Answers to Your Most Pressing Questions About Impairment Ratings: What Every Attorney and Claims Professional Must Know

This presentation will provide comprehensive insights into impairment ratings, a critical component in personal injury claims and workers' compensation cases. Attendees will gain a deep understanding of the legal and medical principles governing impairment assessments, enabling them to make more informed decisions and effectively advocate for their clients.

Christopher R. Brigham, MD

Part One: June 25, 2025

Part Two: July 9, 2025

Christopher R. Brigham, MD

Senior Contributing Editor for the AMA Guides, Sixth Edition and the AMA Guides Casebook. He has served as the Past Editor-in-Chief of the Guides Newsletter and is the author of several publications, including 'Excellent IME Report', 'Comprehensive IME Systems', and 'Living Abled'. With over three decades of experience with the AMA Guides, Dr. Brigham is a Board-certified Occupational Medicine specialist and a Fellow of the American College of Occupational and Environmental Medicine, as well as the International Academy of Independent Medical Evaluators. Chris has been involved in innovative approaches to improve our ability to evaluate and manage medical issues by using technology, including the use of artificial intelligence.

Let's communicate. Share in chat and use Q/A (questions answered at end) .

What do you want to achieve from this webinar?

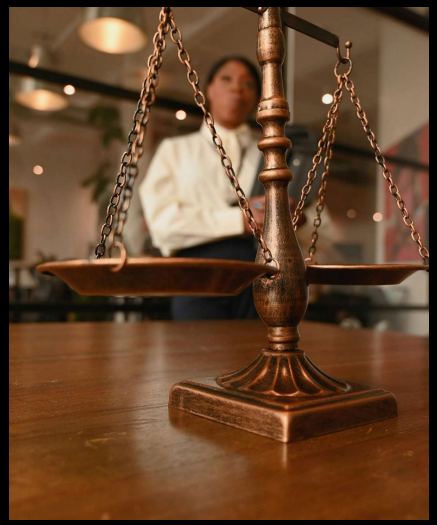
Please type (quickly) in Chat.

Why are we here, where are we going, and what are we going to do?

Why are we here?

Ensuring Accurate and Equitable Impairment Ratings

Impairment ratings are a critical part of the workers' compensation process, with significant implications for injured workers, employers, and the overall system. However, errors in these ratings can lead to substantial human and financial costs, including unfair outcomes, increased litigation, and higher system-wide expenses.



Plans for June 24 and July 29

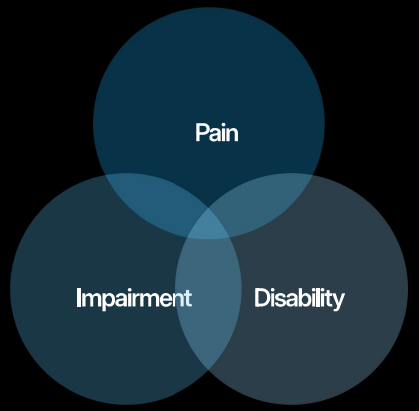
Navigating Impairment Ratings: Strategies for Accuracy and Fairness

- **What is the foundation?**
  Understanding the legal and medical frameworks that underpin impairment ratings
- **How often are impairment ratings wrong?**
  Studies suggest that up to 30% of impairment ratings may be inaccurate
- **What are the root causes of erroneous ratings?**
  Lack of training, biases, incomplete medical data, and improper application of the AMA Guides
- **What are the red flags?**
  Inconsistencies in medical records, discrepancies between examinations, and failure to follow guidelines
- **What are some of the specific problems?**
  Misinterpretation of impairment criteria, overreliance on subjective factors, and failure to account for comorbidities
- **How do I best evaluate reports?**
  Carefully review the medical evidence, understand the applicable guidelines, and consult with medical experts
- **How do I obtain an accurate rating?**
  Ensure a comprehensive medical evaluation, advocate for proper application of the AMA Guides, and consider independent reviews
- **What are common referral entity errors?**
  Inadequate communication, misalignment of incentives, and lack of oversight in the referral process
- **What is new with the AMA Guides?**
  Ongoing updates, increased focus on functional assessment, and incorporation of technological advancements
- **What is the role of AI?**
  Leveraging AI to analyze medical data, identify patterns, and assist in more consistent and accurate impairment ratings
- **Can you provide examples of review process?**
  Case studies showcasing effective strategies for reviewing and validating impairment ratings
- **What resources are you providing?**
  Comprehensive guides, expert training, and interactive tools to support accurate impairment rating assessments

What are our goals?

Improving Impairment Rating Accuracy and Consistency

- **Understand impact of inaccurate impairment ratings**
  Discuss how inaccurate ratings can affect outcomes and costs for individuals and organizations
- **Recognize common errors and red flags**
  Identify common issues like incorrect measurements, outdated guidelines, and biased evaluations
- **Use a structured checklist to assess quality**
  Develop a comprehensive checklist to evaluate the validity and accuracy of impairment ratings
- **Take action when flaws are identified**
  Provide guidance on how to address inaccurate ratings through expert review, communication, or challenge
- **Ensure accurate ratings from the start**
  Discuss strategies for selecting the right evaluators and tools to achieve more accurate and consistent ratings
- **Apply key updates from AMA Guides**
  Highlight the latest changes and improvements in the AMA Guides and available digital resources
- **Evaluate the role of AI in improving ratings**
  Explore how artificial intelligence can be leveraged to enhance the accuracy and consistency of impairment ratings
- **Learn from a real-world case study**
  Discuss a case where correcting an inaccurate rating led to a positive outcome for the individual



Understanding Pain, Impairment, and Disability

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.

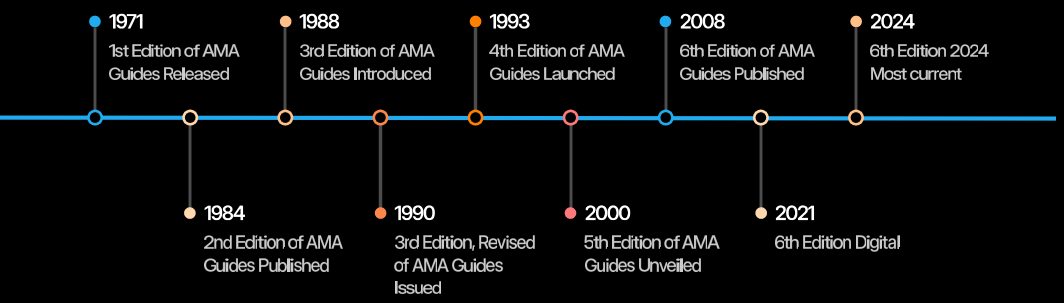
Pain vs Impairment
Pain is a subjective experience, while impairment is an objective measure of a significant deviation or loss of body structure or function.

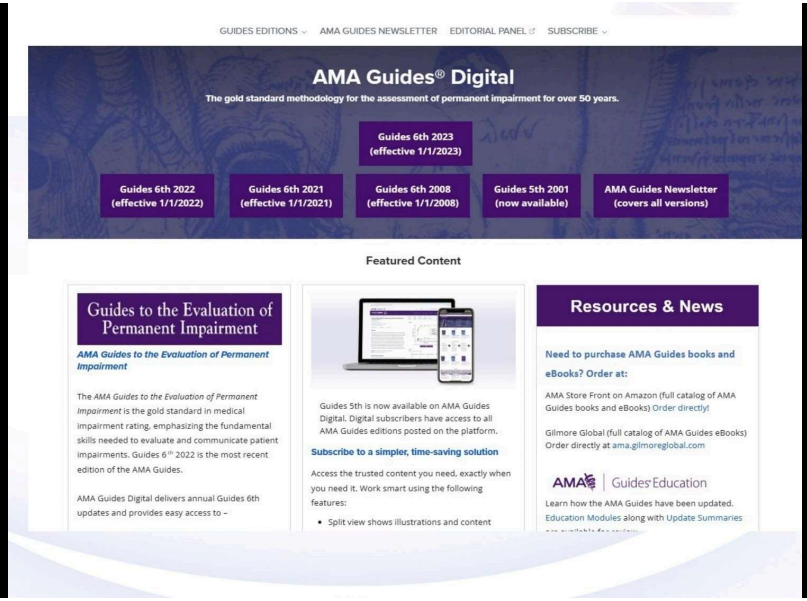
Impairment vs Disability
Impairment is a medical condition, while disability refers to the limitations and restrictions an individual experiences in their daily life as a result of that condition.

Impairment in Perspective

- **Failure to Prevent Injury**
  Impairment reflects a failure to prevent an injury in the first place
- **Failure to Assess Work-Relatedness**
  Impairment may reflect a failure to accurately assess if a condition is work-related
- **Failure to Mitigate Impact**
  Impairment may reflect a failure to effectively mitigate the impact of an injury and restore function
- **Accurate, Unbiased Assessment**
  The goal should be an accurate and unbiased assessment of impairment through efficient means
- **Impairment, Not Treatment**
  Impairment rating should be about the end result, not the treatment the claimant had

Evolution of AMA Guides





How often are impairment ratings wrong?

Respond in chat your estimate of how often you find ratings to be incorrect.

How often are impairment ratings wrong?

Most are inaccurate—especially overestimated

Impairment ratings often do not accurately reflect the true extent of a person's injury or disability, with a tendency to overestimate the level of impairment.

Jurisdictional variation, but consistent trends

Accuracy of impairment ratings can vary depending on the location or jurisdiction, but there are generally consistent trends of overestimation across different regions.

In summary, impairment ratings are frequently inaccurate, with a tendency to overestimate the level of disability, and this pattern is observed across different jurisdictions.

Why are impairment rating errors so prevalent?

Insufficient training of physicians

Many physicians lack specialized training in conducting impairment assessments, leading to inconsistent and inaccurate ratings.

Physician bias

Subjective biases and personal opinions of physicians can influence impairment ratings, leading to disparities in assessments.

Lack of standardization

Failure to follow best practices for evaluations and managing ratings,

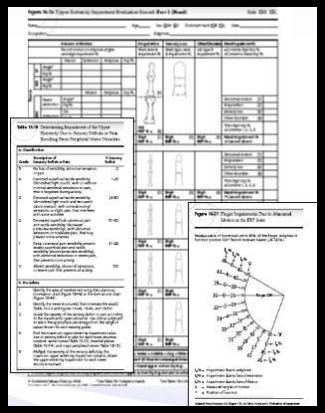
Addressing the issues of insufficient training, physician bias, and lack of standardization is crucial to improve the accuracy and consistency of impairment ratings.

What are the root causes of erroneous ratings?

- **Failure to understand AMA Guides**
  Lack of familiarity with the latest edition of the AMA Guides can lead to inaccurate impairment ratings.
- **Bias - Treating Physician**
  Treating physicians may have a tendency to overestimate or underestimate impairment due to personal biases or relationships with the patient.
- **Bias - Experts**
  Hired experts may have a conflict of interest or predetermined biases that influence their impairment ratings.
- **Clinical and MMI Errors**
  Inaccurate assessment of the patient's clinical condition or failure to determine Maximum Medical Improvement (MMI) can result in incorrect impairment ratings.
- **Causation Errors**
  Incorrect determination of the cause of the impairment, whether it's work-related or pre-existing, can lead to erroneous impairment ratings.
- **No Accountability**
  Lack of a robust system to review and validate impairment ratings can perpetuate the issue of erroneous ratings.

Analogy – Impairment Ratings and Taxes

Complex process. Individuals can provide data which may or may not be accurate) - however, rating experts, using that data, and often software systems, are more likely to determine the correct result



What are common errors and what are the "red flags?"

What are common mistakes in impairment ratings?

Confusion between pain, impairment, disability, and restrictions

Differentiating between these concepts is crucial for accurate impairment ratings.

Faulty clinical reasoning and improper use of the AMA Guides

Lack of understanding or misapplication of the AMA Guides can lead to inaccurate ratings.

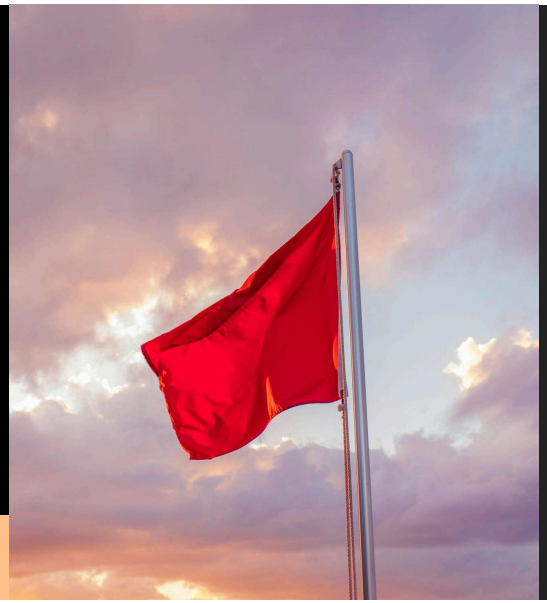
Fifth Edition: ROM misuse, incorrect spine method, muscle strength misapplication

Specific pitfalls in the application of the Fifth Edition of the AMA Guides.

Sixth Edition: Misdiagnosis, invalid use of multiple diagnoses

Potential issues in the application of the Sixth Edition of the AMA Guides.

Avoiding these common mistakes is crucial for accurate and consistent impairment ratings.



How do I recognize a flawed rating?

21 Red Flags in Impairment Evaluation Reports

Key indicators of potentially flawed or biased impairment ratings, equipping claims professionals, attorneys, and independent reviewers to identify and address these issues.

Red Flags

- Biased Treating or Known Biased Evaluator
- Outside Specialty Scope Evaluation
- Untrained or Uncredentialed Evaluator
- Disorganized or Unprofessional Report
- Missing Clinical or Rating Details
- No MMI or Premature Rating
- Incorrect AMA Guides Citation
- Implausible High or Low Rating
- Controversial or Questionable Diagnosis Basis
- Multiple Diagnoses Without Justification
- Missing Guides Table or Method
- Disallowed or Subjective Methods
- Used Software Used Without Clinical Insight
- Invalid or Unreliable Clinical Findings
- Contradictory Report Content
- Non-Standard or Prohibited Methods
- Diagnosis Doesn't Match Injury
- ROM Used Incorrectly
- Errors in Calculations
- Pain Rated Without Basis

⚠️ Red Flags in Impairment Evaluation Reports

(For Use by Claims Professionals, Attorneys, and Independent Reviewers)

🔴 **1. Rating by Treating Physician or Known Biased Evaluator**

- **Red Flag**: Report authored by treating physician or evaluator with known litigation bias (plaintiff or defense-oriented).
- **Why It Matters**: Objectivity is foundational. Treating providers inherently possess therapeutic allegiance, compromising impartiality.
- **Action**: Flag these reports for secondary review. Track evaluator patterns for systemic bias.

🔴 **2. Evaluation Performed Outside Specialty Scope**

- **Red Flag**: Evaluator lacks clinical training in the condition assessed (e.g., chiropractor rating internal organ damage).
- **Why It Matters**: Ratings demand specialized knowledge in the pathology and functional consequences.
- **Action**: Verify clinical appropriateness of specialty. Reject reports outside the evaluator's domain of competence.

🔴 **3. Non-Credentialed or Inadequately Trained Evaluator**

- **Red Flag**: No formal training or certification in AMA Guides, medicolegal evaluation, or impairment rating.
- **Why It Matters**: Rating accuracy depends on technical understanding of Guides methodology.
- **Action**: Prioritize reports from certified professionals (e.g., CIME, CMLEx, CIR). Scrutinize ratings from uncertified sources.

🔴 **4. Poorly Constructed or Unprofessional Report**

- **Red Flag**: Disorganized, unformatted report lacking essential elements (history, exam, rationale).
- **Why It Matters**: Sloppy presentation correlates with low evaluative quality.
- **Action**: Apply high scrutiny or request re-evaluation. Use formatting as a surrogate marker for analytic rigor.

🔴 **5. Incomplete Clinical and Rating Documentation**

- **Red Flag**: Missing history, examination findings, diagnostic correlation, or causation analysis.
- **Why It Matters**: Incomplete documentation undermines validity and reproducibility.
- **Action**: Reject or request supplemental detail before accepting impairment conclusion.

🔴 **6. No MMI Statement or Premature Rating (<6 months)**

- **Red Flag**: Report omits MMI status or assigns rating prematurely (e.g., <6 months for musculoskeletal injury).
- **Why It Matters**: Ratings prior to MMI are invalid due to potential for clinical change.
- **Action**: Confirm date and clinical basis of MMI. Delay rating if premature.

🔴 **7. Incorrect AMA Guides Citation**

- **Red Flag**: Reference to incorrect edition (or vague terms like "AMA Guidelines").
- **Why It Matters**: Jurisdictions mandate edition-specific use. Mislabeling may reflect inexperience.
- **Action**: Verify edition matches jurisdictional requirement and is properly cited (e.g., "AMA Guides, Sixth Edition, 2008").

🔴 **8. Unusually High or Low Impairment Values**

- **Red Flag**: Whole Person Impairment (WPI) >10% without strong objective basis or <10% in cases of significant trauma.
- **Why It Matters**: Outlier ratings should be proportionate to clinical severity.
- **Action**: Assess consistency with objective findings and injury complexity.

🔴 **9. Diagnosis-Related Rating Problems**

- **Red Flag**: Ratings based on conditions with high variability or diagnostic controversy (e.g., CRPS, disc herniation without radiculopathy).
- **Why It Matters**: These conditions are prone to over-rating and subjectivity.
- **Action**: Demand high-level documentation and clear diagnostic substantiation.

🔴 **10. Multiple Diagnoses Rated**

- **Red Flag**: Rating multiple diagnoses, especially if acute injury with documentation that this involved a single region or reported as a cumulative trauma disorder.
- **Why It Matters**: Injuries may result in multiple problems associated with permanent impairment; however, more commonly there is a single ratable diagnosis. If multiple problems are alleged to cumulative trauma, careful causation analysis is required.
- **Action**: Scrutinize multiple diagnosis cases, especially regarding accuracy of the diagnoses and causation.

🔴 **11. Missing Tables, Figures, or Method References**

- **Red Flag**: No citation of Guides Table, Figure, or section used to derive impairment.
- **Why It Matters**: Citations ensure transparency and reproducibility.
- **Action**: Require full citation trail for all numerical impairment findings.

🔴 **12. Use of Disallowed or Subjective Rating Methods**

- **Red Flag**: Strength loss ratings (without clear neurologic deficit), unvalidated hand/nerve rating methods.
- **Why It Matters**: AMA Guides restrict certain methods to minimize subjective inflation.
- **Action**: Reject or challenge methods not explicitly allowed in the Edition used.

🔴 **13. Software-Based Ratings Lacking Clinical Insight**

- **Red Flag**: Rating based solely on software outputs, with no clinical reasoning.
- **Why It Matters**: "Garbage in, garbage out" applies—input errors or software misuse lead to flawed outputs. Physicians may be overly reliant on software and lack knowledge on the use of the Guides/
- **Action**: Require narrative rationale and clinician interpretation beyond software.

🔴 **14. Invalid or Inconsistent Clinical Findings**

- **Red Flag**: Findings not aligned with anatomy, physiology, or clinical exam principles (e.g., sensory loss in non-dermatomal patterns).
- **Why It Matters**: Guides require valid and reliable objective findings.
- **Action**: Challenge inconsistencies; request clarification or second opinion.

🔴 **15. Internal Report Inconsistencies**

- **Red Flag**: Contradictions between history, records, examination, imaging, and impairment conclusions.
- **Why It Matters**: Internal coherence is essential for credibility.
- **Action**: Flag for peer review. Reject reports with unresolved contradictions.

🔴 **16. Use of Non-Standard or Jurisdictionally Prohibited Methods**

- **Red Flag**: Pain ratings not permitted by AMA Guides or jurisdiction (e.g., Chapter 18 inappropriately applied; Almaraz-Guzman misuse in CA).
- **Why It Matters**: Ratings must be based on standardized, accepted methods.
- **Action**: Ensure compliance with both AMA Guides and local legal standards.

🔴 **17. Diagnosis-Inconsistent Impairment Ratings**

- **Red Flag**: Rating derived from a diagnosis that does not match the causally related injury.
- **Why It Matters**: Impairment is often diagnosis-drive, especially with the Sixth Edition; misclassification yields invalid ratings.
- **Action**: Match injury diagnosis with rating process.

