INSIDER'S SECRETS TO AN ACCURATE PERMANENT IMPAIRMENT RATING

Presented by EZ QME CONTINUING EDUCATION

w/ SPECIAL GUEST, CHRIS BRIGHAM, MD

Editor, AMA *Guides Newsletter*

SPRING/SUMMER ZOOMINAR SERIES

DATE	
05/16/23	Steven Feinberg M.D. QME = “Almaraz – Guzman – Alternative Impairment Ratings and Substantial Medical Evidence”
06/14/23	Chris Brigham M.D. – “Accurate Permanent Impairment Ratings”
07/12/23	Glenn Olsen Defense Attorney – “CCR 35.5 How to Answer the Call of the Question
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10/03/23	James Musick D.C. QME – “Begin with the Basics”

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CHRIS BRIGHAM M.D.

- Senior Contributing Editor, *AMA Guides*, Sixth Edition
- Editor-in-Chief, *Guides Newsletter*, and *AMA Guides Casebook*
- Author of *Excellent IME Report*, *Comprehensive IME Systems*, *Living Abled*, and over 300 publications
- Board-certified, Occupational Medicine
- Fellow, American College of Occupational and Environmental Medicine
- Fellow, International Academy of Independent Medical Evaluators
- Involved with the AMA *Guides* for over three decades

HISTORY OF AMA GUIDES IN CALIFORNIA

- SB 899 (Became law 4/10/04)
- LABOR CODE 4660 - schedule shall promote consistency, uniformity, and objectivity
- IMPORTANT CASES:
- ALMARAZ: “Accuracy” – within the 4 corners of the AMA Guides
- GUZMAN: “Accuracy” – within the 4 corners of the AMA Guides
- KITE: “Accuracy” – adding versus combining Impairments

ACCURACY - LEARNING OBJECTIVES

Describe	Describe the concepts of impairment and rating.
Explain	Explain the basics of how the AMA Guides work.
Identify	Identify problems seen with these assessments and providing these services.
Discuss	Discuss best practice approaches and the most effective strategies to achieve consistent and accurate ratings.

ACCURACY – WHY IS IT IMPORTANT?

When physicians and other health care providers are knowledgeable, skilled, and experienced in assessing impairment and other medicolegal concepts:

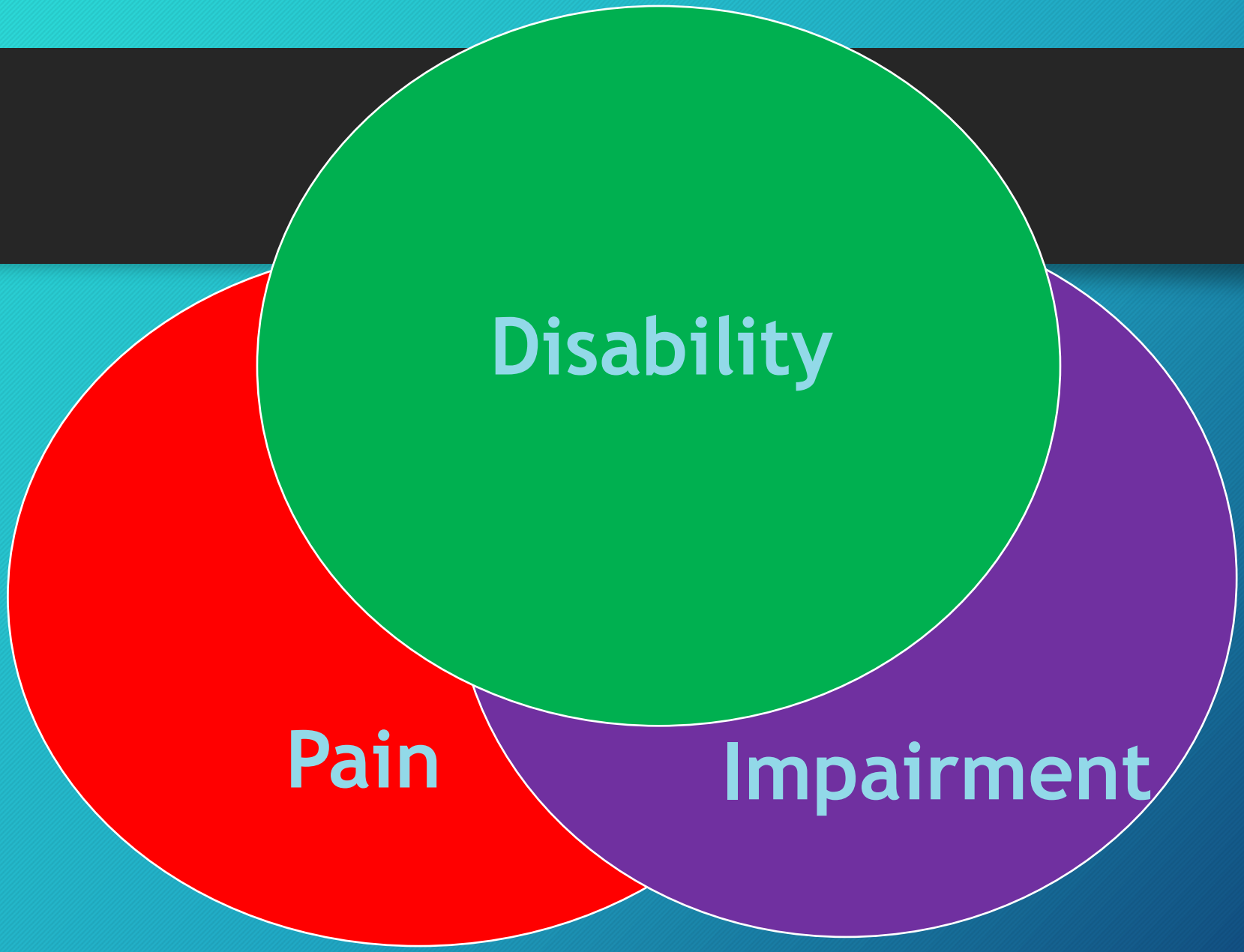
- Medicolegal findings are accurate and unbiased.
- Decisions rendered by benefit systems are accurate.
- Benefit systems function appropriately.

AGENDA

FOUNDATIONS – What do we need to know?

ERRORS TO AVOID – Are erroneous ratings and evaluations a significant issue? Why do errors occur?

BEST PRACTICES – What are the best practice approaches and most effective strategies to achieve accurate ratings?


Disability
Pain
Impairment

DEFINITIONS

- **Pain** - an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
- **Impairment** - A significant deviation, loss, or loss of use of any body structure or function in an individual with a health condition, disorder, or disease.
- **Disability** - An umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease.

WHAT IS AN IMPAIRMENT?

Impairment reflects a failure

- a failure to prevent an injury
- a failure in to assess the condition as work-related when it is not
- a failure in mitigating the impact of an injury – i.e., not achieving restoration of function

Goal of all stakeholders should be an accurate, unbiased assessment of impairment via efficient means

Impairment is not about the treatment the claimant had, but the end result

Impairment rating is an important issue with many workers' compensation, personal injury, and motor vehicle claims.

HOW DO THE GUIDES WORK?

- AMA *Guides to the Evaluation of Permanent Impairment* define a structured approach for calculating impairment
- It is an objective approach, not a subjective approach
  - Two evaluators (unbiased and trained) should reach similar conclusions.
  - Used properly, ratings can be consistent and reliable

CRITICISMS OF THE AMA GUIDES

Fail to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system.

Impairment ratings do not adequately or accurately reflect loss of function.

Numerical ratings were more representative of legal fiction than medical reality.

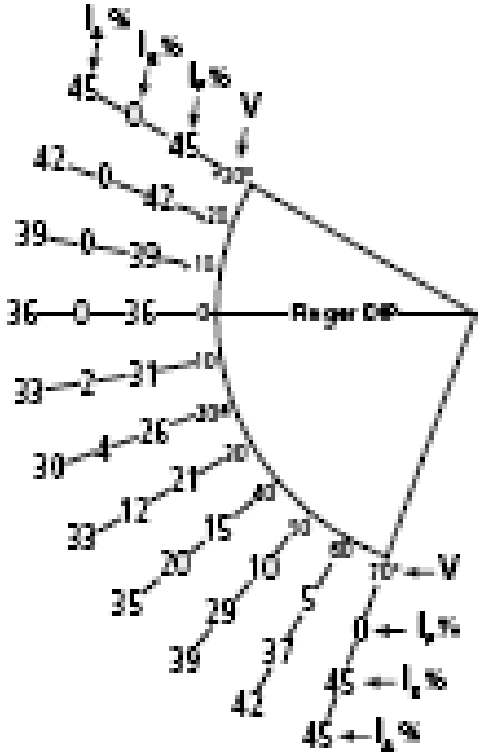
Medicine (Science) Evolves, so does Impairment and Functional Evaluation

Previous Criticisms

- Failure to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system.
- Impairment ratings do not adequately or accurately reflect loss of function.
- Numerical ratings were more representative of legal fiction than medical reality.

Figure 16-21 Finger Impairments Due to Abnormal Motion at the DIP Joint

Relative value of functional unit is 45%, of the finger. Ankylosis in function position (20° flexion) receives lowest I_A% (20%).



