guides to the Evaluation of Permanent Impairment and understand that you are experts in your field.

I appreciate the services you have provided to me in an effort to push my cases to closure. I look forward to a continued relationship with Brigham and Associates and hope that over time the physicians in the industry will come to understand the Guides to a degree in which I am able to have confidence in their impairment ratings. I am sure this will come with time and training.

Thank you for your assistance in this matter. Please feel free to contact me at (858) 385-4048 if you have any questions.

Sincerely,


Michelle Green
Claims Supervisor

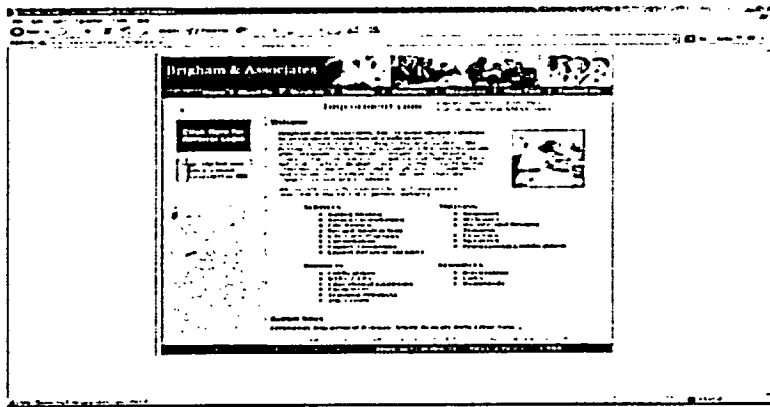
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CASE REFERRAL PROCESS

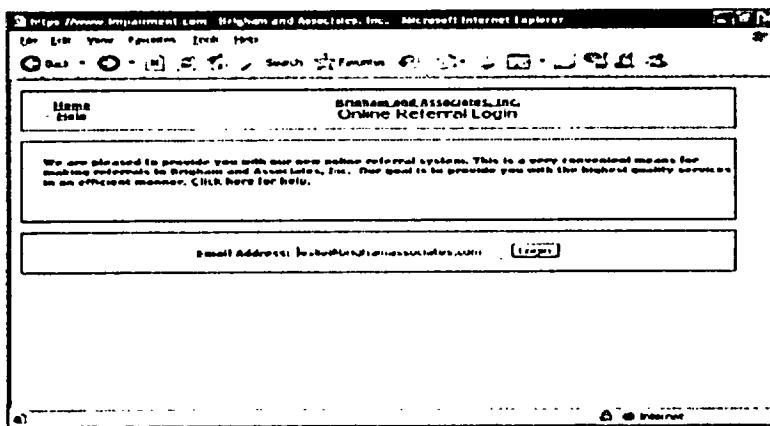
THREE OPTIONS FOR REFERRAL

I. Access our website on-line at www.impairment.com

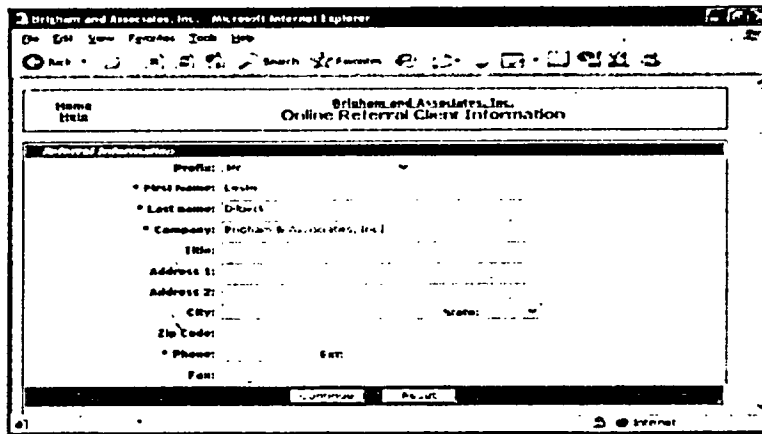
a. Click Here for Referral Button.