🔴 **18. Improper Use of Range of Motion (ROM)**

- **Red Flag**: ROM used where not permitted (e.g., spine under Sixth Edition).
- **Why It Matters**: ROM is highly variable and limited in use.
- **Action**: Confirm edition-specific ROM applicability and documentation rigor.

🔴 **19. Mathematical Errors**

- **Red Flag**: Incorrect use of Combined Values Chart, averaging methods, or formula application.
- **Why It Matters**: Calculation errors can materially alter ratings.
- **Action**: Independently verify all calculations.

🔴 **20. Pain Used as Standalone Impairment**

- **Red Flag**: Pain rated independently of functional or structural impairment.
- **Why It Matters**: AMA Guides discourage pain-only ratings.
- **Action**: Disallow standalone pain ratings unless jurisdictionally permitted *and* clearly justified.

🔴 **21. Sixth Edition: Missing or Incorrect Grade Modifiers**

- **Red Flag**: Omitted or misapplied Grade Modifiers (Functional History, Physical Exam, Clinical Studies).
- **Why It Matters**: Modifiers refine the impairment within a class.
- **Action**: Check documentation and scoring logic for all modifiers.

✅ **Recommendations for Claims Reviewers & Legal Counsel**

- **Implement a structured quality checklist** using the above red flags.
- **Require evaluator credentialing disclosure** as part of report submission.
- **Track evaluator accuracy, bias, and legal defensibility** longitudinally.
- **Engage certified medical reviewers** to audit questionable impairment ratings.
- **Refer to Brigham and Associates, Inc. for expert review** if concerns.

Rating by Treating Physician or Known Biased Evaluator

Treating physician reports
Treating physicians inherently possess therapeutic allegiance, compromising impartiality.

Evaluator with known litigation bias
Evaluators with a history of plaintiff or defense-oriented bias may lack objectivity.

Flag for secondary review
Reports from these sources should be flagged for additional scrutiny and review.

Track evaluator patterns
Analyze evaluator data longitudinally to identify systemic bias.

By identifying and addressing reports from treating physicians or known biased evaluators, claims professionals, attorneys, and independent reviewers can improve the objectivity and reliability of impairment ratings.

Evaluation Performed Outside Specialty Scope

Evaluator lacks clinical training in the condition assessed
For example, a chiropractor rating internal organ damage.

Ratings demand specialized knowledge in the pathology and functional consequences
Evaluators must have the necessary expertise to accurately assess the condition.

Verify the evaluator's clinical appropriateness
Ensure the evaluator's specialty and training match the condition being assessed.

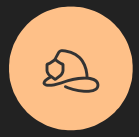
Reject reports outside the evaluator's domain of competence
Do not accept impairment ratings from evaluators without the proper expertise.

Evaluators who lack the necessary clinical training and expertise in the condition being assessed may not be qualified to provide accurate impairment ratings. It is crucial to verify the evaluator's clinical appropriateness and reject reports that fall outside their domain of competence.

Non-Credentialed or Inadequately Trained Evaluator

No formal training or certification in AMA Guides, medicolegal evaluation, or impairment rating
Ratings accuracy depends on the evaluator's technical understanding of the AMA Guides methodology.

Prioritize reports from certified professionals (e.g., CIR, CIME, CMLE)
Certified professionals have the necessary training and expertise to provide accurate and reliable impairment ratings.



Scrutinize ratings from uncertified sources
Ratings from evaluators without proper certification may lack the required technical knowledge and should be reviewed with caution.

By prioritizing reports from certified professionals and scrutinizing ratings from uncertified sources, claims professionals, attorneys, and independent reviewers can ensure the accuracy and reliability of impairment evaluations.

Poorly Constructed or Unprofessional Report

Disorganized, unformatted report
Lack of structure and formatting may indicate low evaluative quality

Missing essential elements
Absence of key components like history, exam findings, rationale, etc.

Use formatting as a surrogate marker
Sloppy presentation can be a proxy for lack of analytic rigor

Apply high scrutiny or request re-evaluation
Poorly constructed reports warrant closer examination or re-evaluation

Disorganized, unformatted reports lacking essential elements may indicate low evaluative quality. Use formatting as a surrogate marker for analytic rigor and apply high scrutiny or request re-evaluation.

Incomplete Clinical and Rating Documentation

Missing history
Lack of detailed patient history undermines the validity of the impairment conclusion.

Incomplete examination findings
Failure to document thorough physical examination results reduces the reproducibility of the assessment.

Absence of diagnostic correlation
Missing links between diagnoses and impairment ratings calls into question the rationale for the conclusions.

Lack of causation analysis
Absence of a clear explanation and science for how the injury or condition is causally related to the impairment undermines the credibility of the report.

Without comprehensive clinical documentation, the validity and reproducibility of the impairment conclusion are compromised. Reject or request supplemental detail before accepting the report's findings.

No MMI Statement or Premature Rating (<6 months)

Ratings prior to MMI are invalid
Ratings assigned before the claimant has reached maximum medical improvement (MMI) are invalid due to the potential for further clinical change.

Confirm date and clinical basis of MMI
Claims reviewers should confirm the date and clinical rationale for when MMI was determined before accepting an impairment rating.

Delay rating if premature
If the impairment rating is assigned prior to MMI, the rating should be delayed until the claimant has reached a stable clinical condition.

By ensuring that impairment ratings are only assigned after the claimant has reached MMI, claims professionals can avoid relying on invalid ratings and better understand the true extent of the claimant's impairment.

Incorrect AMA Guides Citation

Referencing the wrong edition of the AMA Guides
Using the incorrect edition of the AMA Guides may reflect inexperience or lack of attention to jurisdictional requirements.

Using vague terms like "AMA Guidelines"
Ambiguous references to the AMA Guides can indicate a lack of familiarity with the proper citation format.

Verify the edition cited matches jurisdictional requirements
Ensure the edition of the AMA Guides used in the report aligns with the specific edition mandated by the jurisdiction.

Incorrect or vague references to the AMA Guides may signify the evaluator's lack of experience or familiarity with the proper citation requirements. Verifying the edition used and ensuring it matches the jurisdictional standard is crucial for ensuring the credibility and defensibility of the impairment rating.

Unusually High or Low Impairment Values

Whole Person Impairment (WPI) >10% without strong objective basis
Ratings that are disproportionately high compared to the clinical severity should be scrutinized.

WPI <10% in cases of significant trauma
Ratings that are disproportionately low compared to the injury complexity should also be closely examined.

Assess consistency with objective findings and injury complexity
The impairment rating should be proportionate to the clinical evidence and the overall injury picture.

Unusually high or low impairment ratings should raise flags and prompt a closer review to ensure the rating is consistent with the objective clinical data and the overall severity of the injury.

Diagnosis-Related Rating Problems

Conditions with High Variability

Conditions like CRPS or disc herniation without radiculopathy are prone to over-rating and subjectivity due to their high variability.

Diagnostic Controversy

Conditions with diagnostic controversy are also susceptible to over-rating and subjectivity in impairment evaluations.

Demand High-Level Documentation

Require comprehensive, high-level documentation and clear diagnostic substantiation to support impairment ratings for these problematic conditions.

By being vigilant about diagnosis-related rating problems, claims professionals, attorneys, and independent reviewers can ensure that impairment evaluations for conditions with high variability or diagnostic controversy are supported by robust evidence and objectivity.

Multiple Diagnoses Rated

Red Flag: Multiple Diagnoses

Especially if acute injury with documentation that this involved a single region or reported as a cumulative trauma disorder.

Why It Matters

Injuries may result in multiple problems associated with permanent impairment; however, more commonly there is a single ratable diagnosis. If multiple problems are alleged to cumulative trauma, careful causation analysis is required.

Action: Scrutinize Multiple Diagnosis Cases

Especially regarding accuracy of the diagnoses and causation.

Careful review of multiple diagnoses is crucial to ensure accurate assessment and appropriate treatment for injured workers.

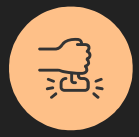
Missing Tables, Figures, or Method References

No citation of Guides Table, Figure, or section used

Lack of citations for the Guides tables, figures, or sections used to derive the impairment compromises transparency and reproducibility.

Lack of transparency in rating methodology

Without citing the specific Guides references, the process used to calculate the impairment rating is unclear.



Inability to independently verify the rating

Without the citation trail, it is impossible for a reviewer to replicate the impairment calculation and assess its accuracy.

Require full citation trails for all numerical impairment findings to ensure transparency, reproducibility, and the ability to independently verify the rating methodology.

Use of Disallowed or Subjective Rating Methods

Strength loss ratings without clear neurologic deficit

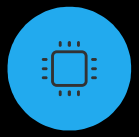
The AMA Guides restrict the use of strength loss ratings unless there is a clear neurologic deficit, as this method is prone to subjectivity and inflation.

Unvalidated hand/nerve rating methods

The AMA Guides also prohibit the use of unvalidated hand and nerve rating methods, as they lack the necessary scientific evidence and standardization.

Claims professionals, attorneys, and independent reviewers should reject or challenge the use of any rating methods that are restricted or disallowed by the AMA Guides, as they can lead to subjective and inflated impairment ratings.

Software-Based Ratings Lacking Clinical Insight



Ratings based solely on software outputs

Software outputs can be prone to errors and misuse if not accompanied by clinical reasoning

Lack of clinician interpretation

Software-based ratings require narrative rationale and clinician interpretation beyond the software

To ensure reliability and validity of impairment ratings, require narrative rationale and clinician interpretation beyond software-based outputs. Evaluators must be knowledgeable about the use of the AMA Guides rather than dependent on software.

Invalid or Inconsistent Clinical Findings

Findings not aligned with anatomy

Findings that do not match the expected patterns based on anatomy and physiology should be challenged.

Findings not aligned with physiology

Physiologically implausible findings should raise concerns and prompt further investigation.

Findings not aligned with clinical exam principles

Findings that do not adhere to established clinical examination techniques and principles should be scrutinized.

By identifying clinical findings that are not aligned with established principles of anatomy, physiology, and clinical examination, claims professionals, attorneys, and independent reviewers can effectively challenge the validity and reliability of the impairment evaluation. Requesting clarification or a second opinion can help address these concerns and ensure the accuracy of the final impairment rating.

Internal Report Inconsistencies

Contradictions between history and records

Inconsistencies between the patient's reported history and the medical records undermine the report's credibility.

Discrepancies in examination findings

Examination findings that do not align with the reported history or medical records raise concerns about the evaluator's objectivity.

Conclusions not justified by clinical evidence

Impairment conclusions that are not clearly linked to and supported by the documented history, examination, and test results should be rejected.

Internal inconsistencies within the report undermine the credibility and validity of the impairment evaluation. These reports should be flagged for peer review, and those with unresolved contradictions should be rejected.

Use of Non-Standard or Jurisdictionally Prohibited Methods

Ratings must be based on standardized, accepted methods

Impairment ratings should comply with both the AMA Guides and local legal standards. In California, carefully evaluate Almaraz-Guzman approaches to determine if appropriate.

Ensure pain ratings or other methods are jurisdictionally permitted

Certain pain rating methods or approaches may be prohibited in some jurisdictions

By ensuring that impairment ratings adhere to standardized, accepted methods and are compliant with jurisdictional requirements, claims professionals, attorneys, and independent reviewers can improve the reliability and defensibility of the conclusions.

Diagnosis-Inconsistent Impairment Ratings

Impairment is often diagnosis-driven

The impairment rating must be derived from the diagnosis that matches the causally related injury.

Mismatched diagnosis and injury

A rating based on a diagnosis that does not align with the causally related injury is invalid.

In the Sixth Edition, match impairment class and category

The impairment rating must be based on the appropriate impairment class and category for the injury diagnosis.

Ensure that the impairment rating is derived from the correct diagnosis that matches the causally related injury. This helps maintain the validity and accuracy of the impairment assessment.

Improper Use of Range of Motion (ROM)

ROM has limited use and may be unreliable.

Range of motion (ROM) has limited use and is subject to edition-specific applicability. Make sure measurements are consistent with other documentation.

Confirm edition-specific applicability

Confirm the edition-specific ROM applicability and documentation rigor.

Reporting forms

With complex hand cases, impairment rating worksheet should always be completed.

By being aware of the proper use and documentation of Range of Motion (ROM) in impairment evaluation reports, claims professionals, attorneys, and independent reviewers can ensure the accuracy and credibility of the impairment conclusions.

Mathematical Errors

Incorrect use of Combined Values Chart

Errors in applying the Combined Values Chart can materially alter the final impairment rating.

Averaging methods errors

Mistakes in the averaging of multiple impairment values can lead to inaccurate final ratings. Maximum value is used.

Formula application mistakes

Improper use of the formulas and calculations specified in the AMA Guides can result in invalid impairment ratings.

To ensure the accuracy of impairment ratings, it is essential to independently verify all calculations and mathematical applications made by the evaluator.

Pain Used as Standalone Impairment

AMA Guides generally discourage pain-only ratings

The AMA Guides generally do not recommend rating impairment based solely on pain, as this can lead to subjective and inflated assessments.

Exception: Jurisdictionally permitted and clearly justified

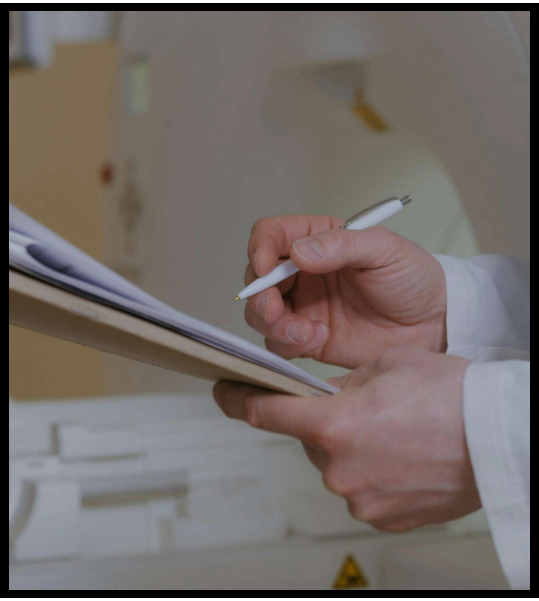
However, there may be some exceptions where pain-only ratings are allowed, but these must be clearly justified and permitted by the jurisdiction.

Disallow standalone pain ratings unless criteria met

Claims professionals, attorneys, and independent reviewers should disallow standalone pain ratings unless they meet the jurisdictional requirements and are clearly justified.

By carefully reviewing impairment evaluation reports for the use of pain-only ratings, claims professionals, attorneys, and independent reviewers can ensure that impairment assessments are based on objective, standardized methods and are in compliance with jurisdictional requirements.

What are some of the specific problems encountered?



Evaluator Errors

- Incomplete and erroneous assessment (resulting from lack of knowledge and skills and incorrect and inefficient processes)
- GIGO (Garbage In – Garbage Out)
- Bias
- Not understanding issues from a biopsychosocial perspective
- Failure to distinguish subjective vs. objective
- Not using evidence-based medicine to assess the facts
- Faulty assessment of maximum medical improvement (MMI), causation, apportionment, and other critical issues
- Failure to adhere to standards and processes defined in the AMA *Guides*

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)

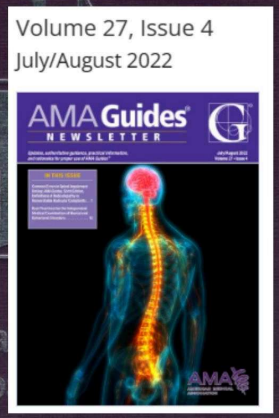
- Inadequate and unreliable clinical evaluation (including motion and strength testing)
- Using unreliable data (e.g., inconsistent with other documentation)
- Ratings based on strength loss
- Misuse of other disorders
- Ratings of CRPS

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

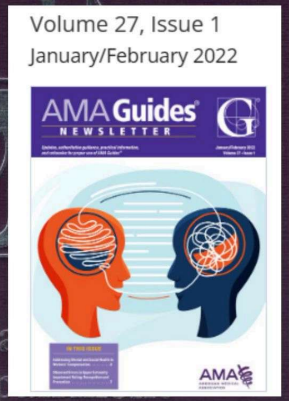
Spine Assessment Errors (Sixth Edition)

- Inadequate and unreliable clinical evaluation
- Incorrect diagnosis
- Not distinguishing radiculopathy vs. nonverifiable radicular complaints



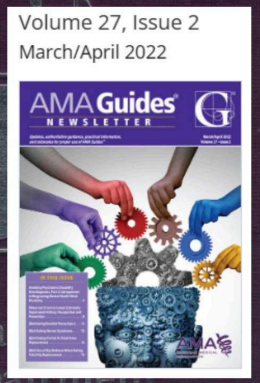
Upper Extremity Assessment Errors (Sixth Edition)

- Inadequate and unreliable clinical evaluation
- Incorrect diagnosis
- Rating for more than one diagnosis
- Incorrect assessments of motion loss, nerve injuries, entrapment disorders, and CRPS.



Lower Extremity Assessment Errors (Sixth Edition)

- Inadequate and unreliable clinical evaluation
- Incorrect diagnosis
- Rating for more than one diagnosis
- Incorrect assessments of gait, motion loss, nerve injuries, and CRPS.

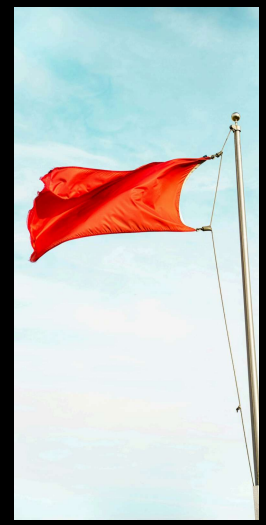


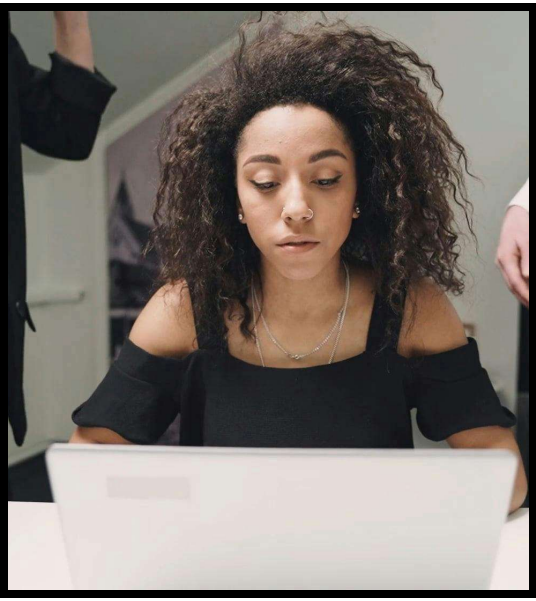
Red Flags

- Biased Treating or Known Biased Evaluator
- Outside Specialty Scope Evaluation
- Untrained or Uncredentialed Evaluator
- Disorganized or Unprofessional Report
- Missing Clinical or Rating Details
- No MMI or Premature Rating
- Incorrect AMA Guides Citation
- Implausible High or Low Rating
- Controversial or Questionable Diagnosis Basis
- Multiple Diagnoses Without Justification
- Missing Guides Table or Method
- Disallowed or Subjective Methods
- Used Software Used Without Clinical Insight
- Invalid or Unreliable Clinical Findings
- Contradictory Report Content
- Non-Standard or Prohibited Methods
- Diagnosis Doesn't Match Injury
- ROM Used Incorrectly
- Errors in Calculations
- Pain Rated Without Basis

Summary of Red Flags in Impairment Evaluation Reports

By being aware of these red flags in impairment evaluation reports, claims professionals, attorneys, and independent reviewers can more effectively identify and address issues with the accuracy, objectivity, and credibility of the ratings. Implementing a structured quality checklist, tracking evaluator patterns, and engaging certified medical reviewers can help ensure the reliability and defensibility of the impairment conclusions.





How do I best evaluate reports?