I_A% = Impairment due to ankylosis
I_E% = Impairment due to loss of extension
I_F% = Impairment due to loss of flexion
V = Measured angles of motion
* = Position of function

Adapted from Swanson AB, Hagert CG, de Groot Swanson G. Evaluation of impairment of hand function. In: Hunter JM, Schneider LH, Mackin EJ, Callahan A, eds. Rehabilitation of the Hand. St Louis, Mo: CV Mosby Co; 1978:555–69.

Table 16-10 Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting From Peripheral Nerve Disorders

a. Classification

Grade	Description of Sensory Deficit or Pain	% Sensory Deficit
5	No loss of sensibility, abnormal sensation, or pain	0
4	Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity	1–25
3	Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with some abnormal sensations or slight pain, that interferes with some activities	26–60
2	Decreased superficial cutaneous pain and tactile sensibility (decreased protective sensibility), with abnormal sensations or moderate pain, that may prevent some activities	61–80
1	Deep cutaneous pain sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity	81–99
0	Absent sensibility, abnormal sensations, or severe pain that prevents all activity	100

b. Procedure

1. Identify the area of involvement using the cutaneous innervation chart (Figure 16-46) or the dermatome chart (Figure 16-49).
2. Identify the nerve structure(s) that innervate the area(s) (Table 16-12 and Figures 16-48, 16-49, and 16-50).
3. Grade the severity of the sensory deficit or pain according to the classification given above (a). Use clinical judgment to select the appropriate percentage from the range of values shown for each severity grade.
4. Find the maximum upper extremity impairment value due to sensory deficit or pain for each nerve structure involved: spinal nerves (Table 16-13), brachial plexus (Table 16-14), and major peripheral nerves (Table 16-15).
5. Multiply the severity of the sensory deficit by the maximum upper extremity impairment value to obtain the upper extremity impairment for each nerve structure involved.

Figure 16-1a Upper Extremity Impairment Evaluation Record—Part 1 (Hand)

Side ☐R ☐L

Name_____ Age____ Sex ☐M ☐F Dominant hand ☐R ☐L Date_____

Occupation_____ Diagnosis_____

			Abnormal Motion: Record motion or ankylosis angles and digit impairment %				Amputation: Mark level & impairment %	Sensory Loss: Mark type, level, & impairment %	Other Disorders: List type & impairment %	Hand Impairment %: •Combine digit imp % •Convert to hand imp %
			Flexion	Extension	Ankylosis	Imp %				
Thumb	IP	Angle*								
		Imp %								
	MP	Angle*								
		Imp %								
				Motion	Ankylosis	Imp %				
	CMC	Radial abduction	Angle*							Abnormal motion [1]
			Imp %							Amputation [2]
		Adduction	Cm							Sensory loss [3]
			Imp %							Other disorders [4]
		Opposition	Cm							Total digit imp % •Combine 1, 2, 3, 4
			Imp %							
Add digit impairment % CMC + MP + IP =						[1]	Digit IMP % = [2] 4UE IMP % = [5]	Digit IMP % = [3]	Digit IMP % = [6]	Hand impairment % •Convert above
			Flexion	Extension	Ankylosis	Imp %				
Index	DIP	Angle*								Abnormal motion [1]
		Imp %								Amputation [2]
	PIP	Angle*								Sensory loss [3]
		Imp %								Other disorders [4]
	MP	Angle*								Total digit imp % •Combine 1, 2, 3, 4
		Imp %								
•Combine digit impairment % MP, PIP, DIP =						[1]	Digit IMP % = [2]	Digit IMP % = [3]	Digit IMP % = [6]	Hand impairment % •Convert above
Middle	DIP	Angle*								Abnormal motion [1]
		Imp %								Amputation [2]
	PIP	Angle*								Sensory loss [3]
		Imp %								Other disorders [4]
	MP	Angle*								Total digit imp % •Combine 1, 2, 3, 4
		Imp %								
•Combine digit impairment % MP, PIP, DIP =						[1]	Digit IMP % = [2]	Digit IMP % = [3]	Digit IMP % = [6]	Hand impairment % •Convert above
Ring	DIP	Angle*								Abnormal motion [1]
		Imp %								Amputation [2]
	PIP	Angle*								Sensory loss [3]
		Imp %								Other disorders [4]
	MP	Angle*								Total digit imp % •Combine 1, 2, 3, 4
		Imp %								
•Combine digit impairment % MP, PIP, DIP =						[1]	Digit IMP % = [2]	Digit IMP % = [3]	Digit IMP % = [6]	Hand impairment % •Convert above
Little	DIP	Angle*								Abnormal motion [1]
		Imp %								Amputation [2]
	PIP	Angle*								Sensory loss [3]
		Imp %								Other disorders [4]
	MP	Angle*								Total digit imp % •Combine 1, 2, 3, 4
		Imp %								
•Combine digit impairment % MP, PIP, DIP =						[1]	Digit IMP % = [2]	Digit IMP % = [3]	Digit IMP % = [6]	Hand impairment % •Convert above

Total hand impairment: Add hand impairment % for thumb + index + middle + ring + little finger =	%
Convert total hand impairment to upper extremity impairment* (if thumb-metacarpal intact, enter on Part 2, line E) =	%
Add thumb ray upper extremity amputation imp [5] ____% + hand upper extremity imp ____% =	%
If hand region impairment is only impairment, convert upper extremity impairment to whole person impairment† =	%

* Combined Values Chart (p. 604) †Use Table 16-1 (digits to hand). ‡Use Table 16-2 (hand to upper extremity). §Use Table 16-3.

Analogy – Impairment Rating and Taxes

Complex process - Individuals can provide data (which may or may not be accurate)

Rating experts, using that data, are more able to calculate the result.

IRS Commissioner: 'I Find the Tax Code Complex, So I Use a Preparer'

Tuesday, January 12, 2010

By Nicholas Ballasy, Video Reporter

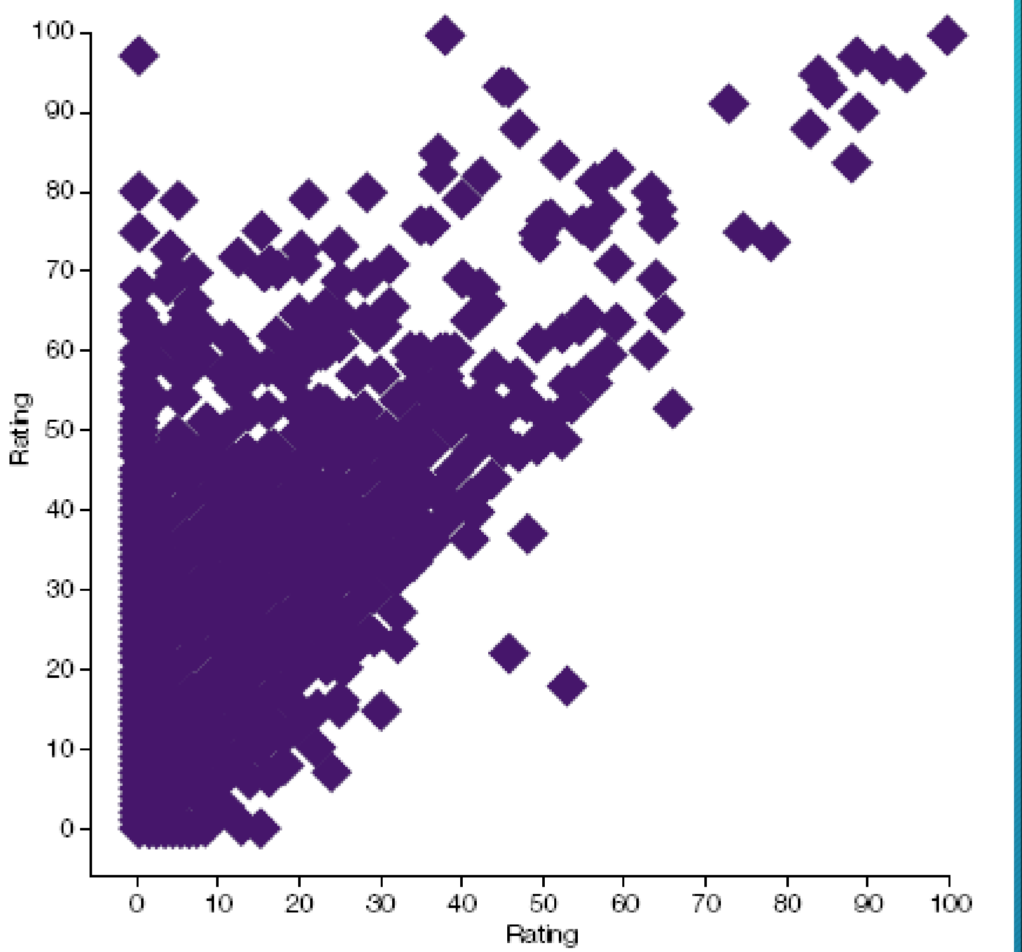
(CNSNews.com) -- The commissioner of the Internal Revenue Service, Douglas Shulman, told C-SPAN on Sunday that he uses a tax preparer to do his federal income tax return because he finds the tax code too complex to handle the job himself.