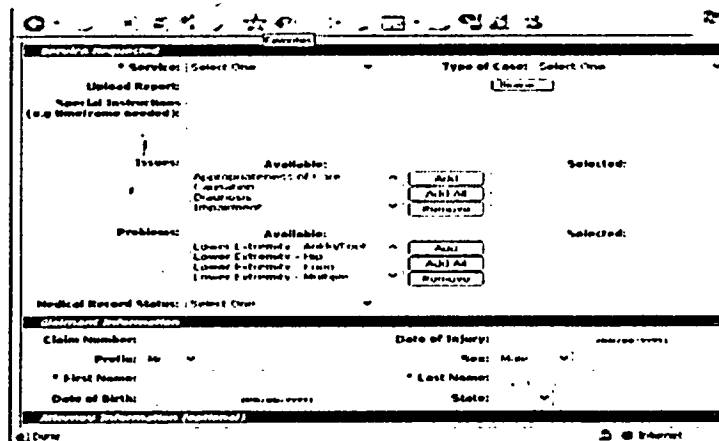
b. Enter email address in space provided.



c. Enter demographic information. This is done only the first time a client makes a referral. The system will capture this information for future referrals.



d. Enter in the case referral information.



e. Confirmation of receipt of referral will follow and will be sent to your email address.

II. Fax Referral

- Fax referral sheet to 1-207-874-9896
- Confirmation of referral will follow and will be sent via fax if an email address is not available.

III. Mail Referral

- Send referral with cover letter stating what service you would like us to provide, what specific questions you would like answered and deadline date, if any. Mailing address: Brigham & Associates, Inc. 59 Baxter Blvd. Portland, ME 04104-1200

All cases will require some level of document review. Those can be sent to our office via mail, fax, and email or downloaded at the time of electronic referral. Generally our turn-around time is 5-10 business days dependant on the service requested and complexity of the case.

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November 21, 2005

***** , ** *****

RE: Individual: Stacie Examinee
File number: *****

Dear Mr. Client:

Thank you for providing us with the opportunity to assess impairment according to the AMA *Guides to the Evaluation of Permanent Impairment*, Fifth Edition. Based on the information provided, there is 0% whole person permanent impairment. Ms. Examinee did sustain significant injuries at the time of her fall on February 24, 2003, including a head injury, a fracture of her wrist, and a right knee injury. She received care that was appropriate, and as a result of this care had from an objective perspective an excellent outcome. She is fortunate in having no permanent impairment as a result of that injury.

MEDICAL REVIEW

The extensive medical documentation you provided was carefully reviewed. It is our understanding that this material was a copy of documents and will be purged from our files. We have made and retain an electronic image of this material. The history is presented in the medical records provided.

A March 3, 2003 neurological examination by Jeffrey T. Examiner, M.D. provides a history of the February 24, 2003 injury:

I had the privilege of seeing Ms. Examinee, a 52 year old, white, married, right-handed woman in the office today in the company of her daughter, Dana, for complaints related to a fall down a flight of stairs one week ago on February 24th. Ms. Examinee states that they had just returned for dinner and she was descending flight of stairs in a stairwell that apparently had no handrail or banister and on the second step, she lost her balance and pitched forward. She states that she struck the left side of her head against the wall or a beam and fell the rest of the flight of stairs. She does not remember the rest of the fall. Her daughter, Dana, states that she was summoned by her sister who lives behind her mother and arrived within a few minutes and that Ms. Examinee had loss of consciousness with staring and unresponsiveness lasting perhaps up to five minutes. She was taken to North Shore University Hospital where she was found to have fractured her right wrist, which was placed in a cast. A left frontal extra-calvarial hematoma was noted both clinically and on a CAT scan. She was hospitalized overnight and then discharged the following day. Since the injury, she has noted intermittent room-spinning dizziness with change in head position particularly turning her head or rolling to the right. This will last up to two minutes, it is associated with some mild nausea but no vomiting. She denies hearing loss or tinnitus. She has had some mild headache but her chief pain is in the right wrist. She was using some Percocet but states that she only received a limited quantity and has no analgesic medication left. There