✅ Independent Medical Evaluation and Impairment Rating Report Checklist

Section 1: Case Specifics

- ☐ Case/File Number listed
- ☐ Evaluator identified
- ☐ Specialty of evaluator included
- ☐ Qualifications of evaluator to perform evaluation (e.g., Certified Impairment Rater)
- ☐ Type of report (e.g., IME, AME, QME, PTP) clearly indicated
- ☐ Requesting party identified (defense, plaintiff, employer, insurer)
- ☐ Date of injury specified
- ☐ Date of report stated
- ☐ Interval from injury to report calculated (in months)
- ☐ Report length noted (pages or word count)

Section 2: Narrative Critique

1. Structure and Presentation

- ☐ Logical organization and clear headings/subheadings
- ☐ Professional formatting, spelling, and grammar
- ☐ Tone is objective and professional
- ☐ Language is readable for non-medical stakeholders

2. Comprehensiveness

- ☐ All key report components included (history, medical documents, exam, analysis references)
- ☐ Level of detail appropriate to case complexity

3. Introduction

- ☐ Purpose of the report clearly stated
- ☐ Referring source and scope of evaluation defined
- ☐ Historian identified and corroborated with medical records

4. Medical History

- ☐ Full injury history, including onset, symptoms, mechanism, and context
- ☐ Chronological clinical timeline provided
- ☐ Pre-existing and comorbid conditions noted
- ☐ Complete medical background:
  - ○ Past Medical History
  - ○ Review of Systems
  - ○ Family History
  - ○ Personal, Social and Occupational History

5. Medical Record Review

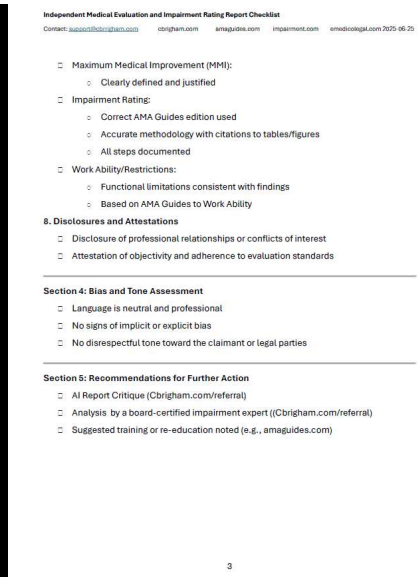
- ☐ Process: Human, Artificial Intelligence, or both
- ☐ Adequate volume and relevancy of reviewed records
- ☐ Key findings integrated into the narrative
- ☐ Inconsistencies, gaps, or missing records identified

6. Physical Examination

- ☐ Exam appropriate to body part and diagnosis
- ☐ Objective measurements provided
- ☐ Distinction made between subjective and objective findings
- ☐ Assessment of non-physiologic findings (e.g., Waddell signs) included

7. Conclusions and Medical Opinions

- ☐ Diagnoses:
  - ○ ICD-10 codes provided
  - ○ Justified and consistent with facts and evidence-based medicine
- ☐ Clinical/Case Analysis:
  - ○ Logical reasoning supported by facts and evidence-based medicine
- ☐ Causation:
  - ○ Consistent with *AMA Guides to Evaluation of Disease and Injury Causation* (www.causation.com) and other evidence-based medical resources.
  - ○ Transparent, reasoned opinion



Independent Medical Evaluation and Impairment Rating Report Checklist

Contact: support@cbrigham.com cbrigham.com amaguides.com impairment.com emedicolegal.com 2025-06-25

- ☐ Maximum Medical Improvement (MMI):
  - ○ Clearly defined and justified
- ☐ Impairment Rating:
  - ○ Correct AMA Guides edition used
  - ○ Accurate methodology with citations to tables/figures
  - ○ All steps documented
- ☐ Work Ability/Restrictions:
  - ○ Functional limitations consistent with findings
  - ○ Based on AMA Guides to Work Ability

8. Disclosures and Attestations

- ☐ Disclosure of professional relationships or conflicts of interest
- ☐ Attestation of objectivity and adherence to evaluation standards

---

Section 4: Bias and Tone Assessment

- ☐ Language is neutral and professional
- ☐ No signs of implicit or explicit bias
- ☐ No disrespectful tone toward the claimant or legal parties

---

Section 5: Recommendations for Further Action

- ☐ AI Report Critique (Cbrigham.com/referral)
- ☐ Analysis by a board-certified impairment expert ((Cbrigham.com/referral)
- ☐ Suggested training or re-education noted (e.g., amaguides.com)

3

What the best way to evaluate a physician's impairment evaluation report?

- **Use a Checklist**
  Develop a comprehensive checklist to guide your evaluation of the physician's impairment report, ensuring all key elements are thoroughly reviewed.
- **Leverage AI Tools**
  Utilize AI-powered technology tools to analyze the report, identify inconsistencies, and flag potential issues for further investigation.
- **Review Methodologies**
  Carefully examine the methodologies and assessment techniques used by the physician to ensure they align with industry standards and best practices.
- **Assess Objectivity**
  Evaluate the physician's objectivity and impartiality in their assessment, looking for any potential biases or conflicts of interest.
- **Validate Findings**
  Cross-reference the physician's findings with other medical records, expert opinions, and relevant guidelines to validate the conclusions.

IME/Impairment Rating Report Checklist

- **Case/File Details**
  Include case/file number, evaluator's name and specialty, qualifications, report type, and requesting party
- **Injury Details**
  Specify date of injury, date of report, and interval from injury to report
- **Narrative Structure**
  Ensure logical organization, clear headings, professional formatting, objective tone, and readable language
- **Comprehensive Evaluation**
  Cover all key report components like history, medical documents, examination, analysis, and references
- **Medical History**
  Provide full injury history, chronological timeline, pre-existing conditions, and complete medical background
- **Record Review**
  Integrate key findings from adequate and relevant medical records, identify inconsistencies or gaps
- **Physical Examination**
  Conduct appropriate exam, provide objective measurements, distinguish subjective and objective findings, assess non-physiologic signs
- **Conclusions & Opinions**
  Justify diagnoses, provide logical clinical analysis, transparent causation opinion, define MMI, calculate accurate impairment rating, and assess work ability

Identify Case Specifics and Track

Case/File Number	Evaluator	Specialty	Qualifications	Report Type	Requesting Party	Date of Injury	Report Date	Interval (months)	Report Length
ABC123	Dr. Jane Doe	Orthopedic Surgeon	Certified Impairment Rater	IME	Defense	01/15/2021	03/01/2021	1.5	12 pages
XYZ456	Dr. John Smith	Physical Medicine and Rehabilitation	Certified Impairment Rater	QME	Plaintiff	07/01/2020	09/15/2020	2.5	20 pages
LMN789	Dr. Sarah Lee	Occupational Medicine	Certified Impairment Rater	AME	Employer	11/20/2019	01/10/2020	1.7	18 pages

*The data for this table was generated specifically for this slide and does not derive from any other work.

Structure and Presentation

Logical Organization
Clearly structured with headings and subheadings to guide the audience through the content

Professional Formatting
Consistent formatting, spelling, and grammar conventions to maintain a polished, credible appearance

Objective Tone
Avoids bias or personal opinions, focusing on facts and data to convey the information objectively

Readable Language
Uses plain language and avoids medical jargon to ensure understanding by non-medical stakeholders

Well-structured, professionally formatted report more likely to reflect a thoughtful evaluation and communicates complex information in a clear, objective manner.

Comprehensive Medical Report

Complete History
Detailed account of patient's medical background, including past illnesses, hospitalizations, and surgical procedures

Thorough Physical Examination
Detailed description of the patient's current physical condition, including vital signs, system-specific findings, and any abnormalities

Comprehensive Medical Documents
Inclusion of all relevant medical records, lab results, imaging studies, and specialist reports

Detailed Analysis and References
In-depth interpretation of the case, with citations to relevant medical literature and guidelines

The report covers all key components in a level of detail appropriate to the case complexity, ensuring a comprehensive understanding of the patient's condition.

Report Introduction

Introduction
Provides an overview of the report and its purpose

Referring source and scope of evaluation
Defines the sources used and the extent of the evaluation

Purpose of the report
Clearly states the objectives and goals of the report

Historian identified and corroborated with medical records
Identifies the historian and verifies the information using medical records

A comprehensive introduction to the report outlines its purpose, scope, and the sources used, ensuring the reader is well-informed about the key aspects of the evaluation.

Medical History Summary

Medical Record Review Process

Medical Record Review
Evaluate the process for reviewing medical records, whether it involves human, artificial intelligence, or a combination of both.

Adequate Volume and Relevancy of Reviewed Records
Ensure that the volume of reviewed records is sufficient and the records are relevant to the assessment or analysis being conducted.

Key Findings Integration
Integrate the key findings from the medical record review into the overall narrative or report.

Inconsistencies, Gaps, or Missing Records Identification
Identify any inconsistencies, gaps, or missing records in the reviewed medical documentation.

Comprehensive Medical Evaluation

- **Diagnoses**
  Diagnose that are justified and consistent with facts and evidence-based medicine
- **Clinical/Case Analysis**
  Logical reasoning supported by facts and evidence-based medicine
- **Causation**
  Consistent with AMA Guides to Evaluation of Disease and Injury Causation and other evidence-based medical resources. Transparent, reasoned opinion
- **Maximum Medical Improvement (MMI)**
  Clearly defined and justified
- **Impairment Rating**
  Correct AMA Guides edition used, accurate methodology with citations to tables/figures, all steps documented
- **Work Ability/Restrictions**
  Functional limitations consistent with findings, based on AMA Guides to Work Ability

Disclosures and Attestations

Disclosure of Professional Relationships
Transparently share any professional relationships, consulting roles, or financial interests that could influence the evaluation or analysis

Disclosure of Potential Conflicts of Interest
Openly acknowledge any personal, financial, or organizational conflicts that may impact objectivity

Commitment to Objectivity
Affirm adherence to evaluation standards and a commitment to providing unbiased, impartial assessments

By transparently disclosing relevant relationships and affirming objectivity, we can build trust and confidence in the evaluation process.

Bias and Tone Assessment

Neutral Language
Objective and impartial language, no emotional or subjective phrasing

No Implicit Bias
No references to race, gender, age, or other protected characteristics

Professional Tone
Formal, respectful, and courteous language towards all parties

The language used in the document is objective, impartial, and devoid of any signs of bias or disrespect towards the claimant or legal parties.

Recommendations for Further Action: Report Critique

Strategize
Provide specific recommendations for next steps based on your initial review.

ImpairmentCheck
Use tool to evaluate rating for common conditins.

Report Critique (cbrigham.com/referral)
Obtain a comprehensive analysis of the report from a board-certified expert

Analysis by a board-certified impairment expert (cbrigham.com/referral)
Engage a qualified professional to provide an in-depth analysis of the report's findings

By implementing these recommendations, you can ensure a thorough and informed approach to addressing the concerns raised in the report.

Addressing Suspected Impairment Rating Errors

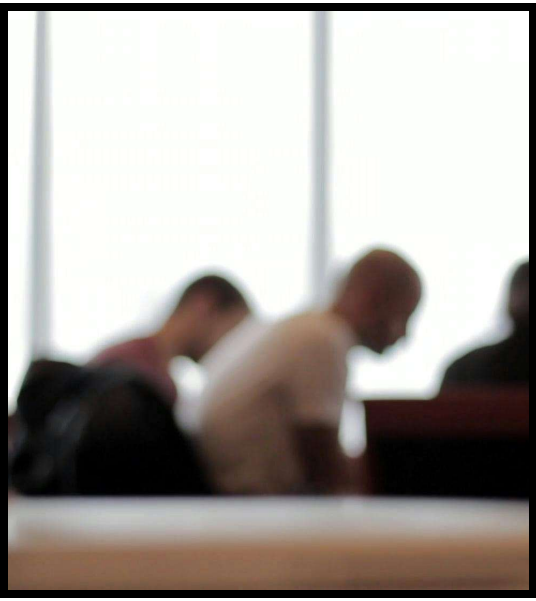
Obtain expert review
Consult a qualified expert to clarify the issues and assist in developing strategies

Communicate with evaluating physicians
Use a carefully designed script to communicate with the evaluating physicians

Perform independent review or IME
Conduct an independent document review or an independent medical examination (IME) by a qualified physician, with appropriate referral letter and standards

Challenge physician with cross-examination
Plan for cross-examination with the assistance of experts, framing questions to challenge the physician's findings

By taking these steps, you can effectively address a suspected impairment rating error and ensure a fair and accurate assessment of the case.



Let's answer more questions.

How do I increase the likeliness of obtaining an accurate rating?

Determine when and how to obtain a rating
Decide if the rating will be requested from the treating physician, through a document review by an experienced rating physician, or an independent medical evaluation

Choose the right expert
Select a trained, qualified and experienced professional to conduct the rating assessment

Provide clear guidance on issues to be addressed and records
Clearly communicate the specific information and documentation the expert should review to ensure an accurate rating based on best practices. If using an IME entity, ensure they are selecting the appropriate provider and offering needed direction.

By following these steps, you can ensure an accurate rating from the start and obtain the necessary information to support your case.

What are common referral entity errors?

- **Selecting an Inappropriate Evaluator**
  Choosing an assessor who lacks the necessary expertise, experience, or qualifications to accurately evaluate the impairment and medicolegal issues.
- **Inadequate Knowledge, Skills, and Credentials**
  Relying on an evaluator who does not possess the required knowledge, skills, and credentials to assess impairment and other medicolegal concerns.
- **Incorrect Specialty**
  Selecting an evaluator whose specialty does not align with the specific medical issues being assessed.
- **Biased Evaluation**
  Allowing personal biases or conflicts of interest to influence the impartiality and objectivity of the evaluation.
- **Prioritizing Cost over Quality**
  Choosing a lower-cost evaluator at the expense of obtaining a comprehensive and high-quality assessment.
- **Inadequate IME Vendor Standards**
  Relying on an independent medical examination (IME) vendor with insufficient quality standards and processes.
- **Incomplete Medical Records**
  Failing to provide the evaluator with all the relevant medical records necessary for a thorough assessment.
- **Lack of Quality Standards and Specific Questions**
  Not establishing clear quality standards and specific questions to be addressed by the evaluator.

What's New with the AMA Guides?

Updates AMA Guides 2024
Revised guidelines and assessment methods for the upcoming year

Available training through AMAGuides.com
Comprehensive training courses and resources on the AMA Guides

www.amaguidesdigital.com
Online platform for accessing and utilizing the AMA Guides

Insights from upcoming talks (e.g., WCI Judiciary College)
Presentations and discussions on the latest developments in the AMA Guides

Stay informed and prepared for the upcoming changes and enhancements to the AMA Guides.

What is the best way to master the AMA *Guides*?

- **Assess your specific needs**
  Determine your learning objectives, areas of focus, and desired outcomes for mastering the AMA Guides
- **Evaluate training options**
  Consider self-study, online courses, in-person workshops, or a combination to find the best fit for your learning style and schedule
- **Look for experienced trainers**
  Seek out trainers with extensive knowledge of the AMA Guides, practical experience, and a proven track record of effective instruction
- **Prioritize interactive learning**
  Choose training methods that encourage active participation, hands-on exercises, and opportunities for discussion and feedback
- **Consider cost and convenience**
  Weigh the direct costs of training, as well as indirect costs like travel and time investment, to find the most cost-effective and convenient option
- **amaguides.com**

What is the role of AI in Impairment Evaluation?

Improved Consistency
AI can standardize the evaluation process, reducing variability and ensuring more consistent assessments; however, it is not yet reliable in assessing impairment.

Nuance and Context Limitations
AI may struggle to fully capture the nuances and contextual factors that are critical in impairment evaluations, requiring human judgment.

Early Error Detection
AI-powered tools can analyze data and flag potential issues or errors early in the evaluation process, allowing for timely corrections.

Human Judgment Importance
Ultimately, human expertise and decision-making remain essential in interpreting the complexity of impairment cases and making informed determinations.

AI can enhance certain aspects of impairment evaluations, but it has challenges in assessing impairment (more so than other areas), thus human expertise and judgment remain crucial in delivering comprehensive and accurate assessments.

Can you provide me with examples and demonstrate what you do?

Examples of Impairment Rating Critiques

Hand injury
Critique of hand injury impairment rating, with inadequate clinical assessment and inappropriate ratings

Spinal injury rating
Critique of spinal injury impairment rating due to incorrect attribution of cumulative trauma

Careful assessment and accurate attribution of impairment is crucial for fair and appropriate compensation.

Case Example: Severe Finger Injury and Surgical Treatment

Mr. Patient, a 63-year-old man, sustained a severe injury to his left middle finger on January 31, 2023, involving comminuted and displaced fractures of the proximal phalanx and distal metacarpal head, with associated tendon damage. He underwent two surgical procedures—initial open reduction and internal fixation, followed by tenolysis, capsulotomy, and hardware removal. Despite rehabilitation, he experienced persistent stiffness, pain, and ulnar deviation.

Primary Treating Physician's Permanent and Stationary Report (PR-4) - Addendum

DOI 1 /3112023

Treatment:12/2012024

Description of how injury/illness occurred:

left middle finger injury

Patient's Complaints:

62 yr old RHD male

iron worker x 16 yrs

S/P left 3rd metacarpal head ORIF, prox phlx ORIF, & ext tendon repair (2/1/23)

SIP left middle finger extensor tenolysis, PIP capsulotomy, & prox phlx hardware removal (6/9/24)

12/20/24:

was using a grinder on 1/31/23, lost control of it and cut/injured left middle finger

had surgery at UCLA; underwent ORIF of 3rd metacarpal head & 3rd proximal phalanx, and extensor tendon repair (2-1-23)

then had post-op hand therapy

eventually had 2nd surgery: L middle finger extensor tenolysis, PIP capsulotomy, & hardware removal (6-19-24)

then again post-op PT as well as Dynasplint

declared Permanent & Stationary on 8-20-24

now using biofreeze, warming pads, and handheld massager

c/o occasional left forearm sharp pain

hand will also ache sometimes with use at work

sometimes hard to lift heavier items, may need assistance

here for PD rating

CONTEXT / MECHANISM: Hurt by equipment.

LOCATION: Left Finger and left Hand.

DURATION: 2 years.

SIGNS / SYMPTOMS: Pain and Stiffness.

QUALITY: Comes and goes and Constant.

Physical Examination:

left hand:

healed laceration/incision to dorsum of left hand by 3rd MP joint, out longitudinally to dorsum of3rd PIP joint

mild swelling around incision and middle finger

no erythema or signs of infection

non tender

ulnar deviation of middle finger at level of PIP joint, 15 degrees ulnar deviation

no rotational deformity

no crepitus

no subluxation ofEDC tendon at dorsal MP joint

intact sensibility to middle finger and remainder of left hand

no hyperesthesia

no allodynia

no triggering

but stiffness visible to left hand

ROM:

Joint	Thumb	Index	Middle	Ring	Small
MP joint	0/70	+10/60	0/70	0/65	+20/75
PIP joint	+20/35	0/95	-15/60	0/90	0/95
DIP joint		0/65	-20/55	0/60	0/70

Abduction 60 deg

Adduction 2.5 cm

Opposition 6cm

Patient's (HPI) History of Present Illness, (PMFSH) Past Medical, Social & Family History, and (ROS) Review of Systems reviewed prior to exam.

Chronic conditions that have or could exacerbate or complicate today's acute symptoms have been reviewed and addressed.

Patient advised F/U with PCP for the treatment and management of other chronic conditions/symptoms.