IRS income tax forms.(AP file photo)

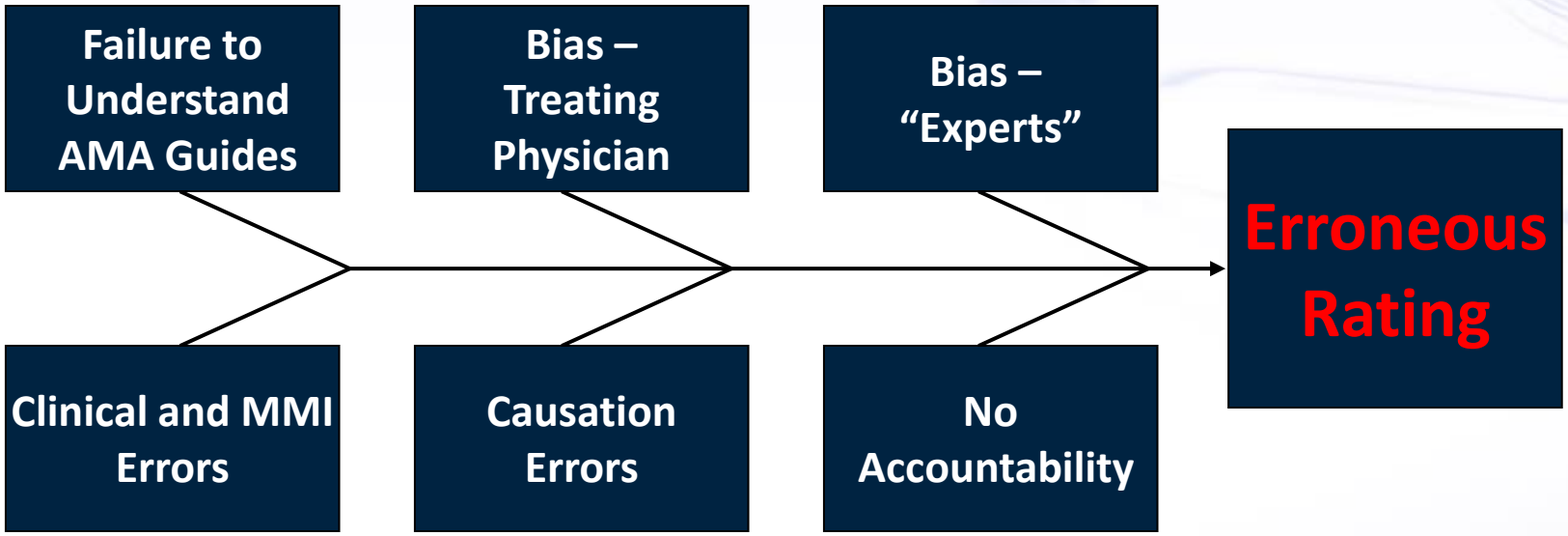
"I use a preparer," Shulman told C-SPAN anchor Steve Scully on the network's *Newsmakers* program. "I've used one for years. I find it convenient. I find the tax code complex, so I use a preparer."

Erroneous Ratings - Most impairment ratings are erroneous, more often inflated, and sometimes lower.

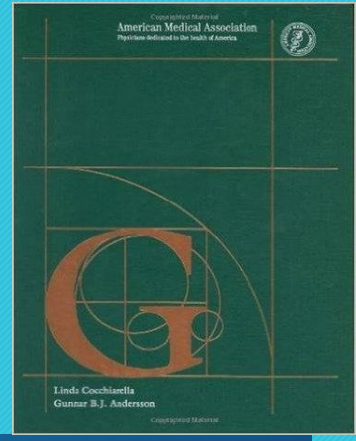
Figure 1. Comparison of Average Original Rating With Average Revised Rating



Causes of Erroneous Impairment Ratings

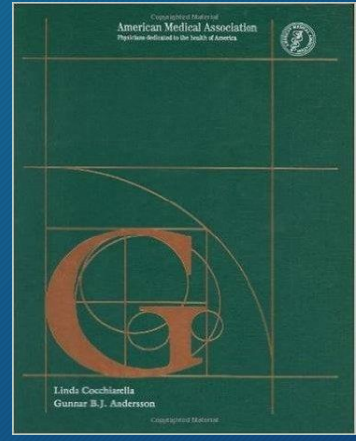


5TH Edition - Flawed Spinal Approaches



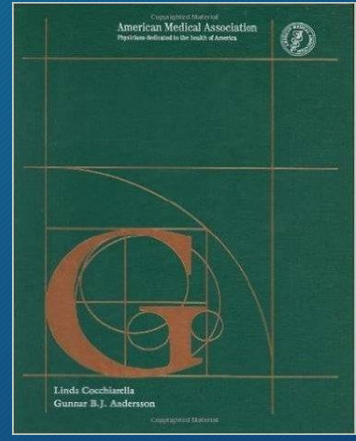
- Range-of-motion findings do not correlate with spinal function.
- Non-specific spinal pain not ratable unless specific (unreliable) findings are present.
- Spinal surgery designed to improve function results in *greater impairment*, e.g., cervical radiculopathy (pinched nerve in neck) results in 15% to 18% WPI and once treated with fusion, with marked improvement, impairment increased to 20% to 23% WPI.

Spine Assessment Errors (Fifth Edition)



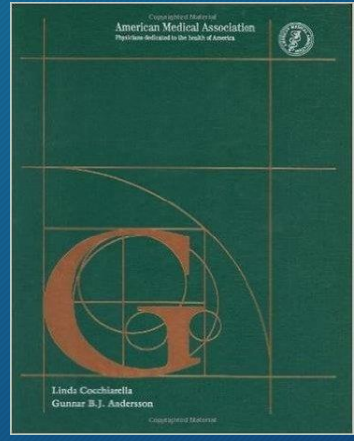
- Inadequate and unreliable clinical evaluation (including the range of motion)
- Use of wrong method (e.g., use of Range of Motion (ROM) when Diagnosis-Related Estimate (DRE) method is required.)
- With DRE, selection of the wrong Category (e.g., Class III when nonverifiable radicular complaints)
- With ROM, unreliable motion assessment

Upper Extremity Assessment Errors (Fifth Edition)



- Inadequate and unreliable clinical evaluation (including motion and strength testing)
- Using unreliable data (e.g., inconsistent with other documentation)
- Ratings based on strength loss
- Misuse of other disorders
- Ratings of CRPS

Lower Extremity Assessment Errors (Fifth Edition)



- Inadequate and unreliable clinical evaluation
- Use of the wrong method, or combining methods
- Using gait derangement to define impairment

Case Example – Ankle Injury

Facts

- 51-year-old man injured his left ankle on October 12, 2021, when he stepped into a hole, flexed, and inverted his left ankle.
- Prior history of left ankle injury in 2005 and underwent left ankle reconstruction; course complicated by “RSD.”
- As result of October 12, 2021 injury, In October 12, 2021 injury, he underwent debridement of the left peroneus brevis and longus with the transfer of the peroneus brevis to the peroneus longus tendon, followed by physical therapy
- Evaluated at February 27, 2023, determined by at MMI. Primary complaint was pain and occasional instability. McConnell:

Case Example – Ankle Injury

Diagnoses

1. Status post injuries to the left ankle
    a. September 28, 2005
    b. October 12, 2021
2. Status post repair of the anterolateral ligament of his ankle with modified Brostrom procedure, 12/29/05
3. Status post-surgical debridement and repair of peroneus longus and peroneus brevis tendon, 3/23/22
    a. Pre and post-operative diagnoses:
        i. Left peroneus brevis tendon tear
        ii. Left peroneus longus tenosynovitis
4. Complex regional pain syndrome, h/o, associated with 2005 injury, history of

Case Example – Ankle Injury

Rating

- Finally, this patient will have some degree of permanent impairment as outlined by the AMA Guidelines for the Evaluation of Permanent impairment, fifth edition. The patient's impairment rating is based upon some range of motion loss, residual ankle instability, weakness of his peroneal tendon repair, and some residual sural nerve dysesthesia.

- Based upon tables 17-11 and 17-12, this patient is assessed a 7% impairment of his lower extremity based upon loss of ankle dorsiflexion. An additional 2% impairment is assessed based upon slight loss of ankle eversion. This totals 9% impairment of the lower extremity based upon range of motion loss.

- Based upon table 17-33, this patient has residual moderate lateral ankle instability which is assessed an additional 10% impairment of the left lower extremity. Additionally, based upon table 17-8, he has an additive 5% impairment of the lower extremity based upon weakness in eversion secondary to his peroneal tendon pathology.

Case Example – Ankle Injury

Rating

- Based upon table 17-33, this patient has residual moderate lateral ankle instability which is assessed an additional 10% impairment of the left lower extremity. Additionally, based upon table 17-8, he has an additive 5% impairment of the lower extremity based upon weakness in eversion secondary to his peroneal tendon pathology.

- Finally, based upon table 17-37, he is assessed an additive 5% impairment of the left lower extremity based upon sural nerve sensory dysesthesia.

- Utilizing the combined values table, this equates to a total of 27% impairment of the left lower extremity. This is equivalent to 11% whole person impairment.