are no memory, visual, speech or other neurological disturbances. There is no prior or subsequent history of head trauma. Because of the dizziness and room spinning, she returned to the North Shore University Hospital emergency room on March 1st and a repeat CT scan of the brain was essentially unremarkable except for left frontal soft tissue swelling. Ms. Examinee was given sonic Antivert, which she thinks made her drowsy and she discontinued this. She takes Paxil 40 mg per day, Synthroid, 0.2 mg per day and trazadone at bedtime for sleep. There is no history of high blood pressure or diabetes but she was hospitalized perhaps 2 ½ years ago for renal failure due to retroperitoneal fibrosis for which she subsequently underwent surgery at Columbia. At the same time, she apparently had her gall bladder removed. In December of 2001, she had a gastric bypass for morbid obesity and has had considerable weight loss. She has otherwise been hospitalized for a T&A, the birth of her two daughters and the c-section birth of her third child, a son, 13 years ago. She states that she apparently had some numbness and tingling in the left leg and saw us at that time. She smokes one pack of cigarettes per day. She does not abuse alcohol, drugs or caffeine.

An April 1, 2003 brain MRI is essentially normal:

No evidence of intracranial hemorrhage or mass lesions.
Minimal paranasal sinus inflammatory changes, as described above.

A June 24, 2003 neurological examination by Dr. Examiner finds a symptomatology of positional vertigo:

Her examination today remains completely unremarkable except for, again, a positive Hallpike-Dix maneuver with the right ear down which after a several second delay, produces counter clockwise rotatory nystagmus lasting, after a delay of a few seconds, perhaps five to ten seconds. This rapidly fatigued. There were no other neurological findings. Her blood pressure was 136/78 in the left arm while seated.

On April 1, 2003 patient was examined by Baruch Examiner II, M.D. for knee and wrist injuries sustained in the February 24, 2003 fall:

PHYSICAL EXAMINATION: On physical examination today, the patient is a well-developed adult female who stands 5 feet 6 inches and weighs 190 pounds. The right short arm cast is removed. There is tenderness and edema over the distal radius. Digital motion is full. Wrist motion is flexion 20 degrees and extension 20 degrees.

Examination of the right knee revealed tenderness over the medial joint line. Knee motion is 0-115 degrees.

RADIOGRAPHS: X-rays of the right wrist shows a nondisplaced distal radius fracture which is healed about 90 percent. The alignment is acceptable.

X-rays of the right knee are normal.

The most recent orthopedic examination is dated February 22, 2005 by Robert J. Examiner III, M.D. This is a thoughtful examination resulting in the conclusions of:

DIAGNOSIS:

Excellent result post healed nondisplaced fracture of the right distal radius treated in a short arm cast for five weeks.

Right knee strain resolved.

DISCUSSION: The only abnormality I can detect at today's orthopedic examination is very mild soft tissue swelling just proximal to the ulnar head, or approximately 3/8" proximal to the radiocarpal joint. Here the tape measurements are 7 1/8" right and 6 7/8" left, indicating 1/4" of soft tissue swelling. There is no underlying bone hypertrophy. There is no swelling at the radiocarpal joint, and there is no forearm atrophy. There is no hand atrophy. There are no symptoms and there are no findings to suggest a right wrist neuropathy, and both wrists have identical excellent ranges of motion.

The examination of the right wrist at that time revealed no ratable impairment:

RIGHT & LEFT WRIST: Examination of both wrists reveals that there is no angular or rotary deformity to the claimant's right wrist when compared to the left. Both wrists have the same excellent dorsiflexion and palmarflexion to 80 degrees. Each wrist has the same radial deviation to 25 degrees, and ulnar deviation to 35 degrees. Each wrist has the same supination to 85 degrees, and the same normal pronation to 80 degrees. The right distal ulna is stable, and there is no distal radio-ulnar crepitation. There is no evidence of reflex sympathetic dystrophy, and perspiration and sensation in the digits are intact. The Phalen and Tinel tests were negative for compressive median and ulnar neuropathy. There is mild soft tissue swelling just proximal to the right wrist at the base of the ulnar head, and this soft tissue swelling measures 7 1/2" right and 6 7/8" left. There is no wrist swelling at the level of the radial styloid where the wrist circumferences were 6 1/4" right and left. There is no hand atrophy as the thenar hypothenar tape measurements were 7 1/4" right and left. There is no forearm atrophy as the maximum forearm circumferences were 10 1/4" right and 10" left.