CONSTITUTIONAL:

Distress: Negative

Lethargy: Negative

Pale Palpebral Conjunctiva: Negative

Discharge: Negative

Ptosis: Negative

NEUROLOGICAL

Disoriented: Negative

Facial Palsy: Negative

Weakness Unilateral: Negative

PSYCHOLOGICAL:

Anxious: Negative

Tearful: Negative

Uncooperative: Negative

SKIN:

Erythema: Negative

Pale: Negative

Jaundice: Negative

Rash: Negative

CARDIOVASCULAR:

Diaphoresis: Negative

Tachycardia: Negative

Bradycardia: Negative

Central Cyanosis: Negative

RESPIRATORY:

Respiratory Distress: Negative

Tachypnea: Negative

Hypoapnea: Negative

Accessory Muscle Use: Negative

MUSCULOSKELETAL - FINGERS:

Site: left

Deformity: Positive

1st Digit/ Thumb: negative

2nd Digit/Index: negative

3rd Digit/Middle: Swelling and Wound

4th Digit/Ring: negative

5th Digit/Pinky: negative

PIP: Swelling

MCP: negative

DIP: negative

Sign of Infection: Negative

Paronychia: Negative

Decreased ROM: Positive

Sensory Deficit: Negative

RANGE OF MOTION: Digit

Site: left Middle (3rd)

MCP Flexion: 70 degrees (NL-90 degrees)

MCP Extension: 0 degrees (NL-5 degrees)

DOI 1/31 /2023

Treatment:12/20/2024

PIP Flexion: 60 degrees (NL-110 degrees)

PIP Extension: -15 degrees (NL-5 degrees)

DTP Flexion: 55 degrees (NL-60 degrees)

DIP Extension: -20 degrees (NL-5 degrees)

RANGE OF MOTION: Thumb

Site: left

MCP Flexion: 70 degrees (NL-90 degrees)

MCP Extension: 0 degrees (NL-5 degrees)

JP Flexion: 35 degrees (NL-110 degrees)

IP Extension: 0 degrees (NL-5 degrees)

Diagnostic Tests Results:

DIAGNOSTIC TEST RESULTS:

The following are the test results for: JAMAR

Dominant Hand: Right

Affected Extremity: Left

Right Extremity- 83 psi (1st attempt)

Right Extremity- 76 psi (2nd attempt)

Right Extremity- 81 psi (3rd attempt)

Left Extremity- 50 psi (1 st attempt)

Left Extremity- 48 psi (2nd attempt)

Left Extremity- 48 psi (3rd attempt)

Clinician ID: ay.

Impairment Rating:

This patient has 15% Whole Person Impairment (WPI). Chapter 16 criteria from AMA Guides, 5th edition were used to determine this. Not only is the left middle finger stiff, but due to the severity of the original injury as well as the post- operative immobilization he underwent for fracture healing, he has developed compensatory stiffness in the other 4 digits of his left hand. He also has ulnar deviation of the middle finger. Grip strength criteria were also used to determine his disability rating.

The patient has stiffness of all 5 digits on his left hand. The thumb has range of motion (ROM) at the MP joint of 0/70. According to page 457, figure 16-15, this is worth 0% & 0% thumb MP impairment, respectively. They add together to give 0% thumb MP impairment. The IP joint has ROM of +20/35. This is rated on page 456, figure 16-12, to be worth 0% & 3.5% IP joint impairment, respectively. They add together to give 3.5% IP joint impairment. He has left thumb abduction of 60 degrees. This is rated on page 459, table 16-88, to be worth 0% thumb impairment. He has left thumb adduction of 2.5 cm. This is rated on page 459, table 16-88, to be worth 2% thumb impairment. He has left thumb opposition of 6 cm. This is rated on page 460, table 16-9, to be worth 3% thumb impairment. All five joint values are added together to give 8.5% thumb impairment. On page 438, table 16-1, this converts to 3.5% hand impairment due to thumb stiffness.

The patient also has stiffness of his left index finger. The four fingers all used similar figures within chapter 16 of the AMA Guides to calculate disability due to stiffness. The index finger MP joint has ROM of +10/60. This is rated on page 464, figure 16-25, to be worth 3% & 17% index finger MP joint impairment, respectively. They add together to give 20% MP joint impairment. The PIP joint has ROM of 0/95. This is rated on page 463, figure 16-23, to be worth 0% & 3% index PIP impairment, respectively. They add together to give 3% PIP joint impairment. The DIP joint has ROM of 0/65. This is rated on page 461, figure 16-21, to be worth 0% & 2.5% DIP impairment, respectively. They add together to give 2.5% DIP joint impairment. The three individual joint values combine together to allow for 24% index finger impairment Using page 438, table 16-1, this converts to 5% hand impairment due to index finger stiffness.

The middle finger MP joint has ROM of 0/70. On page 464, figure 16-25 rates this as 5% & 11% = 16% MP impairment. The PIP joint has ROM of -15/60. On page 463, figure 16-23 rates this as 3% & 24% = 29% PIP impairment. The DIP joint has ROM of -20/55. On page 461, figure 16-21 rates this as 4% & 7.5% = 11.5% DIP impairment. These combine to be worth 47% middle finger impairment due to stiffness. There is also ulnar deviation of the middle finger at the PIP joint of 15 degrees. This is rated on page 500, table 16-20, to be considered "moderate deviation" worth 20% digit impairment. The 47% is combined with 20% to allow for 58% middle finger impairment. On page 438, table 16-1, this converts to 12% hand impairment due to middle finger stiffness and deformity.

The ring finger MP joint has ROM of 0/65. On page 464, figure 16-25 rates this as 5% & 14% = 19% MP impairment. The PIP joint has ROM of 0/90. On page 463, figure 16-23 rates this as 0% & 6% = 6% PIP impairment. The DIP joint has ROM of 0/60. On page 41, figure 16-21 rates this as 0%&5%= 5% DIP impairment. The three joint values combine to be worth 28% ring finger impairment, which is converted on page 438, table 16-1, to be worth 3% hand impairment due to ring finger stiffness.

The small finger MP joint has ROM of +20/70. On page 464, figure 16-25 rates this as 0% & 8.5% = 8.5% MP impairment. The PIP joint has ROM of 0/95. On page 463, figure 16-23 rates this as 0% &3%=3% PIP Impairment. The DIP joint has ROM of 0/70. On page 461, figure 16-21 rates this as 0%&0%= 0% DIP impairment. The three joint values combine to be worth 11.5% small finger impairment, which is converted on page 438, table 16-1, to be worth 1% hand impairment due to small finger stiffness.

The five digital contributions to hand impairment values are then added together to allow for 24.5% total hand impairment. On page 439, table 16-2, this converts to 22.5% upper extremity impairment.

The patient also lacks full grip strength to his left hand. While he has some stiffness of his left hand, it is not so much to prohibit grip strength testing. He is able to grip the Jamar dynamometer.

Furthermore, it has been over 10 minutes since his most recent surgery. It is not likely that another 1.5 months will make a significant change in his grip strength, as the original injury was almost 2 years ago. Therefore, grip strength criteria were included in his Permanent Disability rating. His right (uninjured) hand has grip strength of 83 lbs, 76 lbs, & 81 lbs. These average 80 lbs. His left (injured) hand has grip strength of 50 lbs, 48 lbs, & 48 lbs. These average 48.7 lbs. Using the formula set aside on page 509, this represents 39% strength loss index. On table 16-34, this is worth 20% upper extremity impairment. On page 499, table 16-18, involvement of the entire middle finger is worth a maximum of 18% upper extremity impairment. 20% x 18% = 3.6% upper extremity impairment due to grip strength loss from his middle finger injury. This can be rounded to 3.5% upper extremity impairment.

The 22.5% upper extremity impairment from digital stiffness and deformity is then combined with the 3.5% upper extremity impairment due to strength loss to allow for a total upper extremity impairment of 25%. On page 439, table 16-2, this translates into 15% WPI.

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Pain Assessment:

mild achiness occasionally to left middle finger and hand with use

occasional sharp shooting pains in left forearm with use

Permanent Disability Caused:

15%WPI

Comments:

future medical: repeat MD evaluation if worsening left middle finger stiffness or pain

injury is work related due to acute trauma

no issues of apportionment

Work Restrictions:

full duty

no restrictions

Flawed Impairment Assessment and Need for Comprehensive Evaluation

Physician's impairment assessment

Concluded 15% whole person impairment (WPI) based on deficits in left hand, grip strength loss, and middle finger deformity

Methodological flaws identified

Lack of bilateral range-of-motion measurements, improper inclusion of uninjured fingers, inappropriate grip strength testing, and inadequate consideration of diabetes-related connective tissue pathology

Comprehensive assessment required

Need for a thorough evaluation considering all relevant factors to accurately determine the extent of impairment

The initial impairment assessment was found to be methodologically flawed, highlighting the need for a more comprehensive and accurate evaluation to determine the true extent of the individual's impairment.

Work-Related Left Middle Finger Injury - 7% not 15% Whole Person Impairment

Mr. Patient sustained a work-related injury to his left middle finger, resulting in motion loss and deformity. A corrected, guideline-conforming assessment determined that he has a 58% digit impairment, which converts to a 7% Whole Person Impairment (WPI) according to the AMA Guides (5th Edition). This revised rating reflects the objective anatomical deficits, excluding any non-ratable or unsupported elements.

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www.emedicolegist.com

June 23, 2025

Client
Supervisor
ABC Insurance
Post Office Box 11111
City, State

RE, Individual: Patient
Date of Injury: 1/31/2023
Claim No.: 20230000749
Service: Impairment Rating Analysis

Dear Ms. Client,

Thank you for the opportunity to review the medical records and provide an evaluation of permanent impairment for Mr. Patient, in accordance with the *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition. This assessment was conducted by carefully applying the clinical information found in the provided records to the established processes, procedures, and criteria outlined in the AMA Guides.

Throughout the evaluation, my approach has remained rooted in evidence-based medicine, with a focus on objective clinical findings and adherence to the Guides' methodology. All conclusions presented are offered to a reasonable degree of medical certainty. My objective is to ensure that the resulting impairment determination is accurate, fair, and consistent with the standards set forth in the AMA Guides.

As the former Editor of the *Guides Newsletter*, Editor of the *Guides Casebook*, and Senior Contributing Editor for the musculoskeletal chapters of the *AMA Guides*, Sixth Edition, I bring a deep familiarity with both the theoretical framework and the practical application of the Guides. My intent is to provide an unbiased and clinically grounded assessment that reflects the appropriate use of the Guides and incorporates sound medical judgment.

In the sections that follow, I will present my analysis of Mr. Patient's case. Should there be any need for clarification or further discussion, I would be pleased to assist. If appropriate, this report may also be shared with Dr. Physician as constructive feedback. Given the

complexity of impairment evaluations in cases such as this, my aim is to contribute meaningfully to an equitable and medically supported determination.

Contents

Executive Summary

Mr. Patient, a 63-year-old man, sustained a severe injury to his left middle finger on January 31, 2023, involving comminuted and displaced fractures of the proximal phalanx and distal metacarpal head, with associated tendon damage. He underwent two surgical procedures—initial open reduction and internal fixation, followed by tenolysis, capsulotomy, and hardware removal. Despite rehabilitation, he experienced persistent stiffness, pain, and ulnar deviation.

An impairment assessment by Physician, MD concluded a 15% whole person impairment (WPI) based on deficits across all digits of the left hand, grip strength loss, and middle finger deformity. However, this evaluation was found to be methodologically flawed. Key criticisms included: (1) lack of bilateral range-of-motion measurements; (2) improper inclusion of impairment for uninjured fingers; (3) inappropriate application of grip strength testing in a painful condition; and (4) inadequate consideration of the potential contribution of diabetes-related connective tissue pathology.

A corrected, guideline-conforming assessment—focused solely on motion loss and deformity of the injured middle finger—yielded a 58% digit impairment, which converts to 7% WPI using the AMA Guides (5th Edition). This revised rating reflects objective anatomical deficits, excluding non-ratable or unsupported elements. Therefore, the final credible impairment rating attributed to Mr. Patient's work-related left middle finger injury is 7% Whole Person Impairment.

Documents

You provided 374 pages of documents for analysis; these are reflected in the document chronology appended to this report.

Clinical Summary

Injury

In summary, Mr. Patient is a 63-year-old man who had an injury on 1/31/2023. He had an injury to his left middle finger while using an angle grinder at work. The blade slipped, causing a laceration and fractures to his proximal phalanx and metacarpal head of the left third finger. He reported 10/10 pain.

Pre-Existing Status

Mr. Patient denies prior symptoms. As will be explained, Mr. Patient's diabetes is a significant comorbidity with potential impact on his hands.

History

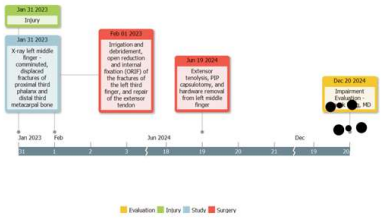
Current Status

Mr. Patient reported to Physician, MD, on December 12, 2024, the following,

> now using biofreeze, warming pads, and hand-held massager c/o occasional left forearm sharp pain. The hand will also ache sometimes with use at work. Sometimes hard to lift heavier items, may need assistance here for PD rating. mild achiness occasionally to left middle finger and hand with use. occasional sharp shooting pains in left forearm with use. full work. no restrictions.

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. Left Middle Finger Pain with Fracture and Surgical History
   a. Comminuted, displaced fractures of proximal third phalanx and distal third metacarpal bone (left middle finger)
      i. S62.625A - Displaced comminuted fracture of proximal phalanx of left middle finger
      ii. S62.305A - Displaced fracture of base of third metacarpal bone, left hand, initial encounter for closed fracture
   b. Status post open reduction and internal fixation (ORIF), tendon repair - 2/1/2023 (one day post injury)
      i. Z96.651 - Presence of left artificial joint or internal fixation device of hand

   c. Extensor tenolysis, PIP capsulotomy, and hardware removal - 6/19/2024
      i. Z47.89 - Encounter for other orthopedic aftercare

These diagnoses are also noted,

2. Diabetes Mellitus
   a. E11.x - Type 2 diabetes mellitus
   b. E11.618 - Type 2 diabetes mellitus with other diabetic arthropathy, probable
3. Hypertension
   a. I10 - Essential (primary) hypertension
4. Hyperlipidemia
   a. E78.5 - Hyperlipidemia, unspecified
5. Chronic Anxiety
   a. F41.1 - Generalized anxiety disorder

Clinical Analysis

Mr. Patient, a 63-year-old man, had an injury to his left middle finger on January 31, 2023, while using an angle grinder at work. The blade slipped, causing a deep laceration that exposed bone and resulted in complex, displaced fractures of both the proximal phalanx (the first bone of the finger) and the metacarpal head (the knuckle bone where the finger connects to the hand).

This type of injury usually affects multiple structures—bone, tendon, and soft tissue. No other digits were involved; the injury was solely to the proximal portion of the left middle finger.

Upon arrival at Centinela Hospital, Mr. Patient presented with severe bleeding, visible bone, and rated his pain at 10/10.

The following is an artificial intelligence image of how this injury may have appeared, based on the description in the records:

Upon arrival at Centinela Hospital, Mr. Patient presented with severe bleeding, visible bone, and rated his pain at 10/10.

The following is an artificial intelligence image of how this injury may have appeared, based on the description in the records:

X-rays confirmed the broken bones were not only fractured but also shifted out of normal alignment. The following day, he underwent surgery that included cleaning the wound, realigning and securing the broken bones with hardware (plates and screws), and repairing the damaged extensor tendon (the tissue that straightens the finger). Initial follow-up showed good healing with the bones properly aligned.

Over the next several months, Mr. Patient participated in occupational therapy to reduce swelling, improve motion, and strengthen his finger. Despite making progress, he continued to experience stiffness with the middle finger, particularly at the proximal interphalangeal), and developed an ulnar deviation (finger angling toward the little finger side). By October 2023, although improving, he still could not make a complete fist and reported intermittent pain.

These persistent limitations led to a second surgery in June 2024, which addressed three problems: freeing up the scarred extensor tendon (tenolysis), releasing the contracted joint capsule (capsulotomy), and removing the hardware previously placed to stabilize the fractures. Following this procedure, Mr. Patient resumed therapy and showed significant improvement in both motion and strength. There is no documentation that there were motion deficits of other digits.

By August 2024, approximately 19 months after the injury, his condition was deemed "permanent and stationary," meaning further significant improvement was unlikely. He was cleared to return to full-duty work. At his December 2024 evaluation, Mr. Patient reported occasional sharp pain in his left forearm, some difficulty lifting heavier items, and mild aching in the finger with use.

Maximum Medical Improvement

The best estimate of the date of achieving Maximum Medical Improvement (MMI), e.g., permanent and stationary status, is August 20, 2024, as opined by Physician, MD.

MMI refers to the point at which a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment. While symptoms and signs of the condition may wax and wane over time, further overall recovery or deterioration is not anticipated.

Impairment Assessment

Based on the facts provided and the processes defined in the AMA *Guides to the Evaluation of Permanent Impairment, Fifth Edition*, permanent impairment is evaluated. Information on impairment assessment is provided at www.amaguides.com.

Critique of Physician, MD Evaluation

Physician, MD, provided the following impairment assessment on December 20, 2024:

> This patient has 15% Whole Person Impairment (WPI). Chapter 16 criteria from AMA Guides, 5th edition were used to determine this. Not only is the left middle finger stiff, but due to the severity of the original injury as well as the post- operative immobilization he underwent for fracture healing, he has developed compensatory stiffness in the other 4 digits of his left hand. He also has ulnar deviation of the middle finger. Grip strength criteria were also used to determine his disability rating.
>
> The patient has stiffness of all 5 digits on his left hand. The thumb has range of motion (ROM) at the MP joint of 0/70. According to page 457, figure 16-15, this is worth 0% & 0% thumb MP impairment, respectively. They add together to give 0% thumb MP impairment. The IP joint has ROM of +20/35. This is rated on page 456, figure 16-12, to be worth 0% & 3.5% IP joint impairment, respectively. They add together to give 3.5% IP joint impairment. He has left thumb abduction of 60 degrees. This is rated on

> page 459, table 16-8B, to be worth 0% thumb impairment. He has left thumb adduction of 2.5 cm. This is rated on page 459, table 16-8b, to be worth 2% thumb impairment. He has left thumb opposition of 6 cm. This is rated on page 460, table 16-9, to be worth 3% thumb impairment. All five joint values are added together to give 8.5% thumb impairment. On page 438, table 16-1, this converts to 3.5% hand impairment due to thumb stiffness.
>
> The patient also has stiffness of his left index finger. The four fingers all used similar figures within chapter 16 of the AMA Guides to calculate disability due to stiffness. The index finger MP joint has ROM of +10/60. This is rated on page 464, figure 16-25, to be worth 3% & 17% index finger MP joint impairment, respectively. They add together to give 20% MP joint impairment. The PIP joint has ROM of 0/95. This is rated on page 463, figure 16-23, to be worth 0% & 3% index PIP impairment, respectively. They add together to give 3% PIP joint impairment. The DIP joint has ROM of 0/65. This is rated on page 461, figure 16-21, to be worth 0% & 2.5% DIP impairment, respectively. They add together to give 2.5% DIP joint impairment. The three individual joint values combine together to allow for 24% index finger impairment Using page 438, table 16-1, this converts to 5% hand impairment due to index finger stiffness.
>
> The middle finger MP joint has ROM of 0/70. On page 464, figure 16-25 rates this as 5% & 11% = 16% MP impairment. The PIP joint has ROM of -15/60. On page 463, figure 16-23 rates this as 5% & 24% = 29% PIP impairment. The DIP joint has ROM of -20/55. On page 461, figure 16-21 rates this as 4% & 7.5% = 11.5% DIP impairment. These combine to be worth 47% middle finger impairment due to stiffness. There is also ulnar deviation of the middle finger at the PIP joint of 15 degrees. This is rated on page 500, table 16-20, to be considered "moderate deviation" worth 20% digit impairment. The 47% is combined with 20% to allow for 58% middle finger impairment. On page 438, table 16-1, this converts to 12% hand impairment due to middle finger stiffness and deformity.
>
> The ring finger MP joint has ROM of 0/65. On page 464, figure 16-25 rates this as 5% & 14% = 19% MP impairment. The PIP joint has ROM of 0/90. On page 463, figure 16-23 rates this as 0% & 6% = 6% PIP impairment. The DIP joint has ROM of 0/60. On page 41, figure 16-21 rates this as 0%&5%= 5% DIP impairment. The three joint values combine to be worth 28% ring finger impairment, which is converted on page 438, table 16-1, to be worth 3% hand impairment due to ring finger stiffness.
>
> The small finger MP joint has ROM of +20/70. On page 464, figure 16-25 rates this as 0% & 8.5% = 8.5% MP impairment. The PIP joint has ROM of 0/95. On page 463, figure 16-23 rates this as 0% &3%=3% PIP impairment. The DIP joint has ROM of 0/70. On page 461, figure 16-21 rates this as 0%&0%= 0% DIP impairment. The three joint values combine to be worth 11.5% small finger impairment, which is converted on page 438, table 16-1, to be worth 1% hand impairment due to small finger stiffness.