Case Example – Ankle Injury

Issues

- Rating based on findings inconsistent with other evaluators since at MMI.
- Combined approaches that cannot be rated together. He rated for motion loss, strength deficit, instability, and neurological involvement.
- Hypothetically, if there were motion deficits of the ankle and hindfoot (facts not in evidence), these values are combined at the foot level.
- Referred to the “AMA Guidelines.” The correct title is “AMA *Guides.*”

Report Example

- Goal is to enhance quality, efficiency and profitability.
- Based on a dynamic template with data elements filled as the result of an online referral.
- Record organization and summary performed offshore, producing Word document in table format (date, provider, type, summary, and page number). Hyperlinks to specific pages. File with all records OCRd and indexed (PDF Index Generator).
- Drafting by a CIR-certified physician located in Pakistan.
- Note formatting with the goal of being organized and easy for non-medical readers.
- Timeline created using Timeline Maker Pro in less than 5 minutes.
- Inclusion files added and modified as appropriate.
- Auto creation of Table of Contents and Index.

&Brigham ASSOCIATES, INC.

91 Harbour Passage, Hilton Head, SC 29926
843-548-1600
www.cbrigham.com

June 11, 2023

Client

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123
Service: Impairment Rating Critique

Dear Ms, Client:

Thank you for the opportunity to review records and evaluate permanent impairment based on the AMA *Guides to the Evaluation of Permanent Impairment*. It is unnecessary to examine Mr. Examinee directly since the clinical data is provided in the medical documents reviewed. The focus is on applying the clinical information to the processes, procedures, and criteria provided in the AMA *Guides*. All conclusions are expressed to a reasonable degree of medical certainty.

As the Editor of the *Guides Newsletter*, Editor of the *Guides Casebook*, and Senior Contributing Editor to the AMA *Guides*, Sixth Edition, responsible for the musculoskeletal chapters, I aim to provide insights resulting in an appropriate and unbiased assessment of permanent impairment. My qualifications are summarized at the end of this report and in the attached curriculum vitae.

As will be explained, as a result of the injury of October 12, 2021, Mr. Examinee has no ratable impairment per the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition, and 1% whole person permanent impairment per the Sixth Edition.

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Documents

You provided 612 pages of documents for analysis; these are reflected in the document chronology appended to this report.

Clinical Summary

Injury

In summary, this 51-year-old man injured his left ankle on October 12, 2021, when he stepped into a hole, flexed, and inverted his left ankle.

Pre-Existing Status

On 9/28/05, he had a left ankle injury resulting in an ankle sprain, Grade 2 – 3. MRI on 19/26/05 revealed marked tenosynovitis of the peroneal tendon. He received physical therapy but continued to have pain and instability problems.

On 12/29/05, he underwent left ankle reconstruction with tendon / Brostrom repair, followed by physical therapy. He developed problems consistent with complex regional pain syndrome.

On 1/5/07, he was determined to be at maximum medical improvement and provided a rating of 15% whole person impairment based on RSD findings, using Table 13.5 on page 336.

On 5/7/08, he continued to report pain, utilized an AFO, and had a mildly antalgic gait.

On 3/17/14 and 3/25/15, he was seen in follow-up for RSD, treated with daily Lyrica, and findings of minimal gait antalgia.

On 4/20/19 and 5/4/20, there is documentation of his RSD symptoms being well controlled with Lyrica.

On 5/31/21, approximately four and a half months before his October 12, 2021 evaluation, he was seen in follow-up for his RSD and reportedly was doing well with Lyrica. The only documentation on physical examination was very minimal discomfort.

History

Mr. Examinee was evaluated, and there was no evidence of acute injury or fracture. MRI on 11/30/21 revealed a **"Recent moderate lateral and medial amide sprain. Recent partial disruption of the sinus tarsi. Mild bone bruise of the fibular tip and lateral process of the talus. No acute fracture line seen. Tendinosis of the plantar aspect of the tibialis posterior tendon. Tendinosis, trace tenosynovitis, and fraying of the peroneus brevis tandem from the fibula: groove to the calcaneal tubercle."**

Brigham and Associates, Inc. June 11, 2023

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

He was involved in physical therapy; however, he had persistent problems. On 3/23/22, he underwent debridement of the left peroneus brevis and longus with the transfer of the peroneus brevis to the peroneus longus tendon. Surgery was followed by physical therapy.

On February 27, 2023, his treating physician, William Treater, MD, opined that Mr. Examinee was at maximum medical improvement and assigned a "disability rating" of "10% of the left ankle". (This would be equivalent to 3% whole person, per Table 16-10 (6th ed, 530).

Current Status

Brian Evaluator, III, MD, on April 12, 2023, reported:

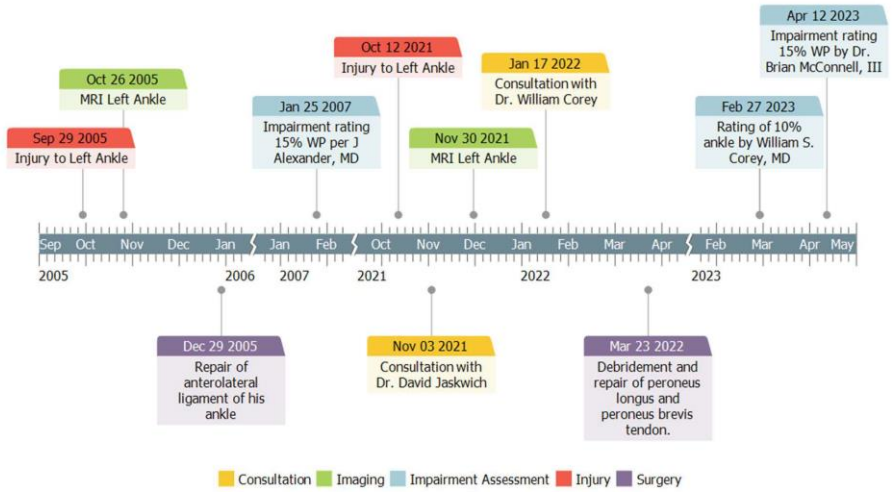
> Currently, the patient's medications include continued use of Lyrica. He is being followed by Dr. Alexander under pain management for that. He does take vitamin B6 as suggested by Dr. Treater, but he does not feel it is making much difference. He does wear his ankle lacer at work. He is not using any orthotics at present but feels he has found some good accommodative shoes which support his foot and ankle.
>
> With respect to current symptoms, his primary issue is some persistence of pain particularly along the lateral ankle and retrofibular region. He does note discomfort at night when he crosses his ankles. He still maintains a tingling "shock" sensation occasionally along the lateral aspect of his ankle and foot. The patient does note occasional mechanical catching and popping particularly when climbing up steps. He does note occasional instability particularly when walking on uneven ground, but states this has happened a few times and his ankle lacer has prevented any significant ankle re-injury.

On February 27, 2023, William Treater, MD reported:

> He states it "has it's moments." It hurts with cold rainy days. He has sensitivity with touch of the lateral ankle. He has been back delivering since October for UPS. It is better compared to prior to surgery.

Clinical Timeline

The clinical chronology is reflected in the following timeline:



Clinical Diagnoses

Based on the review of the documents provided, these diagnoses are identified:

1. Status post injuries to the left ankle
    a. September 28, 2005
    b. October 12, 2021
2. Status post repair of the anterolateral ligament of his ankle with modified Brostrom procedure, 12/29/05
3. Status post-surgical debridement and repair of peroneus longus and peroneus brevis tendon, 3/23/22
    a. Pre and post-operative diagnoses:
        i. Left peroneus brevis tendon tear
        ii. Left peroneus longus tenosynovitis

Brigham and Associates, Inc. June 11, 2023

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

4. Complex regional pain syndrome, h/o, associated with 2005 injury, chronic

These diagnoses are also noted:

5. Epicondylitis, right lateral, h/o (2008)
6. Pulmonary emboli, 2020, secondary to right-sided deep venous thrombosis
7. Hypertension

Clinical Discussion

Mr. Examinee had two injuries, the first over seventeen years ago, on September 28, 2005, and the more recent, approximately a year and a half ago, on October 12, 2022. Both were ligamentous injuries involving his left ankle and requiring surgery. After his 2005 injury and surgery on December 29, 2005, he was diagnosed with complex regional pain syndrome, a chronic issue, and treated with Lyrica.

With his recent injury, on March 23, 2022, he underwent debridement and repair of the peroneus longus and peroneus brevis tendons. Per his treating physician, William Treater, MD, he achieved maximum medical improvement on February 27, 2023. At that time, Dr. Treater documented normal motion and normal strength. He did not reference problems with instability. Mr. Examinee had a good surgical result.

The peroneus tendons are two tendons that run along the outer side of the ankle and connect the peroneus muscles to the foot. These tendons stabilize the foot and ankle during walking and running. One of the most common injuries is peroneal tendonitis, an inflammation of the tendons. Another common injury is a peroneal tendon tear, which can occur due to a sudden injury. Symptoms of a peroneal tendon tear include pain, weakness, and instability in the ankle and foot. Treatment for peroneal tendon injuries varies depending on the severity of the injury. Conservative treatments such as rest, ice, and physical therapy may be sufficient for mild cases of peroneal tendonitis. More severe cases may require immobilization, medication, or surgery to repair or replace the damaged tendons. From an objective perspective, Mr. Examinee had a good result from his treatments.