Dr. Examiner III's examination of Ms. Examinee's right knee is also essentially normal:

RIGHT KNEE: The examination of the claimant's right knee reveals no angular or rotary deformity nor is there atrophy or dystrophy. There is no intra-articular effusion and no capsular or other soft tissue swelling. There is no increased heat to the knee. The claimant's knee has a range of motion from full extension to 140 degrees of flexion. The right patella tracks without patellofemoral crepitation in the supine and weightbearing positions. The patellar apprehension signs are negative. There is no patellar malalignment. The claimant's medial and lateral collateral ligaments are intact (stability with valgus and varus stress). The claimant's anterior posterior stability of the knee is also intact (anterior and posterior cruciate). The claimant has a negative Lachman maneuver. The meniscal signs for posterior horn tears of the menisci are negative. There is no localizing joint line tenderness nor is there tenderness over the tibial tubercle. The distal quadriceps measurements were 18" right and left.

As a result of the February 22, 2005 examination, Dr. Examiner III presents the following diagnoses:

Excellent result post healed nondisplaced fracture of the right distal radius treated in a short arm cast for five weeks.
Right knee strain resolved.

It is probable that Ms. Examinee has achieved maximum medical improvement (MMI), e.g. is permanent and stationary. MMI is defined as the date after which further recovery and restoration of function can no longer be anticipated, based upon a reasonable degree of medical probability.

PERMANENT IMPAIRMENT ANALYSIS

Permanent impairment evaluation was performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment*, Fifth Edition. Adequate information is provided in the medical records to analyze this case and provides the needed data for the rating criteria in the Fifth Edition.¹ The *Guides* state, "if the clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria".² It is not necessary for me to directly examine Ms. Examinee, since she has been seen by other physicians who have provided in their reports the information needed for comparison to criteria in the *Guides*.

Right Knee Impairment

There is no impairment warranted for Ms. Examinee's right knee based upon Dr. Examiner III's examination findings of February 22, 2005 as will be explained:

Right knee examination reveals that the patella tracked smoothly in the supine and weightbearing positions, and the ligaments are intact. There is no distal quadriceps atrophy, and there is no evidence of a meniscal tear. The prognosis, therefore is excellent, and the claimant does not have a disability from any of her usual activities.

The process of assessing lower extremity permanent impairment is described in Chapter 17 Lower Extremities (5th ed., 523-564) and has been reviewed by me in the July 2001 issue of the *Guides* Newsletter (<http://www.brighamassociates.com/articles/newsletter/5-le-overview-07-00.pdf>). Thirteen methods can be used to assess the lower extremities. The *Guides* state: "Typically, only one method will adequately characterize the impairment and its impact on the ability to perform ADL." (5th ed., 527). A cross-usage chart (Table 17-2, 5th ed., 526) indicates which methods and resulting impairment ratings may be combined. The *Guides* states for items marked with an "X" that you "do not use these methods together for evaluating a single impairment."

The following approaches were considered:

17.2b Leg Length Discrepancy: Not applicable.

17.2c Gait Derangement: This is a stand-alone methodology and is not applicable in this case.

¹ Question and Answer. *The Guides Newsletter*, July / August 1999

² *AMA Guides to the Evaluation of Permanent Impairment*, Chapter 2.

17.2d Muscle Atrophy, 17.2e Manual Muscle Testing: No evidence of muscular abnormality, therefore not applicable.

17.2f Range of Motion, 17.2g Ankylosis: No evidence of range of motion deficit, therefore not applicable.

17.2h Arthritis: Not applicable.

17.2i Amputations: Not applicable.