> The five digital contributions to hand impairment values are then added together to allow for 24.5% total hand impairment. On page 459, table 16-2, this converts to 22.5% upper extremity impairment. The patient also lacks full grip strength to his left hand. While he has some stiffness of his left hand, it is not so much to prohibit grip strength testing. He is able to grip the Jamar dynamometer.
>
> Furthermore, it has been over 10 minutes since his most recent surgery. It is not likely that another 1.5 months will make a significant change in his grip strength, as the original injury was almost 2 years ago. Therefore, grip strength criteria were included in his Permanent Disability rating. His right (uninjured) hand has grip strength of 83 lbs, 76 lbs, & 81 lbs. These average 80 lbs. His left (injured) hand has grip strength of 50 lbs, 48 lbs, & 48 lbs. These average 48.7 lbs. Using the formula set aside on page 509, this represents 39% strength loss index. On table 16-34, this is worth 20% upper extremity impairment. On page 499, table 16-18, involvement of the entire middle finger is worth a maximum of 18% upper extremity impairment. 20% x 18% = 3.6% upper extremity impairment due to grip strength loss from his middle finger injury. This can be rounded to 3.5% upper extremity impairment.
>
> The 22.5% upper extremity impairment from digital stiffness and deformity is then combined with the 3.5% upper extremity impairment due to strength loss to allow for a total upper extremity impairment of 25%. On page 439, table 16-2, this translates into 15% WPI.

ROM:

	thumb	index	middle	ring	small
MP joint	0/70	+10/60	0/70	0/65	+20/75
PIP joint	+20/35	0/95	-15/60	0/90	0/95
DIP joint		0/65	-20/55	0/60	0/70

abduction 60 deg
adduction 2.5 cm
opposition 6 cm

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. Physician. There are opportunities for improvement, and I appreciate the challenges that he encountered. I am providing my critique as constructive feedback and I would be pleased to answer questions that Dr. Physician may have, if this is requested and permissible.

Treating Physician

Physician, MD is a treating physician, his specialty is hand orthopedics, and his training and qualifications on assessing permanent impairment are not known. The impairment evaluation in this case was performed by the treating physician, thus has had a significant ongoing relationship with this patient. Therefore, it is not possible for this provider to be truly "independent" or "unbiased" in terms of this case.

Section 2.1 Defining Impairment Evaluations, states:

> An **impairment evaluation** is a medical evaluation performed by a physician, using a standard method as outlined in the *Guides* to determine permanent impairment associated with a medical condition. An impairment evaluation may include a numerical impairment percentage or rating, is defined in the *Guides*. (5th ed., 18)

Section 2.3 Examiner's Roles and Responsibilities, states:

> The physician's role in performing an impairment evaluation is to provide an independent, unbiased assessment of the individual's medical condition, including its effect on function, and identifying abilities and limitations to performing activities of daily living as listed in Table 1-2. Performing an impairment evaluation requires considerable medical expertise and judgment. (5th ed., 18)

This is not to suggest that Dr. Physician acted in anything other than good faith in attempting to provide an accurate impairment rating. However, given his role as the treating physician, the potential limitations in maintaining full independence and objectivity must be acknowledged and taken into account when evaluating the validity of his impairment assessment.

Questionable Clinical Data Used to Define Impairment

Standards of Clinical Evaluation and Document Not Met

When performing impairment evaluations, it is critical to assess active range of motion meticulously, bilaterally, using a goniometer. Three measurements of each motion are obtained to ensure reliability, and the maximum is used to assess impairment. Motion deficits at the metacarpophalangeal (MCP), proximal interphalangeal (PIP) and distal interphalangeal (DIP) should be documented in degrees, and consistency between active and passive measurements should be evaluated to exclude non-organic findings.

Grip strength should only be considered if there is neurologic loss or structural compromise, there are no other conditions that would prohibit this (e.g., pain, motion loss, etc.) and the findings are valid and reliable.

Ratings should be grounded in reproducible, objective deficits and should account for the combined impact of involvement across multiple digits. It is essential to determine the causes of motion deficits.

Measurements were documented on the left and the reliability of the findings and measurements are unknown.

Figure 16-1a, Upper Extremity Impairment Evaluation Record (AMA Guides, 5th ed., p. 436), is specifically designed to document the measurements and calculations required for hand impairment assessments. This form was not completed in the present case. Given the complexity of hand evaluations—which often involve numerous data points and calculations—the use of this standardized form is essential for clarity and transparency. Attempting to convey such detailed information solely through narrative description can obscure key elements, much like attempting to file taxes without the use of structured forms. Proper use of the designated evaluation record enhances both accuracy and comprehensibility.

Validity and Reliability Unknown

Dr. Physician based his rating on his observations and his understanding of the use of the AMA *Guides*. It is imperative that ratable examination findings by valid and reliable. In Section 2.5c, Consistency, the *AMA Guides* requires 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)

In Section 2.5d, Interpolating, Measuring, and Rounding Off, The *AMA Guides* states that findings must be reproducible if they are to serve as a basis for impairment rating:

> Two measurements made by the same examiner using the *Guides* that involve an individual or an individual's function would be considered consistent if they fall within 10% of each other. Measurements should be consistent between two trained examiners or by one observer on two separate occasions, assuming the individual's condition is stable. (5th ed., 20)

Patients may demonstrate less than their full capabilities with motion; therefore, it is imperative to compare findings to other observations since at MMI. I thoroughly reviewed all provided records and found no records to verify the reliability of what he observed with motion.

There is a discrepancy in the range of motion findings for the left middle finger during the physical examination on September 25, 2023, before June 2024 surgery, and during the impairment evaluation by Dr. Physician on December 20, 2024 six months after the surgery. After the surgery, one would hope motion should improve; however, greater motion deficits were reported by Dr. Physician.

No documentation of Measurements Opposite Side

There was no documentation of measurements on the opposite side. This is useful to determine what is "normal" for her. The Fifth Edition discusses in Section 1.2a, Impairment, the determination of normal. The *Guides* states:

> When evaluating an individual, a physician has two options: consider the individual's health preinjury or preillness state or the condition of the unaffected side as "normal" for the individual if this is known, or compare that individual to a normal value defined by population averages of healthy people. The *Guides* uses both approaches. (5th ed., 2).

Section 16.4c, Method for Motion Impairment Calculation, states:

> The measurements reported in the impairment tables and pie charts reflect the accepted average range(s) of motion for each joint. However, certain people can have either lesser or greater joint flexibility than average. Therefore, it is most important to always compare measurements of the relevant joint(s) in both extremities. If a contralateral "normal" joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the report. (5th ed., 453).

The opposite extremity should serve as "normal"; therefore, losses should be determined in relationship to this normal.

Diabetes and Hand Motion Deficits

Mr. Patient is diabetic; information on the severity of his diabetes is not provided in the records I reviewed. This is likely a significant factor for Mr. Patient and recovering from his middle finger injury. Diabetes has many manifestations; the impact on the musculoskeletal system—particularly the upper extremities—is both underrecognized and frequently disabling. The term "diabetic hand" encompasses a spectrum of conditions, with the most consequential and clinically relevant finding is the loss of motion—often insidious, progressive, and functionally significant.

Motion deficits in the diabetic hand are not isolated anomalies but represent the cumulative effect of long-standing hyperglycemia on connective tissue structures. The pathophysiology is now well established: chronic exposure to elevated glucose levels leads to non-enzymatic

glycation of collagen, resulting in the formation of advanced glycation end products (AGEs). These AGEs cause cross-linking of collagen fibers, reducing tissue elasticity and increasing stiffness. In parallel, microvascular changes diminish perfusion to tendon and periarticular tissues, leading to hypoxia, fibrosis, and contracture formation.

Clinically, this process manifests most notably as limited joint mobility (LJM), particularly affecting the metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints. Patients frequently present with a subtle inability to fully extend the fingers. It often begins bilaterally and is noticed only when performing tasks that require complete hand opening—such as placing the hand flat on a surface or grasping large objects. These extension deficits are typically non-tender, non-inflammatory, and progressive, distinguishing them from inflammatory arthropathies.

As the condition advances, contractures may become fixed. While a 10- to 20-degree deficit in PIP extension may seem minor, in aggregate it substantially impairs composite hand function, particularly for tasks requiring coordinated digit motion. This is compounded when patients develop Dupuytren's disease, which is more prevalent and more aggressive in individuals with diabetes. The involvement of the palmar fascia—most often in the ring and little fingers—leads to further loss of extension and functional grip span.

Another frequent contributor to motion loss is stenosing tenosynovitis, or trigger finger. Glycation of the tendon sheath leads to thickening and nodularity along the flexor tendons, producing the classic catching or locking sensation during finger flexion and extension. Initially intermittent, this may evolve into a fixed flexion posture that resists passive correction. When multiple digits are involved, which is not uncommon in diabetic patients, the cumulative effect on hand function is considerable.

From a functional standpoint, these motion deficits may limit the ability to grasp, manipulate, and release objects. Patients may describe difficulty with dressing, tool use, or work requiring fine dexterity. There is no evidence that the impact of his diabetes was considered in the assessment of impairment.

Impairment Rating Higher Than Amputation of Entire Middle Finger

The rating of 15% whole person impairment is higher than would be projected for an injury only involving the left middle finger. Hypothetically, if someone had total loss (amputation) of that digit, the resulting 100%-digit impairment equates to 20% hand impairment, 18% upper extremity, and 11% whole person. Therefore, the rating he provided of 15% whole person is substantially higher than a rating for total loss of that digit.

He provided a very high impairment rating for the left hand by providing the impairment ratings for all the digits for range of motion loss, his only left middle finger was injured, and there was no injury to the other fingers of the left hand there is no other physical examination for the other digits performed and presented in the previous medical records.

Inappropriate to Rate Impairment for Digits Not Injured

His only left middle finger was injured, and there was no injury to the other fingers of the left hand. So, it was not appropriate to provide an impairment rating for loss of range of motion for all the fingers of the left hand.

Inappropriate to Rate Strength Loss

Dr. Physician incorrectly combined the impairment rating for the loss of range of motion with the loss of grip strength of the left hand.

With motion measurement he used a Jamar Dynamometer and reported three attempts at motion. He did not document motion in all five positions, nor did he document rapid alternating grip findings. He then extrapolated the grip strength measure losses to calculate a 39% strength loss index and then apportioned 18% of this to the middle digit.

It was inappropriate to include strength loss in the rating. In terms of rating based on strength loss, the *Guides* discuss the issues of strength evaluation and its very limited role in impairment evaluation. One of the most frequent problems encountered with strength evaluation is the inappropriate application in rating impairment in individuals with pain disorders; the resultant strength determination is typically limited by pain, rather than by objective muscular dysfunction. The primary application for strength evaluation is for the individual who has a specific, objective muscular injury that cannot be adequately assessed by other means.

In Section 16.8, Strength Evaluation, the *AMA Guides* states:

> Because strength measurements are functional tests influenced by subjective factors that are difficult to control, and the *Guides* for the most part is based on anatomic impairment, the *Guides* does not assign a large role to such measurements. Those who have contributed to the *Guides* believe further research is needed before loss of grip and pinch strength is given a larger role in impairment evaluation. (5th ed., 507)

In Section 16.8a, Principles… the limited role for rating by strength loss is discussed:

> In a rare case, if the examiner believes the patient's loss of strength represents an impairing factor that has not been considered adequately, the loss of strength may be rated separately. An example of this situation would be the loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence.* Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (e.g., thumb amputation) that prevent effective application of maximal force in the region being evaluated. (5th ed., 508)

Mr. Patient reports problems with "pain and stiffness" and motion deficits were documented. This is a painful condition, as well documented in the material reviewed, and is not a rare case; therefore, the *AMA Guides* is clear that decreased strength cannot be used in the rating process.

Section 16.8b, Grip and Pinch Strength, emphasizes the importance of obtaining reliable measurements, i.e., less than 20% variation in the readings with readings being "usually repeated three times with each hand at different times during the examination." This section describes two techniques to determine if maximum effort was used, e.g. by plotting out measurements obtained in the five hand settings to determine if a bell-shaped curve was obtained and comparing readings to the "rapid exchange grip technique." Neither of these techniques are referenced in the report.

The issues of grip and pinch strength measurements have also been explored in depth in the *AMA Guides Newsletter*[#60,#61] Bleeker discusses the multiple factors that relate to performance, including effort, motivation, pain, time of day, fatigue, gender, age, sensation, comorbidities, nutritional status, and perhaps handedness. It is recognized that grip strength correlates poorly with ability to perform activities of daily living. Bleeker notes that pain interferes with maximal effort and, if present, may invalidate grip strength measurement.

It was not appropriate to include strength loss in the rating.

Summary of Critique

In summary, there are multiple opportunities for improvement in the rating provided by Dr. Physician. The validity and reliability of the data is questionable, findings were not documented bilaterally, it is likely that there are motion deficits related to his diabetes, the magnitude of impairment is not supportable, impairment for uninvolved digits should not be included, and rating for strength loss is inappropriate.

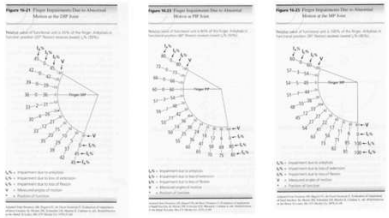
Impairment Analysis

Impairment in this hand injury case is performed as directed in Chapter 16, The Upper Extremities. Impairment is based on the range of motion deficits for the left middle finger, as explained in Section 16.4e, Finger Motion Impairment (5th ed., 461-466), using the provided pie charts for the DIP, PIP, and MP joints, and for deformity.

The physical examination performed by Dr. Physician is the only one showing the range of motion findings for the left middle finger, giving the benefit of the doubt to the patient, it is assumed that the range of motion findings by Dr. Physician are correct. It is recognized that it is possible that deficits associated with his diabetes contribute to his motion loss. Lacking further information about his diabetes and bilateral measurements, I am unable to apportion the etiology of the motion deficits, i.e., those related to the January 31, 2023 injury and his diabetes.

In this case, other than motion deficits, there are no other ratable deficits, e.g. …digit nerve sensory deficits, amputation, and any other ratable disorders, as described in the *Guides*. It is inappropriate to include strength loss in the rating. In terms of rating on the basis of strength loss, the *Guides* discusses the issues of strength evaluation and its very limited role in impairment evaluation.

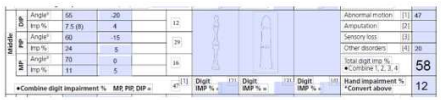
Deficits of impairment for the DIP joint are assessed using Figure 16-21, Finger Impairment Due to Abnormal Motion at the DIP (5th ed., 461).



Finger motion impairment is assessed as explained in Section 16.4e, Finger Motion Impairment (5th ed., 461-466), using the provided pie charts for the DIP, PIP, and MP joints. Deficits of impairment for the DIP joint are assessed using Figure 16-21, Finger Impairment Due to Abnormal Motion at the DIP (5th ed., 461). These are combined with deficits of impairment for the PIP joint, as illustrated in Figure 16-23, Finger Impairment Due to Abnormal Motion at the PIP (5th ed., 463). The result is combined with deficits of impairment for the MP joint, as illustrated in Figure 16-25, Finger Impairment Due to Abnormal Motion at the MP (5th ed., 464).

There is also a digit impairment deformity and I agree that this is rated using Table 16-20 Digit Impairment From Active Ulnar or Radial Deviation (5th ed. 500). He has a moderate deviation that is equal to 20% digit. The combined motion impairment is then converted to hand impairment using Table 16-1, Conversion of Impairment of the Digits to Impairment of the Hand (5th ed., 438). The hand values of the digits are added. The combined motion impairment is then converted to hand impairment using Table 16-1, Conversion of Impairment of the Digits to Impairment of the Hand (5th ed., 438).

Figure 16-1a, Upper Extremity Impairment Evaluation Record (5th ed., 436) illustrates the process. The rating of the digit is reflected below:



By Table 16-1Conversion of Impairment of the Digits to Impairment of the Hand (5th ed., 438), 58% digit impairment for the left middle finger converts to 12% hand impairment. By Table 16-2 Conversion of Impairment of the Hand to Impairment of the Upper Extremity (5th ed., 439), 12% hand impairment converts to 11% upper extremity impairment that converts by Table 16-3 Conversion of Impairment of the Upper Extremity to Impairment of the Whole Person (5th ed., 439) to 7% whole person impairment.

Summary

In summary, the injury to the left middle finger resulted in 7% whole person impairment. The rating of 15% whole person is not supportable for the reasons detailed in this report.

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

Qualifications

Christopher R. Brigham, MD, is a leading expert in impairment and disability evaluations. He has served as a major contributor to multiple editions of the AMA *Guides to the Evaluation of Permanent Impairment*, a key reference work in this field. Specifically, Dr. Brigham was the Senior Contributing Editor for the Sixth Edition of the AMA *Guides*. He co-authored chapters on evaluating impairments of the upper extremities, lower extremities, and spine. He was also an Advisory Committee member and contributor for the Fifth Edition.

In addition to his work on the AMA *Guides*, Dr. Brigham has many other accomplishments related to evidence-based medicine, impairment, and disability. He is Board Certified in Occupational Medicine and a Fellow of multiple professional organizations, including the American College of Occupational and Environmental Medicine and the International Academy of Independent Medical Examiners. He has edited publications such as the AMA *Guides Newsletter* and served as co-author of the textbook *Understanding the AMA Guides in Workers Compensation*. He has written over 300 articles and spoken extensively on these topics.

More details about his background and his curriculum vitae are available at www.cbrigham.com/about-us.

Disclosures

This analysis is based only on the information that the requesting party provided at this time. It assumes that the information given is accurate and complete. If additional relevant information becomes available later, I may provide an updated report. Such new information could potentially change the opinions stated here.

My assessment complies with the processes and procedures specified in the AMA *Guides to the Evaluation of Permanent Impairment*. Examining the claimant directly was unnecessary since the provided documents contained needed information. My role focused on issues related to causation, apportionment, impairment rating, and work ability - not clinical care. No doctor-patient relationship was established.

The comments in this report reflect my independent professional opinions based on the specifics of this case and the documentation reviewed. They should not be taken as generally supportive or critical of any providers or disciplines involved.

The opinions expressed here do not constitute recommendations for specific claims actions or administrative enforcement. This report reflects only the information reviewed and my impartial expert judgment.

I affirm that the information in this report and attachments is true and accurate to the best of my knowledge, except for information received from others. Regarding such third-party information, I affirm it accurately represents what was provided to me unless otherwise noted. To the best of my knowledge, the contents of this report and billing are truthful and correct.

Sincerely,

Christopher R. Brigham, MD
MMS, FACOEM, FIAIME, CEDIR, CIME
President, Brigham and Associates, Inc.

Medical Record Chronology

The initial organization and analysis of these records was performed by artificial intelligence (Wisedocs) in a secure manner, consistent with HIPPA. Each record was reviewed by me with revisions to the notes as required. This information is provided to assist the reader in understanding the details of this case.

Date	Author	Type	Notes
January 31, 2023	Physician	Emergency	HPI: The claimant presented with a laceration to the left hand after getting it caught in a grinder at work approximately 60 minutes prior to arrival. He reported being unable to feel sensation in the hand, but had positive movement and pulses. The chief complaint was documented as "LACERATION TO LEFT HAND AFTER GETTING IT CAUGHT IN GRINDER AT WORK X40 MIN AGO. PT STATES UNABLE TO FEEL SENSATION IN HAND. + MOVEMENT. + PULSES." Upon initial assessment, the claimant rated his pain as 10 out of 10. During subsequent reassessments, his pain level decreased to 3 out of 10 and later increased slightly to 4 out of 10. Exam: Neurological assessment revealed the claimant was alert and oriented, with a Glasgow Coma Scale score of 15. The claimant demonstrated clear speech, appropriate behavior, and comprehension of concepts. Neurovascular examination showed strong pulses, good mobility, and sensation in all extremities. Capillary refill was less than 2 seconds, and extremities were warm. Cardiovascular assessment noted a sinus rhythm. Respiratory examination found no cough. Abdominal examination revealed a soft abdomen. The claimant was voiding normally. A skin assessment identified a laceration on the left side of the head. The Braden Scale for skin risk assessment yielded a total score of 23. Pain was assessed multiple times during the visit, with scores ranging from 3 to 4 out of 10. An intravenous line was placed in the right hand using a 22-gauge catheter. Diagnoses: Laceration to left hand, anxiety, knowledge deficit, impaired skin integrity. Plan: The practitioner recommended the claimant to follow up with a hand surgeon. The claimant was prescribed hydrocodone/acetaminophen, cefazolin, ceftriaxone, vancomycin, and lidocaine with epinephrine. A short arm splint was ordered for the left arm. The claimant was advised of the risks of leaving against medical advice, and paperwork was signed acknowledging this decision.
January 31, 2023	Physician	Emergency	HPI: The claimant, a 60-year-old male, presented with a left hand injury. He was using a metal grinder earlier when the blade slipped, resulting in a large-sized laceration of his left hand. The injury was described as a large wound extending between the first and second digit interspace, with exposed and sharp bone. There was severe bleeding noted. The claimant reported that his tetanus was up-to-date within the last 6 months. No other injuries were reported. The chief complaint was listed as laceration/avulsion, specifically a laceration to the left hand with severe bleeding.