It is essential to assess the reliability of the subjective information presented. The importance of discerning between "subjective" and "objective" was discussed in the March / April 2012 issue of the *Guides Newsletter.*[1] Reports of tenderness and decreased sensation are based on the patient's subjective report; therefore, these are not objective. Patients may demonstrate less than their full capacity with a range of motion and strength evaluation. Therefore, it is

crucial to determine if such demonstrations are consistent with other documentation, including records of other doctors, health care providers, and other observations.

It is useful to contrast the physical examination findings of Brian Evaluator, III, MD, on April 12, 2023, and William Treater, MD, on February 27, 2023.

The following are physical examination findings reported by Brian Evaluator, III, MD, on April 12, 2023:

- Deformity: moderate pes planus in the left foot
- Scars
- Tenderness was reported over the anterior talofibular ligament complex as well as the fibulocalcaneal complex
- Motion deficits:
  - dorsiflexion to 10 degrees (limited)
  - plantar flexion of 40 degrees (full)
  - Inversion is greater than 30 degrees
  - eversion to 10 degrees
- Instability:
  - Moderate ankle instability to varus stress testing in plantar flexion with 1+ instability in the neutral position
- Strength:
  - Ankle eversion, 5-/5
  - Posterior tibialis strength, 3/5.
  - Plantar flexion, normal
  - Anterior tibialis, normal
- Sensory:
  - Sural nerve: some hypersensitivity on clinical palpation

Physical examination, on February 27, 2023, by William Treater, MD, who had opined that Mr. Examinee was at maximum medical improvement, revealed:

Gait and Station: Appearance: ambulating with no assistive devices.

Ankles and Feet: Inspection Right: no erythema, swelling, or deformity. Inspection Left: no erythema, swelling, or warmth. Bony Palpation of the Ankle/Foot Right: no tenderness of the ankle, the metatarsals, or the tarsometatarsal joints. Bony Palpation of the Ankle/Foot Left: no tenderness of the metatarsals or the tarsometatarsal joints and **tenderness of the lateral ankle**. Soft Tissue Palpation of the Ankle/Foot Right: no tenderness of the tibialis posterior, the tibialis anterior, or the achilles tendon. Soft Tissue Palpation of the Ankle/Foot Left: no tenderness of the achilles tendon and **tenderness of the peroneus longus and brevis**. Active Range of Motion Right: dorsiflexion normal and plantar flexion normal. Active Range of Motion Left: dorsiflexion normal and plantar flexion normal. Strength Right: tibialis anterior (5/5) and gastrocnemius (5/5). Strength Left: peroneus longus (5/5) and brevis (5/5) and tibialis anterior (5/5) and gastrocnemius (5/5).

Neurological System: Sensation on the Right: normal distal extremities. Sensation on the Left: **tactile dysesthesia/hyperesthesia distal extremities.**

Skin: Right Lower Extremity: normal. Left Lower Extremity: normal.

The findings reported by Dr. Treater, his treating physician, are compared with those reported by Dr. Evaluator:

1. **Deformity:** No deformity was reported by Dr. Treater.
2. **Motion deficits:** Dr. Treater reported normal motion; this is inconsistent with what Dr. Evaluator reported.
3. **Instability:** Dr. Treater did not document problems win instability; this is inconsistent with what Dr. Evaluator reported.
4. **Strength:** Dr. Treater reported normal strength; this is inconsistent with what Dr. Evaluator reported.
5. **Sensory:** Dr. Treater reported "tactile dysesthesia/hyperesthesia lower extremities," a finding that has been a chronic issue consistent with the diagnosis of complex regional pain syndrome before the October 12, 2021 injury. (There is no documentation of specific involvement of the sural nerve.)

There were reports in the past of limited motion; however, Dr. Treater documented normal motion at maximum medical improvement. There is no documentation by other examiners or by imaging of instability after surgical repair. There is no documentation by any examiner of

posterior tibialis strength of 3/5, which is consistent with movement only against gravity. Dr. Treater documented normal strength.

Causation Analysis

Causation analysis must be based on facts and scientific evidence. The AMA *Guides* series of publications (*Guides to the Evaluation of Disease and Injury Causation)* provide guidance on causation and apportionment analysis.[2] This publication guides understanding work-relatedness, methodology, causality examination, and chapters dealing with specific regions.

The October 12, 2021, injury aggravated the ligamentous consequences of the September 29, 2005, injury.

Maximum Medical Improvement

On February 27, 2023, William Treater, MD, opined that Mr. Examinee was at maximum medical improvement. I agree.

Impairment Assessment

Permanent impairment is evaluated based on the facts provided and the processes defined in the AMA Guides to the Evaluation of Permanent Impairment.

Bright Evaluator MD, on April 13, 2023, provided the following impairment assessment:

> Finally, this patient will have some degree of permanent impairment as outlined by the AMA Guidelines for the Evaluation of Permanent impairment, fifth edition. The patient's impairment rating is based upon some range of motion loss, residual ankle instability, weakness of his peroneal tendon repair, and some residual sural nerve dysesthesia.
>
> Based upon tables 17-11 and 17-12, this patient is assessed a 7% impairment of his lower extremity based upon loss of ankle dorsiflexion. An additional 2% impairment is assessed based upon slight loss of ankle eversion. This totals 9% impairment of the lower extremity based upon range of motion loss.
>
> Based upon table 17-33, this patient has residual moderate lateral ankle instability which is assessed an additional 10% impairment of the left lower extremity. Additionally, based upon

> table 17-8, he has an additive 5% impairment of the lower extremity based upon weakness in eversion secondary to his peroneal tendon pathology.
>
> Finally, based upon table 17-37, he is assessed an additive 5% impairment of the left lower extremity based upon sural nerve sensory dysesthesia.
>
> Utilizing the combined values table, this equates to a total of 27% impairment of the left lower extremity. This is equivalent to 11% whole person impairment.

Based on the facts provided and the processes defined in the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition, I respectfully disagree with the assessment provided by Dr. Evaluator.

There are opportunities for improvement in his evaluation and report. It does not fully comply with the best practice standards for independent medical evaluations, as published by the American Medical Association in the *Guides Newsletter* in September – October 2017. Training on the performance of independent medical and impairment evaluations is not a component of traditional training.

The following is my constructive feedback:

- The rating was based on inconsistent findings. As discussed above, Dr. Treater documented normal motion and strength. There is no documentation of instability. In Section 2.5c, Consistency, the *AMA Guides* require that findings be consistent:

  > Consistency tests are designed to ensure reproducibility and greater accuracy...The physician must utilize the entire range of clinical skills and judgment when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If in spite of any observation or test result the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing. (5th ed., 19)

- He combined approaches that cannot be rated together. He rated for motion loss, strength deficit, instability, and neurological involvement. A cross-usage chart (Table 17-2, 5th ed., 526) indicates which methods and resulting impairment ratings may be combined. In the footnote to Table 17-2 (5th ed., 526), *Guides* states,

> ...for items marked with an "X" that you "do not use these methods together for evaluating a single impairment.

Table 17-2 Guide to the Appropriate Combination of Evaluation Methods

Open boxes indicate impairment ratings derived from these methods can be combined.

	Limb Length Discrepancy	Gait Derangement	Muscle Atrophy	Muscle Strength	ROM Ankylosis	Arthritis (DJD)	Amputation	Diagnosis-Based Estimates (DBE)	Skin Loss	Peripheral Nerve Injury	Complex Regional Pain Syndrome (CRPS)	Vascular
Limb Length Discrepancy		X					X					
Gait Derangement	X		X	X	X	X	X	X	X	X	X	X
Muscle Atrophy		X		X	X	X	X	X		X	X	
Muscle Strength		X	X		X	X		X		X	0	
ROM Ankylosis		X	X	X		X		X			0	
Arthritis (DJD)		X	X	X	X							
Amputation	X	X	X	X								
Diagnosis-Based Estimates (DBE)		X	X	X	X							
Skin Loss		X										
Peripheral Nerve Injury		X	X	X							X	
Complex Regional Pain Syndrome (CRPS)		X	X	0	0					X		X
Vascular		X									X	

X = Do not use these methods together for evaluating a single impairment.
0 = See specific instructions for CRPS of the lower extremity.

The methods he used cannot be combined.

- Hypothetically, if there were motion deficits of the ankle and hindfoot (facts not in evidence), these values are combined at the foot level.

- He referred to the "AMA Guidelines." The correct title is "AMA *Guides.*" Although this appears to be a minor point, based on my review of several thousands of impairment evaluations, misnaming is commonly seen with physicians who have not been formally trained in impairment assessment.

Therefore, his rating is inconsistent with the processes we defined in the AMA *Guides* and cannot serve as a valid and reliable assessment of impairment.

Based on the information documented, I provide my ratings for the Fifth Edition and Sixth Editions.

Brigham and Associates, Inc. June 11, 2023

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

Fifth Edition

The process of assessing lower extremity permanent impairment is described in Chapter 17, Lower Extremities (5th ed., 523-564). Thirteen methods can be used to assess the lower extremities. The *Guides* states,

> Typically, only one method will adequately characterize the impairment and its impact on the ability to perform ADL" (5th ed., 527).