17.2j Diagnosis-based Estimates: None applicable

17.2k Skin-loss: Not applicable.

17.2l Peripheral Nerve Injuries: No evidence of peripheral nerve involvement, therefore not applicable.

17.2m Causalgia and Reflex Sympathetic Dystrophy: Not applicable.

17.2n Vascular Disorders: Not applicable

Final Lower Extremity Impairment

There is no impairment warranted for patient's right knee.

Right Wrist Impairment

There is no impairment warranted for Ms. Examinee's right wrist based upon Dr. Examiner III's examination findings of February 22, 2005 as will be explained:

DISCUSSION: The only abnormality I can detect at today's orthopedic examination is very mild soft tissue swelling just proximal to the ulnar head, or approximately 3/8" proximal to the radiocarpal joint. Here the tape measurements are 7 1/8" right and 6 7/8" left, indicating 1/4" of soft tissue swelling. There is no underlying bone hypertrophy. There is no swelling at the radiocarpal joint, and there is no forearm atrophy. There is no hand atrophy. There are no symptoms and there are no findings to suggest a right wrist neuropathy, and both wrists have identical excellent ranges of motion.

In a February 22, 2005 examination, Edward M. Examiner IV, M.D. also finds full range of motion, as well as no sensory or motor deficits:

There were subjective complaints of pain with light palpation over the extensor surface of the right wrist. However, no associated joint crepitus or effusions were noted in this region. There was full range of motion of the right wrist and digits of the right hand. Tinel's sign was absent over the right wrist. No hypertrophic neuropathic changes were noted in the distal aspect of the right upper extremity. The Nylen-Bárány maneuver failed to reveal any evidence of provocative nystagmus.

The segmental motor evaluation revealed 5/5 power resistance throughout. Sensation was intact to all primary and cortical modality testing. There was no reproducible dermatomal or peripheral nerve distribution sensory loss noted. Deep tendon reflexes were normoactive throughout, with plantar flexor responses bilaterally. There were no myelopathic signs. Gait and coordination skills were within normal limits. There was no evidence of a foot drop or hip tilt.

Based upon the examinations by Dr. Examiner III and Dr. Examiner IV, Ms. Examinee has no motion deficit, no sensory deficit, and no motor deficit. There are no other upper extremity disorders reported. Therefore, there is no ratable impairment related to the right wrist.

Head Trauma Impairment

On February 22, 2005 a neurological examination was performed by Edward M. Examiner IV, M.D. with the following patient complaints and examination findings:

At present, [redacted] inues to complain of periodic headache without associated bulbar dysfunction. She docs complain of episodic lightheadedness with abrupt change in head positioning. At times she does complain of neck pain radiating to the right arm and has experienced pain in the region of her right hand and wrist with weightbearing activities.

A detailed neurologic examination was performed. Cognitive functions were intact, without evidence of aphasia or apraxia. Funduscopic examination failed to reveal any signs of raised intracranial pressure. The corneal reflex was intact. The extraocular movements were full, without evidence of nystagmus. The pupils were equal and briskly reactive to light and accommodation. Facial sensation and the muscles of facial expression were normal. Air conduction was greater than bone conduction bilaterally. The Weber test was midline. The head-tilt maneuver failed to identify any evidence of nystagmus. The palate moved upward symmetrically and the tongue protruded midline, without fasciculation.

Ms [redacted] ates experiencing multiple injuries during a slip and fall accident on 02/24/03. However, I can find no evidence of any lateralizing neurological deficits at the present time. I do not feel that any further neurological investigational studies or neurologic treatment modalities are warranted given her current physical evaluation today.

I see no reason why the claimant should not be able to perform activities of daily living and seek gainful employment activities, from a neurologic perspective, based upon her physical examination findings noted today. I find no primary neurologic disability at the present time as it relates to the injuries reportedly occurring on 02/24/03.