			Exam: The physical examination revealed the claimant was alert, in no acute distress, and not ill appearing. The head was atraumatic, eyes showed conjugate gaze with normal sclera and EOMI. The ENT examination revealed a normal nose with no congestion. The neck was supple with no lymphadenopathy. Respirations were normal with no signs of distress or tachypnea. Cardiovascular examination showed a regular rate. The abdomen was soft, non-tender, and non-distended. Skin showed no petechiae, rashes, or jaundice. Neurological examination revealed movement in all 4 extremities with no focal deficit. The left hand showed a large avulsed laceration with exposed bone extending from the DIP of the third finger to approximately 3 cm down through the second and third digit web space. Oozing and pulsatile bleeding were noted. X-rays of the left hand revealed comminuted displaced fractures of the proximal third phalanx and the distal third metacarpal bone, with preserved joint spaces and soft tissue swelling of the hand and third digit. Hemostasis was achieved with epinephrine, direct pressure, and bandaged. A custom splint was placed under the physician's supervision. Diagnoses: Acute open fracture of left third MCP bowel, Acute fracture of left third phalanx, Acute left hand avulsion, Open fracture of left hand. Plan: The claimant required prompt surgical repair by hand surgery. Transfer to a trauma center was initiated. The practitioner informed the claimant and his friend about the current situation, as no neighboring hospitals had room to accept the patient for transfer at that time. They planned to continue attempting to transfer the claimant. The claimant was to be signed out to the oncoming provider.
January 31, 2023	HOSPITAL FROM	Emergency	Complaint: The claimant presented with a laceration to the left hand after getting it caught in a grinder at work approximately 40 minutes prior to arrival. He reported being unable to feel sensation in the hand, but had positive movement and pulses. The chief complaint was recorded as "LACERATION/AVULSION" with a pain scale rating of 10 out of 10. This appeared to be a work-related injury. Exam: The claimant was alert and oriented appropriately for age. The physical examination revealed a laceration to the left hand with severe bleeding. The claimant reported being unable to feel sensation in the hand, but positive movement and pulses were noted. Pain was rated at 10 out of 10 on the pain scale. Diagnoses: Laceration to left hand.
January 31, 2023	Hospital Center	Assessment Report	HPI: The claimant, a 60-year-old male, presented with a left hand injury. Earlier that day, while using a metal grinder, the blade slipped, resulting in a large avulsed laceration of his left hand. The incident occurred at 9 AM on the day of presentation. There was a 5 cm laceration over the dorsal side of the left third digit. The claimant had sensation over the left third digit palmar area and the tip of his finger but was unable to flex the left third digit. He was holding the left third digit in extension. X-ray findings showed comminuted displaced acute fractures of the proximal third phalanx and the distal third metacarpal bone. Medical Encounters: The examination revealed a 5 cm laceration over the dorsal side of

			the left third digit. The claimant had sensation over the left third digit palmar area as well as the tip of his finger. However, he was unable to flex the left third digit and was holding it in extension. Bleeding was controlled. X-ray findings showed comminuted displaced acute fractures of the proximal third phalanx and the distal third metacarpal bone. Conclusions: The claimant had a large avulsed laceration of his left hand from a metal grinder accident. X-ray showed comminuted displaced acute fractures of the proximal third phalanx and the distal third metacarpal bone. Examination revealed a 5 cm laceration over the dorsal side of the left third digit, with sensation present but inability to flex the digit. Multiple attempts to transfer the claimant to a higher level of care for hand surgery were unsuccessful due to capacity issues at various facilities. The emergency physician advised the claimant to stay for the transfer process, but the claimant decided to leave against medical advice to seek care at a higher-level facility himself. The physician informed the claimant of the risks associated with leaving, including worsening condition, bleeding, limb loss, infection, sepsis, and possible death. The claimant was deemed to have decision-making capacity and understood the risks. His condition at discharge was stable.
January 31, 2023	Hospital Center	Non-Medical Form	No pertinent information available.
January 31, 2023	Hospital Center	Non-Medical Form	No pertinent information available.
January 31, 2023	Hospital Center	Non-Medical Form	No pertinent information available.
January 31, 2023	Hospital Medical Center	Non-Medical Form	No pertinent information available.
January 31, 2023	Physician	Emergency	HPI: The claimant, a 60-year-old male with a history of hypertension, diabetes, and hyperlipidemia, presented with a left hand laceration. He reported that on the morning of the incident at around 0800, he was working with an angle grinder when it slipped, cutting his hand. The injury resulted in a large full thickness, dorsal tissue defect on the left hand. He stated he had sensation in all his fingers but was having difficulty moving the left middle finger. The claimant initially went to an outside hospital immediately after the injury where he received pain medications, antibiotics, and x-rays. However, he left that facility and came to the current hospital later in the day. He reported good distal sensation but continued difficulty moving the left middle finger. Exam: The claimant presented with a large full thickness, dorsal tissue defect on the left hand. He had sensation in all fingertips and capillary refill was less than 3 seconds in all fingers. He was unable to flex or extend the middle finger. The finger was warm and appeared well-perfused. The physical exam revealed the claimant was alert and oriented x4, generally well-appearing, and in no acute distress. His neck was supple without lymphadenopathy. Heart examination showed normal rate and regular rhythm with normal S1/S2 and no murmurs, rubs, or gallops. Lungs were clear to auscultation bilaterally with no crackles or wheezes. The abdomen was soft, nontender, and

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References

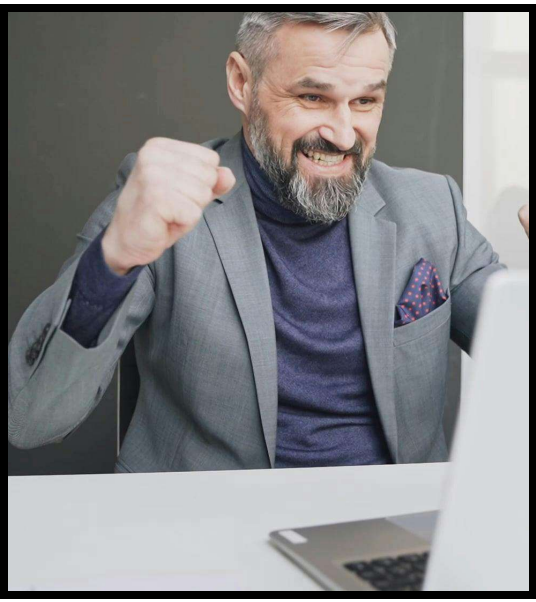
[i] Question and Answer. *AMA Guides Newsletter*. March/April 1997.

[ii] Bleeker ML, Amr S. Strength Testing - Grip and Pinch. *AMA Guides Newsletter* pp. 9-10, May/June 1999.

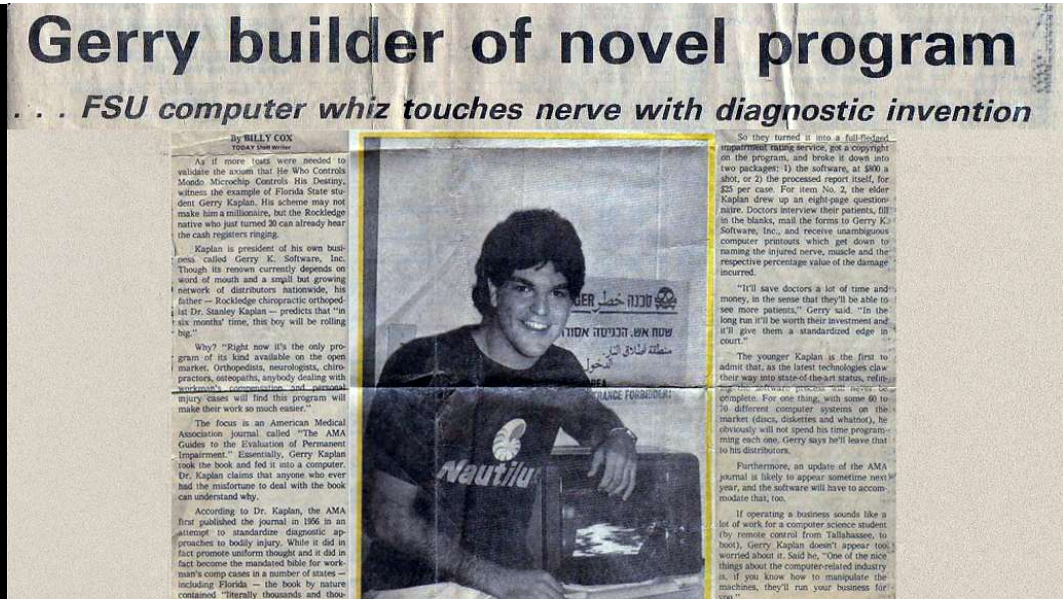
[iii] Haralson R, Brigham CR. Evaluating Impairment Due to Other Disorders of the Upper Extremity. *AMA Guides Newsletter* pp. 8-9. *AMA Guides Newsletter*. pp. 8-9, May/June 1999.

[iv] Brigham CR. Question and Answer. *AMA Guides Newsletter* p. 11, May/June 1999.

[v] Brigham CR. Grip Strength: An Uncommon Impairment. *AMA Guides Newsletter*, September / October 2003.



What is the role of impairment rating software ?



Gerry builder of novel program

. . . FSU computer whiz touches nerve with diagnostic invention

By BILLY COX
TODAY Staff Writer

As if more cats were needed to validate the axiom that He Who Controls Mondo Microchip Controls His Destiny, witness the example of Florida State student Gerry Kaplan. His scheme may not make him a millionaire, but the Rockledge native who just turned 20 can already hear the cash registers ringing.

Kaplan is president of his own business called Gerry K. Software, Inc. Though its renown currently depends on word of mouth and a small but growing network of distributors nationwide, his father — Rockledge chiropractic orthopedist Dr. Stanley Kaplan — predicts that "in six months' time, this boy will be rolling big."

Why? "Right now it's the only program of its kind available on the open market. Orthopedists, neurologists, chiropractors, osteopaths, anybody dealing with workmen's compensation and personal injury cases will find this program will make their work so much easier."

The focus is an American Medical Association journal called "The AMA Guides to the Evaluation of Permanent Impairment." Essentially, Gerry Kaplan took the book and fed it into a computer. Dr. Kaplan claims that anyone who ever had the misfortune to deal with the book can understand why.

According to Dr. Kaplan, the AMA first published the journal in 1956 in an attempt to standardize diagnostic approaches to bodily injury. While it did in fact promote uniform thought and it did in fact become the mandated bible for workman's comp cases in a number of states — including Florida — the book by nature contained "literally thousands and thou-

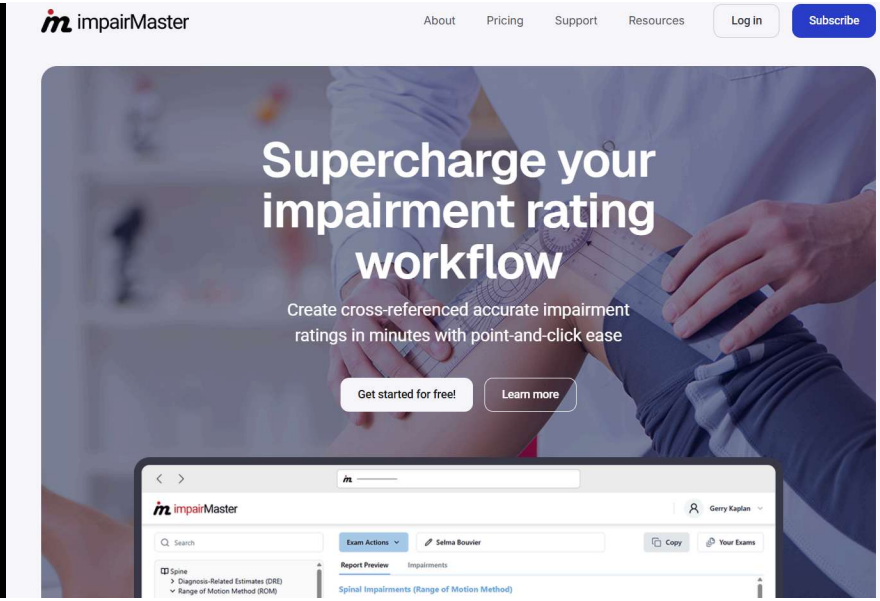
So they turned it into a full-fledged impairment rating service, got a copyright on the program, and broke it down into two packages: 1) the software, at $400 a shot, or 2) the processed report itself, for $25 per case. For item No. 2, the elder Kaplan drew up an eight-page questionnaire. Doctors interview their patients, fill in the blanks, mail the forms to Gerry K. Software, Inc., and receive unambiguous computer printouts which get down to naming the injured nerve, muscle and the respective percentage value of the damage incurred.

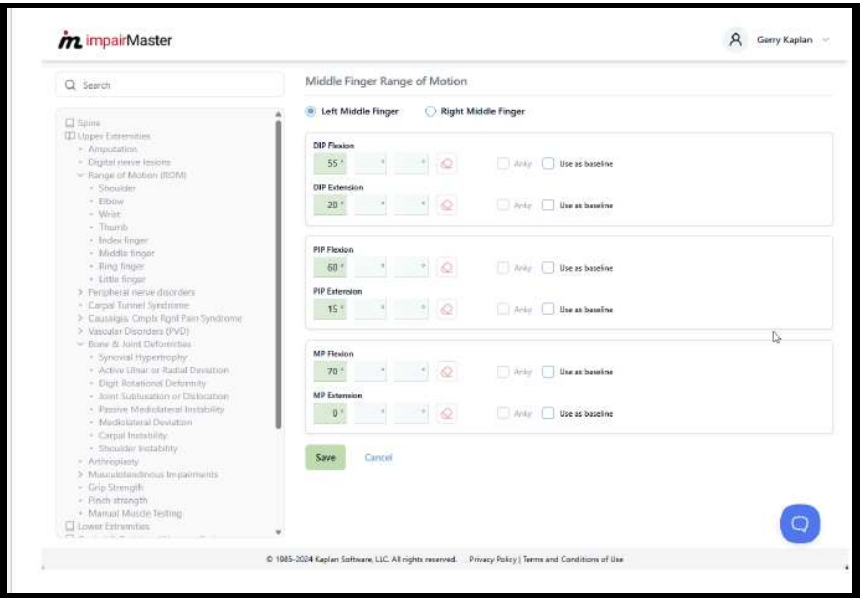
"It'll save doctors a lot of time and money, in the sense that they'll be able to see more patients," Gerry said. "In the long run it'll be worth their investment and it'll give them a standardized edge in court."

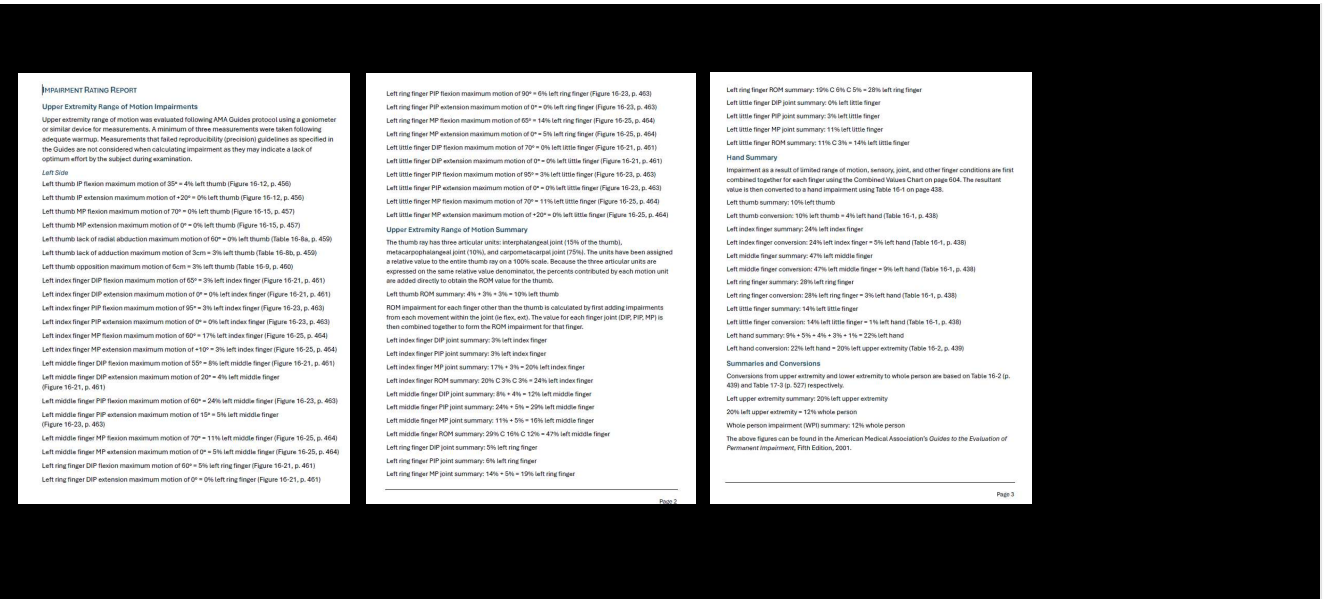
The younger Kaplan is the first to admit that, as the latest technologies claw their way into state-of-the-art status, refining the software packets will never be complete. For one thing, with some 60 to 70 different computer systems on the market (discs, diskettes and whatnot), he obviously will not spend his time programming each one. Gerry says he'll leave that to his distributors.

Furthermore, an update of the AMA journal is likely to appear sometime next year, and the software will have to accommodate that, too.

If operating a business sounds like a lot of work for a computer science student (by remote control from Tallahassee, to boot), Gerry Kaplan doesn't appear too worried about it. Said he, "One of the nice things about the computer-related industry is, if you know how to manipulate the machines, they'll run your business for







IMPAIRMENT RATING REPORT

Upper Extremity Range of Motion Impairments

Upper extremity range of motion was evaluated following AMA Guides protocol using a goniometer or similar device for measurements. A minimum of three measurements were taken following adequate warmup. Measurements that failed reproducibility (precision) guidelines as specified in the Guides are not considered when calculating impairment as they may indicate a lack of optimum effort by the subject during examination.