The following approaches were considered:

17.2b Leg Length Discrepancy: Not applicable. This approach is rarely used to assess impairment unless there is documented significant leg shortening due to the injury.

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

17.2d Muscle Atrophy, 17.2e Manual Muscle Testing: Dr. Evaluator did not document quantitative circumferential measurements. Dr. Treater reported normal strength; however, Dr. Evaluator reported strength deficits, including a finding of 3/5 strength, not documented by others.

Table 17-6, Impairment Due to Unilateral Muscle Atrophy (5th ed., 530), is used to rate atrophy (measurements are compared 10 cm above the patella and at the maximum circumference of the calf). However, no measurements are documented. Given the significant prior problems with his left ankle, if there was any atrophy, it would be necessary to determine if this is new. Section 17.2c Manual Muscle Testing states:

> Manual muscle testing, which typically involves groups of muscles, depends on the examinee's cooperation and is subject to his or her conscious and unconscious control. To be valid, the results should be concordant with other observable pathologic signs and medical evidence. In general, this method is best used for pathology that does not have a primary neurologic basis, eg, a compartment syndrome or direct muscle trauma. Weakness caused by an identifiable motor deficit of a specific peripheral nerve should be assessed according to Section 17.2l, Peripheral Nerve Injuries.
>
> Measurements can be made by one or two observers. If the measurements are made by one examiner, they should be consistent on different occasions. If made by two, they should be consistent between examiners. Even in a fully cooperative individual, strength may vary from one examination to another, but not by more than one grade. If they vary by more than one grade between observers, or by the same examiner on separate occasions, the measurement should be considered invalid. In those individuals, impairment estimates should not be made

> using this section. Individuals whose performance is inhibited by pain or the fear of pain are not good candidates for manual muscle testing, and other evaluation methods should be considered for them. Table 17-7 shows the criteria on which estimates and grades of the lower extremity's strength are based, and Table 17-8 lists the actual ratings based on lower extremity weakness.

Therefore, based on the inconsistencies Section 17.2d and 17.2 are not applicable.

17.2f Range of Motion: Section 17.2f states:

> Lower extremity impairment can be evaluated by assessing the range of motion of its joints, recognizing that pain and motivation may affect the measurements. If it is clear to the evaluator that a restricted range of motion has an organic basis, three measurements should be obtained and the greatest range measured should be used. If multiple evaluations exist, and there is inconsistency of a rating class between the findings of two observers, or in the findings on separate occasions by the same observer, the results are considered invalid. Figures 17-1 to 17-6 illustrate one method of measuring range of motion in the lower extremity. The ranges listed in Tables 17-9 through 17-14 are examples of mild, moderate, and severe impairments and are to be used as guides. Range-of-motion restrictions in multiple directions do increase the *impairment. Add* range-of-motion impairments for a single joint to determine the total joint range-of-motion impairments.

Dr. Treater reported normal findings; however, Dr. Evaluator observed deficits. However, per the *Guides,* given this inconsistency, "the results are considered invalid" and cannot serve as the basis of defining impairment.

17.2g Ankylosis: Not applicable.

17.2h Arthritis: Not applicable.

17.2i Amputations: Not applicable.

17.2j Diagnosis-Based Estimates: Specific conditions are rated per Table 17-33, Impairment Estimates for Certain Lower Extremity Impairments (5th ed., 546-547). In this case, none are applicable.

Dr. Treater has not documented instability since Mr. Examinee has achieved maximum medical improvement.

Instability is not based on clinical findings but rather on radiographic findings, i.e., stress X-rays. A stress X-ray is an anterior-posterior view taken with a varus or valgus stress applied by a knowledgeable physician.

17.2k Skin-loss: Not applicable.

17.2l Peripheral Nerve Injuries: There is no objective documentation of a sural nerve injury; therefore, this is not ratable. Table 17-37, Impairments Due to Nerve Deficits (5th ed., 552), specifies maximum loss for motor, sensory, and dysesthesia deficits. For sensory deficits, deficits are graded using Table 16-10 (5th ed., 482). Hypothetically, if there was an objective neurological deficit, this would need to be graded. Dr. Evaluator assigned the maximum value for dysesthesia involving the sural nerve without explaining why this was done.

17.2m Causalgia and Reflex Sympathetic Dystrophy: The process defined in Section 13.8 Criteria for Rating Impairments Related to Chronic Pain (5th ed., 343 – 344), Chapter 13, The Central and Peripheral System, is used to rate complex regional pain syndrome (causalgia and RSD). Although there is a reported history of CRPS, there were no objective findings of CRPS in 2021 to 2023.

17.2n Vascular Disorders: Not applicable.

Final Lower Extremity Impairment

There is no ratable impairment. Although Mr. Examinee has subjective complaints, he had a good outcome from his surgery and therapy, resolving objective evidence of impairment.

Sixth Edition

Chapter 16: The Lower Extremities is used to assess lower extremity impairments. For evaluation purposes, the lower extremity is divided into three regions (distal to proximal):

- Foot and ankle: from the midshaft of the tibia to the tips of the toes.
- Knee: from the midshaft of the femur to the mid-shaft of the tibia.
- Hip: from the articular cartilage of the acetabulum to the mid shaft of the femur.

The principles of assessment are provided in Section 16.1. Impairments are typically based on the diagnosis with modification of the impairment based on adjustments for function, physical examination, and clinical studies. Diagnoses for the lower extremity are defined in 3 major categories:

- Soft tissue.

- Muscle/tendon.
- Ligament/bone/joint

Section 16.2 Diagnosis-Based Impairment states:

> Most impairments are based on the Diagnosis-based Impairment (DBI) where impairment class is determined by the diagnosis and specific criteria; this is then adjusted by non-key factors (grade modifiers) and may include Functional History (FH), Physical Examination (PE), and Clinical Studies (CS). The grade modifiers, or non-key factors, are considered only if they are determined by the examiner to be reliable and associated with the diagnosis. Typically, these other factors will support the class and default grade assignment; however in some circumstances a lower or higher grade may be assigned, depending on the specifics of the case.
>
> Alternative approaches are also provided for calculating impairment for peripheral nerve deficits, complex regional pain syndrome, amputation, and range of motion. Range of motion is primarily used as a physical examination adjustment factor and is only used to determine actual impairment values when it is not possible to otherwise define impairment. Ratings based on range of motion or for complex regional pain syndrome cannot be combined with other approaches.
>
> Figure 16-2, Lower Extremity Impairment Evaluation Record, should be completed or all information on that record should be provided in the impairment rating report. The terms class, default impairment, adjustments and assigned grade modifier and optional AAOS Lower Limb Score used in the evaluation record are described in detail in this chapter. An example of a completed Lower Extremity Impairment Evaluation Record (Figure 16-13) is provided at the end of this chapter.
>
> Diagnosis-based impairment (DBI) is the primary method of evaluation for the lower limb. Three regional grids, listing relevant diagnoses, are provided in this section, 1 for each region of the lower extremity (foot/ankle, knee, and hip). An impairment will be defined by class and grade. The Impairment Class (IC) is determined first, by using the corresponding diagnosis-based regional grid. The grade is then determined using the adjustment grids.
>
> Once the impairment class has been determined, based on the diagnosis, the grade is initially assigned the default value, C. The final impairment grade, within the class, is calculated using the grade modifiers, or non-key factors, as described in Section 16.3. Grade modifiers include functional history, physical examination, and clinical studies. The grade modifiers are used in

> the net adjustment formula described in Section 16.3d to calculate a net adjustment. The final impairment grade is determined by adjusting the grade up or down from the default value C, by the calculated net adjustment (≤2 to ≥2). The lowest possible grade is A, (adjustments less than —2 from the default value C will automatically be considered A) and the highest possible grade is E (adjustments greater than +2 will automatically be considered E). The regional grid is then consulted again to determine the appropriate impairment value for the selected class and grade. Grade modifiers allow movement within a class, but do not allow movement into a different class.
>
> The regional grid is used for 2 purposes: (1) to determine the most appropriate class for a specific regional diagnosis and (2) to determine the final impairment after appropriate adjustments are made using the grade modifiers.
>
> There are 5 classes in the diagnosed-based regional grids:
>
> - Class 0: no objective problem.
> - Class 1: mild problem.
> - Class 2: moderate problem.
> - Class 3: severe problem.
> - Class 4: very severe problem approaching total function loss.
>
> Subjective complaints without objective physical findings or significant clinical abnormalities are typically assigned class 0 with no ratable impairment.
>
> This process is repeated for each separate diagnosis in each limb involved. In most cases, only 1 diagnosis in a region (ie, hip, knee and/or foot/ankle) will be appropriate. If a patient has 2 significant diagnoses, for instance, ankle instability and posterior tibial tendonitis, the examiner should use the diagnosis with the highest impairment rating in that region that is causally-related for the impairment calculation. If an examiner is routinely using multiple diagnoses without objective supporting data, the validity and reliability of the evaluation may be questioned.
>
> Vascular conditions are rated per Section 4.8, Vascular Diseases Affecting the Extremities, and may be combined in the Lower Extremity Worksheet using the Combined Values Chart in the Appendix. The diagnosis of complex regional pain syndrome, CRPS I, previously known as reflex sympathetic dystrophy (RSD), and CRPS II, known as causalgia, must be supported by consistent, objective findings, and is rated as explained in Section 16.5.