The consequences of a traumatic brain injury are assessed using Chapter 13, The Central and Peripheral Nervous Systems, Section 13.2 Criteria for Rating Impairment Due to Central Nervous System Disorders (5th ed., 308) and Section 13.3 Criteria for Rating Cerebral Impairments (5th ed., 309-327). The five steps are:

1. Assess disturbance in the level of consciousness or awareness. In this case there are no ratable deficits according to Tables 13-2, 13-3, and 13-4.
2. Evaluate mental status and highest integrative function, as explained in Section 13.3d Mental Status, Cognition and Highest Integrative Function (5th ed., 319-322). Table 13-5 Clinical Dementia Rating (CDR) is used to quantify deficits. The following illustrates scores of 0 to 1.0, note is that scores are also provided for 2.0 (moderate) and 3.0 (severe) on page 321

Table 13-9 Clinical Dementia Rating (CDR)

	Impairment Level and CDR Score		
	None 0	Questionable 0.5	Mild 1.0
Memory (M)	No memory loss or slight inconsistent forgetfulness	Consistent slight forgetfulness, partial restriction of events, "benign" forgetfulness	Moderate memory loss, more marked for recent events, defect interferes with everyday activities
Orientation (O)	Fully oriented	Fully oriented except for slight difficulty with time relationships	Moderate difficulty with time relationships, oriented for place at examination, may have geographic disorientation elsewhere
Judgment and Problem Solving (JPS)	Solves everyday problems and handles business and financial affairs well, judgment good in relation to past performance	Slight impairment in solving problems, situations, and differences	Moderate difficulty in handling problems, situations, and differences, social judgment usually maintained
Community Affairs (CA)	Independent function at usual levels in job, shopping, volunteer and social groups	Slight impairment in these activities	Unable to function independently at these activities, although may still be engaged in some, appears normal to casual inspection
Home and Hobbies (HH)	Life at home, hobbies, and intellectual interests well maintained	Life at home, hobbies, and intellectual interests slightly impaired	Mild but definite impairment of function at home, new difficulties acquired, more complicated hobbies and interests abandoned
Personal Care (PC)	Fully capable of self-care	Fully capable of self-care	Needs prompting

According to clinical assessments, the examinee's clinical dementia rating is 0. She does not have significant memory loss especially recent events, is oriented to time and place. She has no significant difficulty handling problems, does function at some simple home chores, and handles personal care. According to Table 13-6 Criteria for Rating Impairment Related to Mental Status (5th ed., 320), a CDR of 0 imparts 0% whole person impairment.

Table 13-6 Criteria for Rating Impairment Related to Mental Status

Class 1 0%-14% Impairment of the Whole Person	Class 2 15%-29% Impairment of the Whole Person	Class 3 30%-49% Impairment of the Whole Person	Class 4 50%-70% Impairment of the Whole Person
Paranormal disorder with pre-impairment event, but is able to perform activities of daily living CDR = 0.5	Impairment requires direction of some activities of daily living CDR = 1.0	Impairment requires assistance and supervision for most activities of daily living CDR = 2.0	Unable to care for self and be safe in any situation without supervision CDR = 3.0

- Identify any difficulty with understanding and use of language. This is not applicable to this case.
- Evaluate any emotional or behavioral disturbances, such as depression, that can modify cerebral function. This process is explained in Section 13.3f Emotional or Behavioral Impairments (5th ed., 325 – 327) and is based on Table 13-8 Criteria for Rating Impairment Due to Emotional or Behavioral Disorders (5th ed., 325). Ms. Examinee does not display behavioral disorders.

Table 13-8 Criteria for Rating Impairment Due to Emotional or Behavioral Disorders

Class 1 0%-14% Impairment of the Whole Person	Class 2 15%-29% Impairment of the Whole Person	Class 3 30%-49% Impairment of the Whole Person	Class 4 70%-90% Impairment of the Whole Person
Mild limitation of activities of daily living and daily social and interpersonal functioning	Moderate limitation of some activities of daily living and some daily social and interpersonal functioning	Severe limitation in performing most activities of daily living, impeding useful action in most daily social and interpersonal functioning	Severe limitation of all daily activities, requiring total dependence on another person

- Identify the most severe cerebral impairment listed above, and combine with any or multiple neurologic impairments listed in Table 13-1 (5th ed., 308) using the Combined Values Chart (5th ed., 604-606).