Left Side

Left thumb IP flexion maximum motion of 35° = 4% left thumb (Figure 16-12, p. 456)

Left thumb IP extension maximum motion of +20° = 0% left thumb (Figure 16-12, p. 456)

Left thumb MP flexion maximum motion of 70° = 0% left thumb (Figure 16-15, p. 457)

Left thumb MP extension maximum motion of 0° = 0% left thumb (Figure 16-15, p. 457)

Left thumb lack of radial abduction maximum motion of 60° = 0% left thumb (Table 16-8a, p. 459)

Left thumb lack of adduction maximum motion of 3cm = 3% left thumb (Table 16-8b, p. 459)

Left thumb opposition maximum motion of 6cm = 3% left thumb (Table 16-9, p. 460)

Left index finger DIP flexion maximum motion of 65° = 3% left index finger (Figure 16-21, p. 461)

Left index finger DIP extension maximum motion of 0° = 0% left index finger (Figure 16-21, p. 461)

Left index finger PIP flexion maximum motion of 95° = 3% left index finger (Figure 16-23, p. 463)

Left index finger PIP extension maximum motion of 0° = 0% left index finger (Figure 16-23, p. 463)

Left index finger MP flexion maximum motion of 60° = 17% left index finger (Figure 16-25, p. 464)

Left index finger MP extension maximum motion of +10° = 3% left index finger (Figure 16-25, p. 464)

Left middle finger DIP flexion maximum motion of 55° = 8% left middle finger (Figure 16-21, p. 461)

Left middle finger DIP extension maximum motion of 20° = 4% left middle finger (Figure 16-21, p. 461)

Left middle finger PIP flexion maximum motion of 60° = 24% left middle finger (Figure 16-23, p. 463)

Left middle finger PIP extension maximum motion of 15° = 5% left middle finger (Figure 16-23, p. 463)

Left middle finger MP flexion maximum motion of 70° = 11% left middle finger (Figure 16-25, p. 464)

Left middle finger MP extension maximum motion of 0° = 5% left middle finger (Figure 16-25, p. 464)

Left ring finger DIP flexion maximum motion of 60° = 5% left ring finger (Figure 16-21, p. 461)

Left ring finger DIP extension maximum motion of 0° = 0% left ring finger (Figure 16-21, p. 461)

Left ring finger PIP flexion maximum motion of 90° = 6% left ring finger (Figure 16-23, p. 463)

Left ring finger PIP extension maximum motion of 0° = 0% left ring finger (Figure 16-23, p. 463)

Left ring finger MP flexion maximum motion of 65° = 14% left ring finger (Figure 16-25, p. 464)

Left ring finger MP extension maximum motion of 0° = 5% left ring finger (Figure 16-25, p. 464)

Left little finger DIP flexion maximum motion of 70° = 0% left little finger (Figure 16-21, p. 461)

Left little finger DIP extension maximum motion of 0° = 0% left little finger (Figure 16-21, p. 461)

Left little finger PIP flexion maximum motion of 95° = 3% left little finger (Figure 16-23, p. 463)

Left little finger PIP extension maximum motion of 0° = 0% left little finger (Figure 16-23, p. 463)

Left little finger MP flexion maximum motion of 70° = 11% left little finger (Figure 16-25, p. 464)

Left little finger MP extension maximum motion of +20° = 0% left little finger (Figure 16-25, p. 464)

Upper Extremity Range of Motion Summary

The thumb ray has three articular units: interphalangeal joint (15% of the thumb), metacarpophalangeal joint (10%), and carpometacarpal joint (75%). The units have been assigned a relative value to the entire thumb ray on a 100% scale. Because the three articular units are expressed on the same relative value denominator, the percents contributed by each motion unit are added directly to obtain the ROM value for the thumb.

Left thumb ROM summary: 4% + 3% + 3% = 10% left thumb

ROM impairment for each finger other than the thumb is calculated by first adding impairments from each movement within the joint (ie flex, ext). The value for each finger joint (DIP, PIP, MP) is then combined together to form the ROM impairment for that finger.

Left index finger DIP joint summary: 3% left index finger

Left index finger PIP joint summary: 3% left index finger

Left index finger MP joint summary: 17% + 3% = 20% left index finger

Left index finger ROM summary: 20% C 3% C 3% = 24% left index finger

Left middle finger DIP joint summary: 8% + 4% = 12% left middle finger

Left middle finger PIP joint summary: 24% + 5% = 29% left middle finger

Left middle finger MP joint summary: 11% + 5% = 16% left middle finger

Left middle finger ROM summary: 29% C 16% C 12% = 47% left middle finger

Left ring finger DIP joint summary: 5% left ring finger

Left ring finger PIP joint summary: 6% left ring finger

Left ring finger MP joint summary: 14% + 5% = 19% left ring finger

Page 2

Left ring finger ROM summary: 19% C 6% C 5% = 28% left ring finger

Left little finger DIP joint summary: 0% left little finger

Left little finger PIP joint summary: 3% left little finger

Left little finger MP joint summary: 11% left little finger

Left little finger ROM summary: 11% C 3% = 14% left little finger

Hand Summary

Impairment as a result of limited range of motion, sensory, joint, and other finger conditions are first combined together for each finger using the Combined Values Chart on page 604. The resultant value is then converted to a hand impairment using Table 16-1 on page 438.

Left thumb summary: 10% left thumb

Left thumb conversion: 10% left thumb = 4% left hand (Table 16-1, p. 438)

Left index finger summary: 24% left index finger

Left index finger conversion: 24% left index finger = 5% left hand (Table 16-1, p. 438)

Left middle finger summary: 47% left middle finger

Left middle finger conversion: 47% left middle finger = 9% left hand (Table 16-1, p. 438)

Left ring finger summary: 28% left ring finger

Left ring finger conversion: 28% left ring finger = 3% left hand (Table 16-1, p. 438)

Left little finger summary: 14% left little finger

Left little finger conversion: 14% left little finger = 1% left hand (Table 16-1, p. 438)

Left hand summary: 9% + 5% + 4% + 3% + 1% = 22% left hand

Left hand conversion: 22% left hand = 20% left upper extremity (Table 16-2, p. 439)

Summaries and Conversions

Conversions from upper extremity and lower extremity to whole person are based on Table 16-2 (p. 439) and Table 17-3 (p. 527) respectively.

Left upper extremity summary: 20% left upper extremity

20% left upper extremity = 12% whole person

Whole person impairment (WPI) summary: 12% whole person

The above figures can be found in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, 2001.

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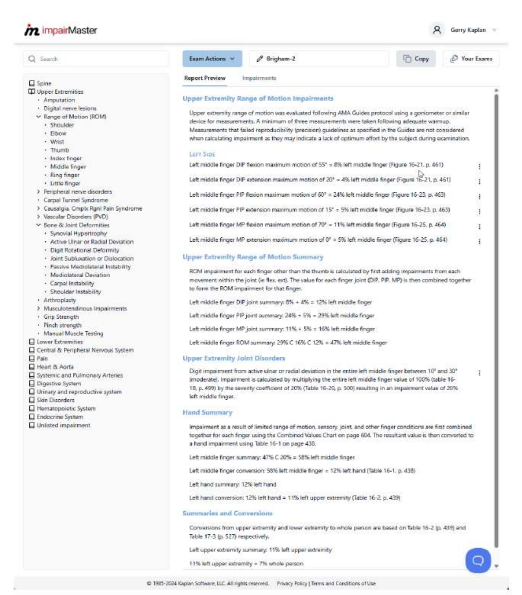
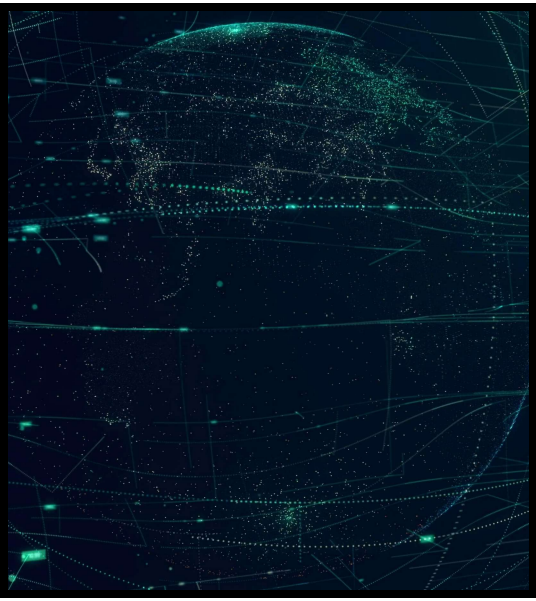
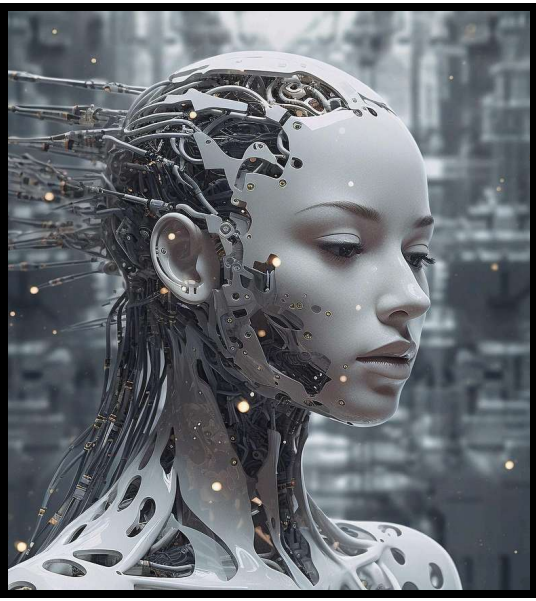




How can AI assist?



Report Screen by Brigham and Associates, Inc.

- Hybrid Model
- AI technology (sophisticated engineering and local knowledge bases)
- Human oversight by AMA Guides expert physicians.

Independent Medical Evaluation Report Critique for Attorneys and Claims Professionals

Disclaimer and Contextual Statement:

This review has been generated with the assistance of advanced artificial intelligence (AI) systems developed by Brigham and Associates, Inc., designed to enhance the quality, consistency, and efficiency of medicolegal evaluations. These proprietary tools integrate specialized engineering with localized knowledge bases that reflect current best practices.

While AI can provide structured, constructive feedback and highlight potential areas for improvement, it is not a substitute for expert clinical judgment. The interpretation of medical reports and the assignment of impairment ratings must be performed by a qualified physician with substantial expertise in medicolegal issues, including the proper application of the AMA Guides to the Evaluation of Permanent Impairment.

If questions arise or deficiencies are suggested by the AI critique, the report should be reviewed by a physician with specialized training in medicolegal evaluation. This AI-generated analysis should be considered in the context of all available documentation, and its findings should be validated by a human expert before being used for clinical decision-making or claims determinations.

Section 1: Case Summary Table

Key Information	Details
Case number or file ID	2023-00001
Author of report	John Physician, MD
Specialty of author	Not specified
State	Not specified (possibly California based on PR-4 form)
Type of report	Primary Treating Physician's Permanent and Stationary Report (PR-4) - Addendum
Requesting party	Not specified
Date of injury	1/31/2023
Date of report	12/20/2024
Interval from injury to report	23 months
Primary diagnosis	Left middle finger injury with multiple surgeries

Key Information	Details
Length of report	Approximately 7 pages

Section 2: Case Summary

This is a Permanent and Stationary (P&S) report for a 62-year-old right-hand dominant male iron worker who sustained a left middle finger injury on 1/31/2023 while using a grinder. The injury required two surgeries: 1) ORIF of 3rd metacarpal head, proximal phalanx, and extensor tendon repair on 2/1/2023, and 2) left middle finger extensor tenolysis, PIP capsulotomy, and hardware removal on 6/9/2024. The patient was declared permanent and stationary on 8/20/2024. The evaluator determined a 15% Whole Person Impairment (WPI) based on the AMA Guides 5th Edition, citing stiffness in all five digits of the left hand, ulnar deviation of the middle finger, and reduced grip strength.

Section 3: Narrative Critique

1. Report Structure and Presentation

The report follows a somewhat standard clinical format but lacks the comprehensive structure expected in a high-quality medicolegal report. There are inconsistencies in formatting and organization, with some sections appearing more detailed than others. The report jumps between different elements without clear transitions or headings [3]. The formatting is inconsistent with multiple typos (such as "biofrccze," "Trcatmcnt," and "prox phlx"), suggesting poor quality control.

2. Comprehensiveness

The report is incomplete compared to standard IME/impairment evaluation requirements. It lacks several essential elements including a thorough introduction, complete medical records review, work history, and a structured clinical discussion connecting the findings to the conclusions [3]. While it includes physical examination findings and impairment calculations, the overall comprehensiveness is inadequate for a medicolegal report.

3. Introduction

The report lacks a proper introduction stating the purpose, referral source, and scope of the evaluation. There is no statement about the physician's role, qualifications, or relationship to the case [5]. It fails to establish the framework for the evaluation or indicate what specific questions the evaluation aims to answer.

4. Medical History

The medical history is extremely brief and disorganized. While it mentions the injury and subsequent surgeries, it lacks detail about the initial treatment, rehabilitation course, and response to interventions. The description of the injury mechanism is minimal ("was using a grinder... lost control of it and cut/injured left middle finger"). The past medical, social, and family history is mentioned as "reviewed" but not documented. The review of systems is present but in a checklist format without narrative integration [3].

5. Medical Records Review

There is no evidence of a medical records review section. The report fails to list what medical records were reviewed or to incorporate their findings into the narrative [6]. This is a significant deficiency as an impairment evaluation should include review of relevant medical documentation to establish chronology, consistency, and support the impairment conclusions.

6. Physical Examination

The physical examination is relatively detailed for the affected body part but lacks organization and context. It includes range of motion measurements for all digits of the left hand and grip strength testing. However, there's no clear comparison to normative values in all instances, and the findings are not clearly related to functional limitations. The examination includes appropriate objective findings (ROM measurements, deformity description) but could be better organized to distinguish subjective from objective findings [3].

7. Conclusions and Medical Opinions

Diagnoses

The report lacks specific diagnostic conclusions with ICD-10 codes. While it references the injuries and surgeries, it does not provide formal diagnoses for the current clinical status [5].

Clinical/Case Discussion

The clinical discussion is minimal, with little explanation of how the clinical findings relate to the functional limitations or impairment. There is no thoughtful analysis connecting the objective findings to the ultimate conclusions beyond the impairment calculation itself [1].

Causation Analysis

The causation statement is extremely brief: "injury is work related due to acute trauma" without any methodology or analysis. There is no discussion of potential alternative causes, aggravation of pre-existing conditions, or application of causation methodology [5].

Maximum Medical Improvement (MMI)

The report indicates the patient was declared permanent and stationary on 8/20/2024 but provides no rationale for this determination. There is no discussion of why the condition is considered stable or whether further improvement is expected [1].

Impairment Rating

The impairment rating section is the most detailed portion of the report, using the AMA Guides 5th Edition. It includes references to specific tables and figures with page numbers, which is appropriate [5]. However, there are several issues:

1. The narrative is verbose and sometimes difficult to follow without a clear separation of each impairment component.
2. The evaluator combines ROM deficits across all five digits when the primary injury was to the middle finger, which may not be appropriate without clear causation linkage.
3. The evaluator uses grip strength testing as an additional rating factor, which is generally discouraged in the AMA Guides when there are other objective deficits being rated (such as ROM).
4. The explanation for including grip strength testing appears to justify its use by noting it's been "over 10 minutes since his most recent surgery" when the Guides typically recommends waiting until a year post-surgery.
5. The evaluator uses an unusual formula to reduce the grip strength impairment by multiplying it by the maximum potential impairment for the middle finger (20% × 18% = 3.6%), which is not a standard approach in the Guides.

Work Ability/Restrictions

The work restrictions section is extremely brief, stating only "full duty, no restrictions" without any explanation of how this conclusion was reached given the documented impairments [5]. There is no discussion of functional capabilities or how the impairments might affect different types of work activities.

8. Disclosures and Attestations

The report lacks standard disclosures regarding the physician's role, any potential conflicts of interest, or attestations about the objectivity of the evaluation [6]. There is no statement about the physician's qualifications or certification in impairment rating.

Section 4: Bias and Tone Assessment

The report appears somewhat neutral in tone but shows signs of possible bias toward minimizing functional impact despite significant impairment. This is evidenced by the disconnect between a 15% WPI rating and the conclusion of "full duty, no restrictions" without explanation. The report also seems to minimize the patient's complaints, providing little detail about how the impairments affect daily activities or work function. There is no apparent defense or applicant bias in the language, but the overall presentation lacks the depth and analysis expected in a high-quality medicolegal report.

Section 5: Summary Critique Table

Evaluation Criteria	Score (0-4)	Explanation
Structure and Presentation	2	Poor organization, inconsistent formatting, typos throughout report.
Comprehensiveness	1	Missing multiple essential elements of a quality IME report.
Introduction	0	No formal introduction stating purpose, scope, or referral source.
Medical History	1	Minimal injury details, no prior history documentation.
Medical Record Review	0	No evidence of records review or incorporation into analysis.
Physical Examination	3	Detailed ROM measurements but lacking systematic organization.
Diagnoses	1	No formal diagnostic statements with ICD-10 codes.
Clinical/Case Discussion	1	Minimal analysis connecting findings to conclusions.
Causation Analysis	1	Single sentence without methodology or analysis.
MMI Determination	1	States MMI date without rationale or explanation.
Impairment Rating	2	Detailed calculations but methodological concerns and excessive narrative.
Work Ability Assessment	1	No explanation for "full duty" conclusion despite 15% WPI.
Recommendations	1	Minimal future medical recommendation.
Disclosures/Attestations	0	No disclosures about evaluator role or objectivity.
Bias and Tone	2	Somewhat neutral but disconnected conclusions from findings.
Overall Quality Rating	1	Multiple significant deficiencies undermine report utility.

Scoring System: 4 = Excellent, 3 = Good, 2 = Fair, 1 = Poor, 0 = Deficient

Section 6. Impairment Rating Red Flag Assessment

Red Flag Pattern Matching

#	Red Flag	Red Flag Present?	Explanation
1	Treating or Biased Physician	☑	Report is from treating physician (PR-4 form), creating potential bias.
2	Out-of-Scope Evaluation	☐	Not determinable without physician specialty information.
3	Lack of Training or Credentialing	☑	No evidence of AMA Guides training or certification mentioned.
4	Unprofessional Report	☑	Multiple typos, formatting issues, and poor organization.
5	Incomplete Documentation	☑	Missing key sections including records review and proper history.
6	No MMI / Premature Rating	☐	MMI established 4 months prior to report.
7	AMA Guides Misnamed or Incorrect Edition	☐	Correctly identifies 5th Edition.
8	Outlier Rating Value	☐	15% WPI not excessive for multiple surgeries and documented ROM deficits.
9	Problematic Diagnosis (CRPS, disc, etc.)	☐	Standard orthopedic diagnoses.
10	Multiple Diagnoses rated	☑	Rated stiffness in all five digits without clear causation linkage.
11	No Table/Figure Citation	☐	Provides detailed table/figure citations.
12	Disallowed or Subjective Methods Used	☑	Combines ROM with grip strength when ROM deficits already present.
13	Software-Only Rating	☐	No evidence of automated software-based rating.
14	Invalid Clinical Findings	☐	Measurements appear consistent with injury.
15	Narrative Inconsistencies	☑	15% WPI but "full duty, no restrictions" without explanation.
16	Jurisdictionally Barred Method Used	☐	Unknown without state jurisdiction information.
17	Diagnosis-Rating Mismatch	☐	Rating generally aligns with documented digit injuries.
18	Improper Use of ROM	☑	Combines ROM deficits across all five digits without clear causation.
19	Mathematical Errors	☐	Calculations appear mathematically correct.
20	Pain Used as Standalone Impairment	☐	Pain not used as standalone impairment.

Clinical Validity and Legal Defensibility

This report demonstrates significant methodological and structural deficiencies that undermine its medicolegal utility. While the impairment calculation includes appropriate references to the AMA Guides, the methodology combines ROM deficits across all five digits without clear causation linkage and inappropriately includes grip strength when ROM deficits are already being rated. The report's numerous structural flaws and incomplete documentation further compromise its defensibility.

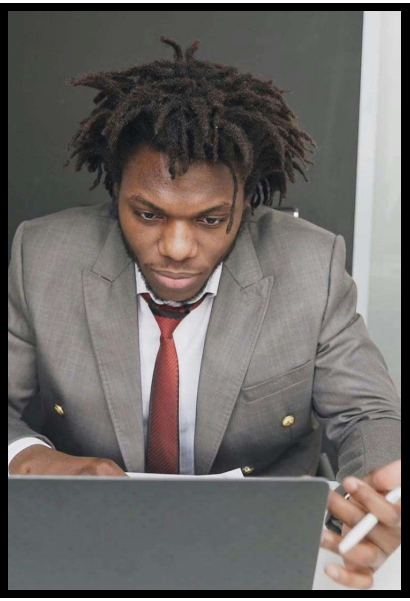
Probability of Inaccuracy: 🟠 Moderate (9 flags) - Several moderate flags and methodological concerns; requires peer review.

Section 7: Recommendations for Further Action

Based on the significant deficiencies identified in this report, the following recommendations are provided:

1. The report should be reviewed by a physician with substantial experience in medicolegal evaluations and impairment rating, particularly regarding the appropriateness of rating all five digits and combining ROM deficits with grip strength measurements.
2. The author would benefit from obtaining further training in independent medical and impairment rating evaluations through programs offered at AMAGuides.com, with specific focus on report structure, comprehensive documentation, and proper application of the AMA Guides methodology.
3. The referring party should consider requesting a supplemental report that addresses:
    - A proper introduction stating the purpose and scope of the evaluation
    - Documentation of medical records reviewed
    - A clear explanation of how the documented impairments relate to work restrictions
    - A more comprehensive causation analysis
    - Proper rationale for the MMI determination
4. The referring party may benefit from AI-supported tools to assist in:
    - Conducting structured patient interviews (e.g., SmartMedHx.ai)
    - Organizing and analyzing voluminous medical records
    - Enhancing the quality and consistency of reports via intelligent quality assurance systems as found at eMedicolegal.com

Confidentiality Note: This critique is to be used for internal review, peer consultation, or legal quality assurance only.