Steps in Determining Impairment

1. Perform history and examination, and determine if individual is at MMI.
2. Establish the appropriate diagnosis for each part of the lower limb to be rated.
3. Use the regional grid in the corresponding region to determine the associated class.
4. Use the adjustment grid and the grade modifiers, including functional history, physical exam, and clinical studies, to determine what grade of associated impairment should be chosen within the class defined by the regional grid.
5. Use the regional grid to identify the appropriate impairment rating value for the impairment class, modified by the adjustments as calculated.
6. Combine lower extremity percentages using the Combined Values Chart in the same extremity as appropriate. If both lower extremities are involved, convert impairments to whole person and combine. (6th ed, 497-499).

The use of regional grids is explained in Section 16.2a Diagnosed-Based Class Assignment—Regional Grids:

> The first step in determining an impairment rating is to choose the diagnosis that is most applicable for the region being assessed. Diagnoses are divided into 3 categories including soft tissue, muscle/tendon, and ligament/bone/joint. Typically, soft-tissue diagnoses are assigned the lowest impairments and ligament/bone/joint diagnoses the highest impairments. As much as possible, impairment values from prior editions were retained, unless adjustments were necessary to more appropriately reflect the impairment or were required because of changes in the methodology. On the basis of the diagnosis and other specific differentiators that may be associated with that diagnosis, the condition is assigned to a specific class in the regional grid.
>
> Reliability of the diagnosis is essential and the diagnosis should be consistent with the clinical history and findings at the time of impairment assessment. Surgery does not necessarily result in an impairment rating, unless it is a factor that contributes to placing a diagnosis within a class. Surgical intervention is only relevant if it alters the functional status of the condition evaluated at MMI. For example, surgical repair of a torn cruciate ligament can decrease the instability from a higher class to class 0 if the instability is resolved. That the joint has been treated surgically does not result in an add-on value or additional impairment percentage. Impairment ratings are based on the patient's condition at the time of the rating and do not anticipate or account for the possibility of future interventions.

> Selecting the optimal diagnosis requires judgment and experience. If assignment to a class is determined by severity of ROM deficit (ie, normal, mild, moderate, severe, very severe), this severity is determined using Sec. 16.7 ROM Impairment. If more than 1 diagnosis in a region (ie, hip, knee and/or foot/ankle) can be used, the 1 that provides the most clinically accurate and causally-related impairment rating should be used; this will generally be the more specific diagnosis. Typically, 1 diagnosis will adequately characterize the impairment and its impact on ADLs. Certain diagnoses may span more than 1 class; therefore, these diagnoses are associated with specific objective findings on physical examination or clinical studies to ensure placement in the appropriate class.
>
> In the event that a specific diagnosis is not listed in the diagnosed-based impairment grid, the examiner should identify a similar listed condition to be used as a guide to the impairment calculation. The rationale for this decision should be described.
>
> The regional grids have 1 column that includes diagnoses and 5 columns reflecting impairment classes. Identify the applicable diagnosis in the left-most column. The permissible class assignments (0–4) are specified in the horizontal rows. Reference the specific criteria in the row for that diagnosis, to determine which class is appropriate. Above the criteria in each cell are 5 numbers reflecting the range of impairment associated with those specific diagnostic criteria. Each of these numbers corresponds to grades A, B, C, D, and E, with A the mildest and E the most severe. The middle value is grade C and represents a default impairment value, which typically corresponds with the impairment value assigned in prior editions of the *Guides*. Grades and the corresponding final impairment value are modified by the use of the adjustment grids and the net adjustment formula, as discussed above. The impairment calculation process is described in detail in Section 16.3d.

General Considerations

> Instructions for using the diagnosed-based impairment grids are provided in Section 16.3 Adjustment Grid and Grade Modifiers—Non-Key Factors. The evaluator should select the most accurate diagnosis and identify the class containing that diagnosis. As previously described, the numerical value of the impairment associated with that diagnosis, located above each diagnosis, may be increased or decreased within an impairment class based upon grade modifiers, as determined using the adjustment grids as described in Section 16.3.
>
> Prior to using the regional grids, the examiner must review Section 16.1, Section 16.2, and Section 16.3. In some cases, the class will be defined by physical examination findings or clinical studies results. When this is the case, those same findings may not be used as grade

modifiers to adjust the rating. Range of motion will, in some cases, serve as an alternative approach to rating impairment. It is not combined with the diagnosis-based impairment, and stands alone as an impairment rating.

Clinical examples are provided in Section 16.3e. The *Guides*' user is encouraged to read the entire chapter for a complete understanding of the impairment rating method before attempting to interpret the ratings or to perform the calculations that accompany the examples. (6th ed, 499-500).

The examiner must identify the most clinically accurate specific diagnosis causally related to the injury that results in the highest impairment. Impairment is not based on multiple diagnoses within a region.

The diagnosis upon which his rating is based is peroneal tendon strain. In Table 16-2, Foot and Ankle Regional Grid – Lower Extremity Impairments (6th ed, 501-508) under the Muscle/Tendon section for the Diagnosis, "Strain; tendonitis; or h/o ruptured tendon, specifically involving posterior tibial, anterior tibial, achilles, or peroneal tendon" (6th ed., 503), using the physical examination findings of tenderness, he meets the description of "palpatory findings and/or radiographic findings." He does not have objective evidence of motion deficits. Therefore, the default rating is 1% lower extremity impairment.

TABLE 16-7
Physical Examination Adjustment – Lower Extrem

	Grade Modifier 0	Grade Modifier 1
CLASS DEFINITIONS	No problem	Mild problem
OBSERVED AND PALPATORY FINDINGS (tenderness, swelling, mass, or crepitance)	No consistent findings	Minimal palpatory findings, consistently documented, without observed abnormalities
STABILITY	Stable	Grade 1 (slight) instability
KNEE		Grade 1 Lachman's test; slight laxity patellar mechanism
ALIGNMENT/ DEFORMITY	Normal for individual with symmetry to opposite side	Mild
RANGE OF MOTION (reference Section 16.7)	None	Mild or arthrodesis in position of function
MUSCLE ATROPHY (asymmetry compared to opposite normal)	<1 cm	1.0–1.9 cm
LIMB LENGTH DISCREPANCY	<1.9 cm	2.0–2.9 cm

In Section 16.3a, Adjustment Grid: Functional History (6th ed. 516), and Table 16-6, Functional History Adjustment: - Lower Extremities (6th ed.516), the patient is assigned a Grade Modifier 1; the Functional History is consistent with "mild problem." He does not meet the criteria for a higher assignment.

In Section 16.3b, Adjustment Grid: Physical Examination (6th ed. 517), and Table 16-7, Physical Examination Adjustment: Lower Extremities (6th ed.517), the patient is not assigned a Grade Modifier since the examination findings were used to place him in the regional grid. However, if this was considered, the examination findings would be consistent with a mild problem.

In Section 16.3c, Adjustment Grid: Clinical Studies (6th ed.518), and Table 16-8, Clinical Studies Adjustment: Lower Extremities (6th ed.519), providing the benefit of the doubt, he could be assigned as "moderate problem" and Grade Modifier 2.

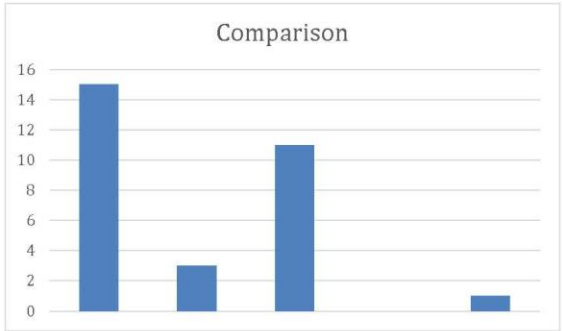
In summary, the adjustments are: Functional History Grade Modifier 1, Physical Examination N/A (or 1), and Clinical Studies 2. The net adjustment compared to Diagnosis Class 1 is +1; Grade D, 2% lower extremity impairment.

This converts to 1% whole person using Table 16-10 (6th ed, 530).

Comparison of Ratings

The impairment ratings provided are converted to the whole person and compared:

Evalaluator	WPI
J. Robert Smith, Jr., MD - Fifth Edition - 1/26/07	15
William Treater, MD - Fifth Edition - 2/27/23	3
Brian Evaluator, III, MD - Fifth Edition - 4/12/23	11
Christopher R. Brigham, MD - Fifth Edition - 5/8/23	0
Christopher R. Brigham, MD - Sixth Edition - 5/8/23	1



Apportionment Assessment

Typically permanent impairment is apportioned by subtracting prior impairment ratings for the regions involved. The impairment rating for 2005 injury was 15%, whole person. This rating was based on complex regional pain syndrome; however, now he has no objective evidence of CRPS.

Summary

In summary, based on the injury of October 12, 2021, Mr. Examinee has, per the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition, no ratable impairment and, per the Sixth Edition, 1% whole person permanent impairment.

Thank you for asking me to review this case. If you have further questions, do not hesitate to contact me.