**Table 13-1 Neurologic Impairments That Are Combined
With the Most Severe Cerebral Impairment**

Cranial nerve impairments
Station, gait, and movement disorders
Extremity disorders related to central impairment
Spinal cord impairments
Chronic pain
Peripheral nerve, motor, and sensory impairments
These are central nervous system or peripheral nervous system impairments, and all are combined when appropriate with the most severe cerebral impairment (see Tables 13-2 through 13-4, Tables 13-6 through 13-8, and the Combined Values Chart, p. 604).

There are no impairments in this case that are reflected in Table 13-1.

Based upon review of the medical records and evaluation of cerebral impairment criteria outlined in the *Guides*, as explained above, there is no basis for neurological impairment.

FINAL PERMANENT IMPAIRMENT

As explained in the above sections, there is no ratable impairment for the right wrist, right knee, or the head trauma. It is fortunate that Ms. Examinee from an objective perspective had an excellent outcome.

QUALIFICATIONS

Christopher R. Brigham, MD is Board-Certified in Occupational Medicine (ABPM), Founding Director of the American Board of Independent Medical Examiners (ABIME), a Certified Independent Medical Examiner (CIME), a Fellow of the American Academy of Disability Evaluating Physicians (FAADEP), a Fellow of the American College of Occupational Environmental Medicine (FACOEM), and a Master Fellow of the Academy of Independent Medical Examiners of Hawaii (AIMEHI). He serves as the Editor of The Guides Newsletter (the American Medical Association publication on the use of the AMA Guides to the Evaluation of Permanent Impairment), Primary Editor of The Guides Casebook (the companion AMA textbook to the Guides for both the Fourth and Fifth Editions), co-author of the text *Understanding the AMA Guides in Workers Compensation*, has authored over one hundred articles on impairment and disability evaluation and two other texts, has trained thousands of physicians throughout the US, Canada and Australia on how to use the AMA Guides, and has consulted for several organizations (including governmental jurisdictions) on the AMA Guides. Dr. Brigham is an internationally recognized expert on impairment and disability assessment, and Chaired the Medical Advisory Board for the text *the Medical Disability Advisor*. He is on the Attending Staff in the Department of Medicine at the Maine Medical Center. Dr. Brigham is licensed to practice medicine in Maine and Hawaii. His curriculum vitae is available at <http://www.impairment.com/chrisbrigham.htm>.

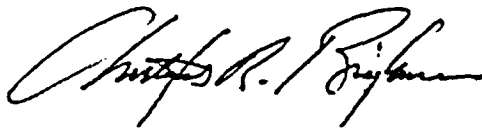
DISCLOSURE STATEMENT

The above analysis is based upon the available information provided by the requesting party at this time; it is assumed that the information provided is correct. If more information becomes available at a later date, an additional report may be requested; such information may or may not change the

opinions rendered in this report. The opinions are based on reasonable degree of medical certainty, i.e. more likely than not. Medicine is both an art and a science, and although an individual may appear to be fit for functional activity, there is no guarantee that the person will not be reinjured or suffer additional injury. Comments expressed in this report are professional opinions based upon the specifics of the case and documentation reviewed; they should not be generalized, nor necessarily be considered supportive or critical of the involved providers or disciplines. Any recommendations offered are provided as guidance and not as medical orders. The opinions expressed in this report do not constitute a recommendation that specific claims or administrative action be made or enforced. This report reflects solely the information reviewed and an independent professional opinion.

I declare under penalty of perjury that the information contained in this report and its attachments is true and correct, to the best of my knowledge and belief, except as to information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted in this report, that I believe to be true. I further declare under penalty of perjury that to the best of my knowledge and belief, the contents of this report and bill are true and correct.

Sincerely,



Christopher Brigham, MD, MMS, FAADEP, FACOEM, CIME
President, Brigham and Associates, Inc.

CRB/CAL:nd