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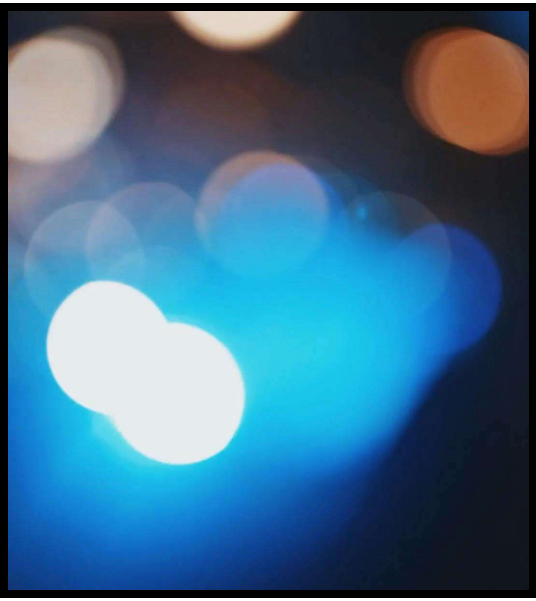


What did we learn?

Summary

Improving Impairment Ratings: Addressing Common Errors and Enhancing Accuracy

Impairment ratings often wrong

Common errors stem from poor training, bias, and misapplication of the AMA Guides

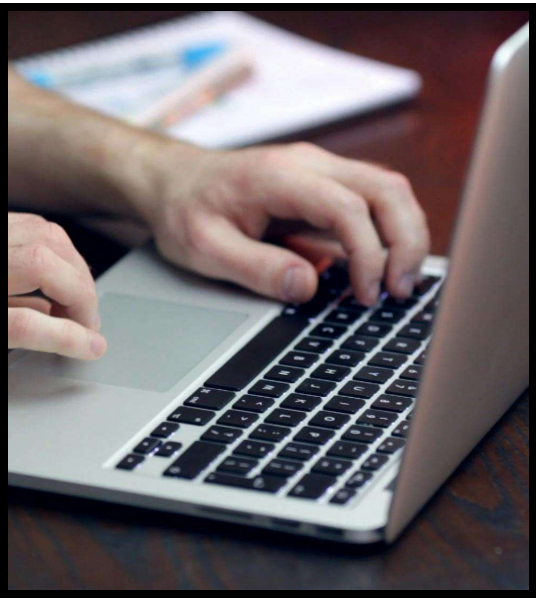
Red flags identify flawed reports

Objective, consistent methodology is essential for defensible ratings

Expert review and standardized checklists improve accuracy

Early engagement of qualified evaluators reduces costly errors

Accurate and defensible impairment ratings require consistent methodology, expert review, and a clear understanding of key concepts.



What resources are we providing you?

Medical Evaluation and Impairment Rating Resources

Downloadable

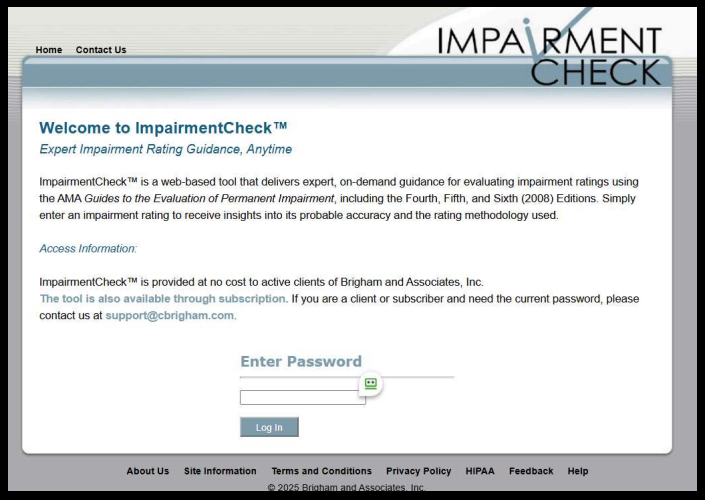
- Presentation slides
- "Independent Medical Evaluation and Impairment Rating Report Checklist"
- "Impairment Rating Red Flag Checklist"

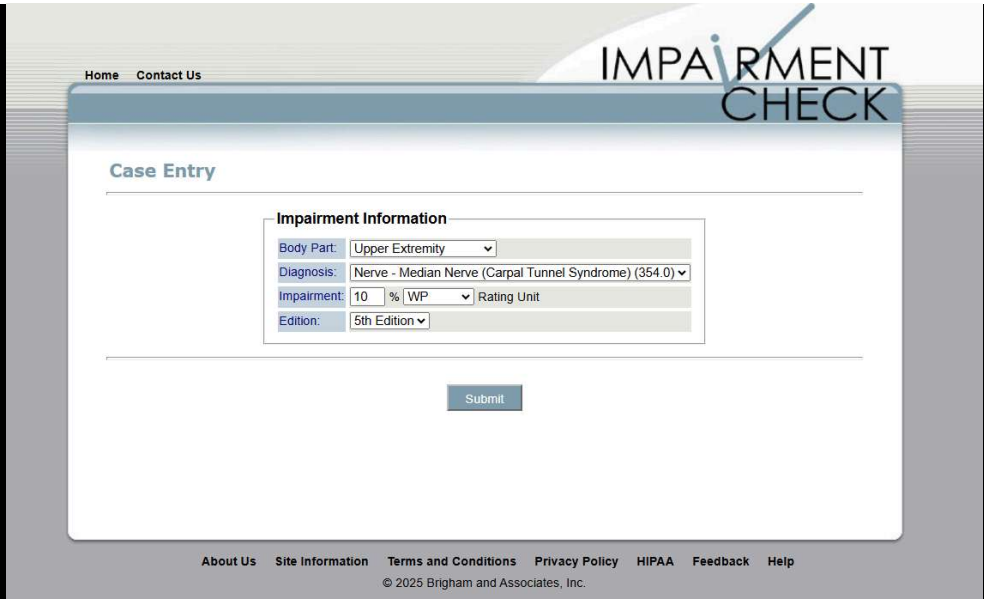
Access to:

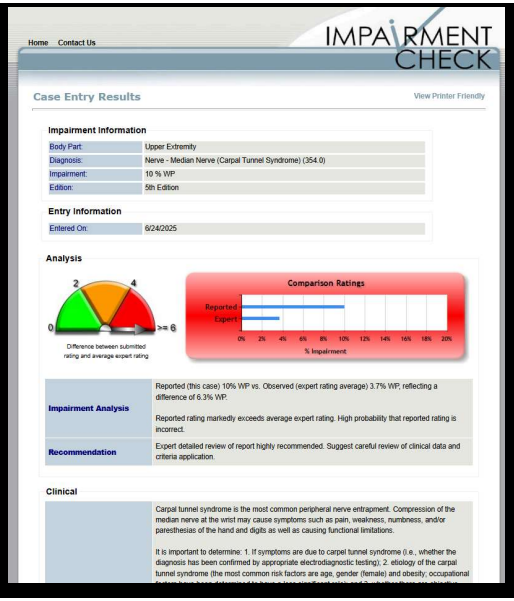
- ImpairmentCheck (Free Access – June Launch)
- Report Critique – AI with human oversight (Free Trial)

cbrigham.com
impairment.com
amaguides.com
certifiedrater.com

https://impairmentcheck.com/client/CaseEntry.aspx







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IMPAIRMENT CHECK

Case Entry Results

View Printer Friendly

Impairment Information

Body Part:	Upper Extremity
Diagnosis:	Nerve - Median Nerve (Carpal Tunnel Syndrome) (354.0)
Impairment:	10 % WP
Edition:	5th Edition

Entry Information

Entered On:	6/24/2025

Analysis

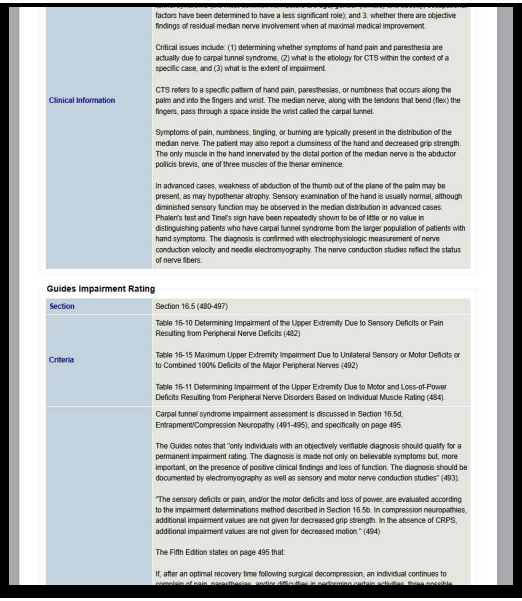
Difference between submitted rating and average expert rating

Impairment Analysis	Reported (this case) 10% WP vs. Observed (expert rating average) 3.7% WP, reflecting a difference of 6.3% WP. Reported rating markedly exceeds average expert rating. High probability that reported rating is incorrect.
Recommendation	Expert detailed review of report highly recommended. Suggest careful review of clinical data and criteria application.

Clinical

Carpal tunnel syndrome is the most common peripheral nerve entrapment. Compression of the median nerve at the wrist may cause symptoms such as pain, weakness, numbness, and/or paresthesias of the hand and digits as well as causing functional limitations.

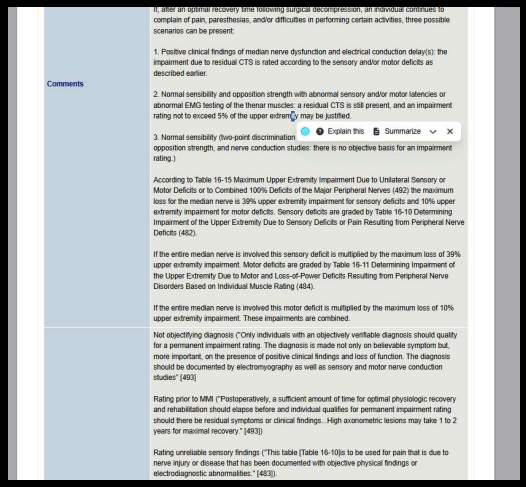
It is important to determine: 1. If symptoms are due to carpel tunnel syndrome (i.e., whether the diagnosis has been confirmed by appropriate electrodiagnostic testing); 2. etiology of the carpal tunnel syndrome (the most common risk factors are age, gender (female) and obesity; occupational



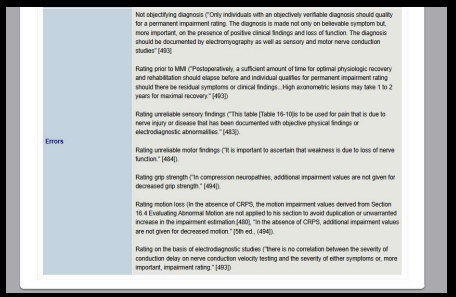
Clinical Information	factors have been determined to have a less significant role); and 3. whether there are objective findings of residual median nerve involvement when at maximal medical improvement. Critical issues include: (1) determining whether symptoms of hand pain and paresthesia are actually due to carpal tunnel syndrome, (2) what is the etiology for CTS within the context of a specific case, and (3) what is the extent of impairment. CTS refers to a specific pattern of hand pain, paresthesias, or numbness that occurs along the palm and into the fingers and wrist. The median nerve, along with the tendons that bend (flex) the fingers, pass through a space inside the wrist called the carpal tunnel. Symptoms of pain, numbness, tingling, or burning are typically present in the distribution of the median nerve. The patient may also report a clumsiness of the hand and decreased grip strength. The only muscle in the hand innervated by the distal portion of the median nerve is the abductor pollicis brevis, one of three muscles of the thenar eminence. In advanced cases, weakness of abduction of the thumb out of the plane of the palm may be present, as may hypothenar atrophy. Sensory examination of the hand is usually normal, although diminished sensory function may be observed in the median distribution in advanced cases. Phalen's test and Tinel's sign have been repeatedly shown to be of little or no value in distinguishing patients who have carpal tunnel syndrome from the larger population of patients with hand symptoms. The diagnosis is confirmed with electrophysiologic measurement of nerve conduction velocity and needle electromyography. The nerve conduction studies reflect the status of nerve fibers.

Guides Impairment Rating

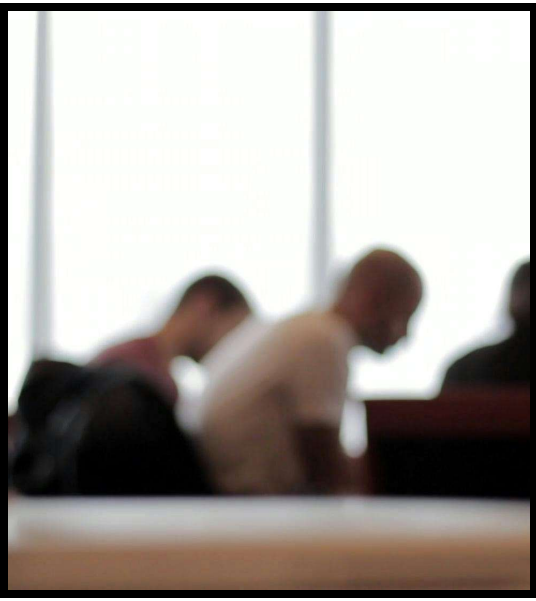
Section	Section 16.5 (480-497)
Criteria	Table 16-10 Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Deficits (482) Table 16-15 Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to Combined 100% Deficits of the Major Peripheral Nerves (492) Table 16-11 Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting from Peripheral Nerve Disorders Based on Individual Muscle Rating (484).
	Carpal tunnel syndrome impairment assessment is discussed in Section 16.5d, Entrapment/Compression Neuropathy (491-495), and specifically on page 495. The Guides notes that "only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating. The diagnosis is made not only on believable symptoms but, more important, on the presence of positive clinical findings and loss of function. The diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies" (493). "The sensory deficits or pain, and/or the motor deficits and loss of power, are evaluated according to the impairment determinations method described in Section 16.5b. In compression neuropathies, additional impairment values are not given for decreased grip strength. In the absence of CRPS, additional impairment values are not given for decreased motion." (494) The Fifth Edition states on page 495 that: If, after an optimal recovery time following surgical decompression, an individual continues to



Comments	If, after an optimal recovery time following surgical decompression, an individual continues to complain of pain, paresthesias, and/or difficulties in performing certain activities, three possible scenarios can be present: 1. Positive clinical findings of median nerve dysfunction and electrical conduction delay(s): the impairment due to residual CTS is rated according to the sensory and/or motor deficits as described earlier. 2. Normal sensibility and opposition strength with abnormal sensory and/or motor latencies or abnormal EMG testing of the thenar muscles: a residual CTS is still present, and an impairment rating not to exceed 5% of the upper extremity may be justified. 3. Normal sensibility (two-point discrimination, opposition strength, and nerve conduction studies: there is no objective basis for an impairment rating.) According to Table 16-15 Maximum Upper Extremity Impairment Due to Unilateral Sensory or Motor Deficits or to Combined 100% Deficits of the Major Peripheral Nerves (492) the maximum loss for the median nerve is 39% upper extremity impairment for sensory deficits and 10% upper extremity impairment for motor deficits. Sensory deficits are graded by Table 16-10 Determining Impairment of the Upper Extremity Due to Sensory Deficits or Pain Resulting from Peripheral Nerve Deficits (482). If the entire median nerve is involved this sensory deficit is multiplied by the maximum loss of 39% upper extremity impairment. Motor deficits are graded by Table 16-11 Determining Impairment of the Upper Extremity Due to Motor and Loss-of-Power Deficits Resulting from Peripheral Nerve Disorders Based on Individual Muscle Rating (484). If the entire median nerve is involved this motor deficit is multiplied by the maximum loss of 10% upper extremity impairment. These impairments are combined.
	Not objectifying diagnosis ("Only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating. The diagnosis is made not only on believable symptom but, more important, on the presence of positive clinical findings and loss of function. The diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies" [493] Rating prior to MMI ("Postoperatively, a sufficient amount of time for optimal physiologic recovery and rehabilitation should elapse before and individual qualifies for permanent impairment rating should there be residual symptoms or clinical findings...High axonometric lesions may take 1 to 2 years for maximal recovery." [493]) Rating unreliable sensory findings ("This table [Table 16-10]is to be used for pain that is due to nerve injury or disease that has been documented with objective physical findings or electrodiagnostic abnormalities." [483]).



Errors	Not objectifying diagnosis ("Only individuals with an objectively verifiable diagnosis should qualify for a permanent impairment rating. The diagnosis is made not only on believable symptom but, more important, on the presence of positive clinical findings and loss of function. The diagnosis should be documented by electromyography as well as sensory and motor nerve conduction studies" [493] Rating prior to MMI ("Postoperatively, a sufficient amount of time for optimal physiologic recovery and rehabilitation should elapse before and individual qualifies for permanent impairment rating should there be residual symptoms or clinical findings...High axonometric lesions may take 1 to 2 years for maximal recovery." [493]) Rating unreliable sensory findings ("This table [Table 16-10]is to be used for pain that is due to nerve injury or disease that has been documented with objective physical findings or electrodiagnostic abnormalities." [483]). Rating unreliable motor findings ("It is important to ascertain that weakness is due to loss of nerve function." [484]). Rating grip strength ("In compression neuropathies, additional impairment values are not given for decreased grip strength." [494]). Rating motion loss (In the absence of CRPS, the motion impairment values derived from Section 16.4 Evaluating Abnormal Motion are not applied to his section to avoid duplication or unwarranted increase in the impairment estimation.[480]. "In the absence of CRPS, additional impairment values are not given for decreased motion." [5th ed., (494]). Rating on the basis of electrodiagnostic studies ("there is no correlation between the severity of conduction delay on nerve conduction velocity testing and the severity of either symptoms or, more important, impairment rating." [493])



What questions do you have?

Questions and Answers

Clarifying Doubts
Encourage participants to ask questions and resolve any uncertainties.

Exploring Perspectives
Invite diverse viewpoints and encourage discussion.

Building Knowledge
Provide thorough explanations and share relevant information.

Reinforcing Understanding
Offer opportunities for participants to demonstrate their comprehension.

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Answers to Your Most Pressing Questions About Impairment Ratings: What Every Attorney and Claims Professional Must Know

Christopher R. Brigham, MD

Next Session
Part Two: July 9, 2025 at 1 pm ET
(Need to register)

Plans for June 24 and July 29
Navigating Impairment Ratings: Strategies for Accuracy and Fairness

- **What is the foundation?**
  Understanding the legal and medical frameworks that underpin impairment ratings
- **How often are impairment ratings wrong?**
  Studies suggest that up to 30% of impairment ratings may be inaccurate
- **What are the root causes of erroneous ratings?**
  Lack of training, biases, incomplete medical data, and improper application of the AMA Guides
- **What are the red flags?**
  Inconsistencies in medical records, discrepancies between examinations, and failure to follow guidelines
- **What are some of the specific problems?**
  Misinterpretation of impairment criteria, overreliance on subjective factors, and failure to account for comorbidities
- **How do I best evaluate reports?**
  Carefully review the medical evidence, understand the applicable guidelines, and consult with medical experts
- **How do I obtain an accurate rating?**
  Ensure a comprehensive medical evaluation, advocate for proper application of the AMA Guides, and consider independent reviews
- **What are common referral entity errors?**
  Inadequate communication, misalignment of incentives, and lack of oversight in the referral process
- **What is new with the AMA Guides?**
  Ongoing updates, increased focus on functional assessment, and incorporation of technological advancements
- **What is the role of AI?**
  Leveraging AI to analyze medical data, identify patterns, and assist in more consistent and accurate impairment ratings
- **Can you provide examples of review process?**
  Case studies showcasing effective strategies for reviewing and validating impairment ratings
- **What resources are you providing?**
  Comprehensive guides, expert training, and interactive tools to support accurate impairment rating assessments