Qualifications

Christopher R. Brigham, MD, is the Senior Contributing Editor for the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition, and was a contributor/author for several chapters, including Upper Extremities, Lower Extremities, and Spine. With the Fifth Edition, he served on the Advisory Committee and as a contributor. Dr. Brigham is Board-Certified in Occupational Medicine (ABPM), is the Founding Director of the American Board of Independent Medical Examiners (ABIME), a Fellow of the American College of Occupational Environmental Medicine (FACOEM), a Fellow of the International Academy of Independent Medical Evaluators (FIAIME) with Certification in Evaluation of Disability and Impairment Rating (CEDIR), a Certified Independent Medical Examiner (CIME), a Certified Impairment Rater (CIR), and a graduate of the Washington University School of Medicine – St. Louis.

He is the Editor of the AMA publications, the *AMA Guides Newsletter,* and *The Guides Casebook*. He was co-author of the text *Understanding the AMA Guides in Workers Compensation*, Third Edition. He has written over three hundred published articles on impairment and disability evaluation and other texts. He chaired the Medical Advisory Board for the *Medical Disability Advisor*, Fourth Edition, is featured in several videos, audio, and web-based productions in the medicolegal field, and has trained thousands of physicians,

Brigham and Associates, Inc. June 11, 2023

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

attorneys, claims professionals, and fact-finders throughout the US, Canada, and internationally. He is an experienced professional speaker.

As a clinician with over thirty years of experience, he has performed several thousand independent medical and impairment evaluations, providing excellent insight into the complexities of human potential, impairment, and disability. Because of this experience, he has consulted for numerous organizations (including governmental jurisdictions).

Disclosures

The above analysis is based on 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 later, an additional report may be requested; such information might change the opinions rendered in this report.

My assessment was based on considering all the information provided and the processes and procedures specified in the AMA *Guides to the Evaluation of Permanent Impairment,* Sixth Edition. It was unnecessary to examine the claimant directly since all needed information was provided in the reviewed documents. The issues I addressed were unrelated to clinical care but focused on pertinent issues and claims management, e.g., causation, apportionment, impairment, and/or workability assessment. No patient-physician relationship was established.

Comments expressed in this report are professional opinions based on the case's specifics and documentation reviewed; they should not be generalized nor considered supportive or critical of the involved providers or disciplines.

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 independent professional opinion.

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

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

Sincerely,

Christopher R. Brigham, MD
MMS, FACOEM, FIAIME, CEDIR, CIME
President, Brigham and Associates, Inc.
Editor-in-Chief, AMA *Guides Newsletter*

Enclosures:

Guides Newsletter articles

Curriculum Vitae

RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

Medical Record Chronology

DATE	SOURCE	TYPE	CONTENT
09/29/05	Dodctor, Julian, MD / Central Medical Centers	CLIN	Progress Note by Julian Doctor M.D. CHIEF COMPLAINT: **Complains about his leg which was injured on 09/29/2005 10:15:00 AM.** PATIENT STATEMENT: Patient states: **"I was stepping out of vehicle rolled ankle off edge of concrete."** **HISTORY OF PRESENT ILLNESS: Patient suffered an inversion injury of left ankle. Pain began immediately. Pain is located on lateral aspect of ankle and posterior aspect of foot. Symptoms are exacerbated by manipulation or movement. Noted pop/snap at time of injury, edema within minutes** PHYSICAL EXAM: Mild distress secondary to pain. Gross exam of the ankle reveals edema of the lateral malleolus. Gait is antalgic and unable to bear weight. Range of Motion testing shows a decrease to dorsiflexion inversion. Palpation is positive for pain at lateral malleolus, talofibular ligament and posterior heel on the left. ANKLE X-RAY: Possible small avulsion fracture. ASSESSMENT: Ankle sprain. Grade 2+. PLAN: Crutches. Ice/cold pack. Ankle brace. Ibuprofen 800 mg. Physical therapy 3 times per week for 1 to 2 weeks. Return in 1 day (09/30/2005). ACTIVITY STATUS: Modified activity. Off work rest of shift with limited activity as follows: Should be sitting 75 percent of time. Must use crutches 100% of time. Rest. Apply Ice, Compression and Elevate. Must wear splint. Anticipated MMI 3-4 weeks.
09/29/05	Garovich, Michael, MD / Charleston Radiologists, PA	IMAGE	X-Ray of Left Ankle by Michael Garovich, M.D. HISTORY: Pain from injury. FINDINGS: Three views of the left ankle are obtained. There is mild soft tissue swelling laterally. There is a small linear density near the fibula: tip that may represent a small avulsion fracture. Rounded density is seen inferior to the medial malleolus rip. It is contested and may represent remote avulsion mature. There is no appreciable son tissue swelling medially. The ankle mortise is not widened. IMPRESSION: **Mild soft tissue swelling laterally. Questionable small avulsion fracture of the lateral malleolar lip.**

DATE	SOURCE	TYPE	CONTENT
			contraindicated based upon his Xarelto medication. Use of a newer type of fabric technology known as incrediwear could be helpful with increasing circulation. This is very cost effective and could be obtained as a simple sock to be worn underneath his ankle lacer. **With respect to work restrictions, this patient should be allowed to return to most activities as long as he is wearing his ankle lacer. He should try to avoid those activities, which will require repetitious kneeling, squatting, steeping, or crawling type activities. If further restrictions are required a functional capacity evaluation could always be considered.** **Finally this patient will have some degree of permanent impairment as outlined by the AMA Guidelines for the Evaluation of Permanent impairment, fifth edition. The patient's impairment rating is based upon some range of motion loss, residual ankle instability, weakness of his peroneal tendon repair, and some residual sural nerve dysesthesia.** **Based upon table 17-11 and 17-12, this patient is assessed a 7% impairment of his lower extremity based upon loss of ankle dorsiflexion. An additional 2% impairment is assessed based upon slight loss of ankle eversion. This totals 9% impairment of the lower extremity based upon range of motion loss.** **Based upon table 17-33, this patient has residual moderate lateral ankle instability which is assessed an additional i0% impairment of the left lower extremity. Additionally, based upon table l7-8, he has an additive 5% impairment of the lower extremity based upon weakness in eversion secondary to his peroneal tendon pathology.** **Finally, based upon table 17-37, he is assessed an additive 5% impairment of the left lower extremity based upon sural nerve sensory dysesthesia.** **Utilizing the combined values table, this equates to a total of 27% impairment of the left lower extremity. This is equivalent to 11% whole person impairment.**

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Brigham and Associates, Inc. June 11, 2023

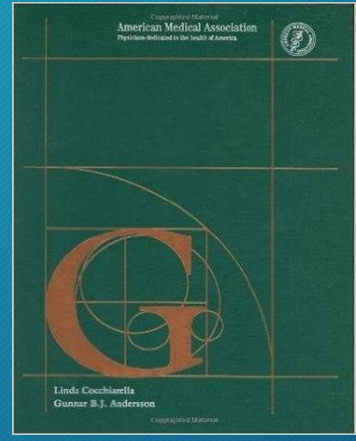
RE: Individual: Donald Examinee
Date of Injury: 10/12/2021
Claim No.: 123

References

[1] Brooks CN, Talmage JB, Mueller K. Subjective, Objective, or Both? Guides Newsletter. March / April 2012.

[2] Melhorn JM, Talmage JB, Ackerman WE, Hyman MH. *Guides to the Evaluation of Disease and Injury Causation, Second Edition.* AMA 2014.

California Variations (e.g., Almaraz-Guzman, Kite, etc.)



- Is the evaluation fully compliant with best practices? (reference AMA *Guides Newsletter*, September – October 2017)
- Are you truly aware of your level of expertise in assessing impairment?
- Is bias (or frustration) impacting the rating?
- Are you distinguishing impairment and disability?
- Have you calculated the Permanent Disability Rating (PDRS) to understand how the impairment converts to disability?

PHYSICIANS

- Focus on excellence and integrity.
- Master the AMA *Guides to the Evaluation of Permanent Impairment* and obtain the knowledge, skills, and qualifications to evaluate crucial medicolegal issues.
- Implement best practice approaches in your QME evaluations.
- Focus on quality, efficiency, and on providing excellent and accurate Reports.
- Seek mentorship.

ESSENTIALS FOR SUCCESS

- Knowledge and skills in medicolegal and impairment assessment.
- Best practice processes to ensure efficiency, accuracy, and quality.

Resources and Recommendations

- Training
  - Virtual - www.emedicolegal.com
  - 200 modules, > 100 hours of learning experiences, annual enrollment fee less than the fee for one QME
  - EZ QME will provide a link for a 10% discount)
- Certification
  - Certified Impairment Rater – www.certifiedrater.com

- Web-based resources
  - www.AMAGuidesDigital.com
    - AMA sponsored, includes digital versions of the Guides and Guides Newsletter with searching
  - www.amaguides.com
  - www.fifthedition.com

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Upcoming Sessions:

- 07/12/23 Glenn Olsen Defense Attorney – "CCR 35.5 How to Answer the Call of the Question
- 08/09/23 Julie Armstrong Psy.D QME – "Eliminating Bias in the Medical Legal Evaluation"
- 09/06/23 Ken Kingdon Applicant Attorney – "Hidden Treasures of the AMA Guides"
- 10/03/23 James Musick D.C. QME – "Begin with the Basics"