

Permanent Impairment – Disability Rating Study:

Impact of the

AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition on Permanent Disability Ratings in the State of California

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Executive Summary

One method of estimating the effect of the adoption of a new California Permanent disability Rating Schedule is to re-rate cases evaluated under the pre-2005 California Permanent disability Rating Schedule by using the current process, i.e. the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*. This paper describes the study, the results, and provides an estimate of the effect caused by the change in rating schedules.

The purpose of this study was to provide the Workers Compensation Insurance Rating Bureau (WCIRB) data that will be useful in assessing the cost impact of workers' compensation reform in the State of California, as a result of SB 899 as it relates to permanent disability ratings. The specific question addressed in the study is how the values of the permanent disability ratings would be affected. The *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* and the emergency Permanent disability Rating Schedule (PDRS) approved by the Office of Administrative Law on December 31, 2004 reflects a fundamental change in the process of determining permanent disability.

The pre-2005 California Permanent Disability Rating Schedule (old schedule) used a "standard rating" for the evaluation of each disability. This rating was adjusted for the age and occupation of the injured worker to produce the final disability rating. The schedule adopted effective January 1, 2005 (new schedule) uses impairment ratings according to *AMA Guides for the Evaluation of Permanent Impairment* (5th edition) as the first step in determining permanent disability. The impairment ratings are adjusted for diminished future earning capacity (FEC) and for occupation and age adjustments.

A sample of cases from the Disability Evaluation Unit (DEU) was used as the empirical data set. These cases reflected summary ratings performed between 1997 and 2002.

An initial one hundred and fifty cases were randomly selected for review, and subsequently an additional one hundred cases were selected for a total of two hundred and fifty (250) cases. Each case consisted of a report prepared by either the treating physician (as a Permanent and Stationary Report), a Qualified Medical Examiner or an Agreed Medical Examiner. Basic demographic data was provided for each case, including assigned case number, DEU office location, age, body part(s) involved, occupational group and occupational variant. The ratings previously prepared by the DEU under the old schedule were not provided to Brigham and Associates until rating of all cases had been completed under the new schedule.

The reports were reviewed by Christopher R. Brigham, MD, a physician with nationally recognized expertise in the use of the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* and knowledgeable about the California Permanent Disability Rating Schedule. He utilized the report(s) provided to independently rate whole person permanent impairment for each body part, according to the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* and the methodology mandated by the PDRS to compute a rating for each body part, which were then combined into a total rating for the claimant. As appropriate, Dr. Brigham incorporated ratings for complaints of pain. A summary of the case and a brief explanation of the rating process were provided in the Microsoft Access Database.

Cases with a defined psychiatric component were reviewed by an experienced evaluating psychologist, Terry Beuret, Psy.D., to determine a probable GAF score and therefore the corresponding permanent disability rating. Forty two of the cases (17%) were independently reviewed by a second experienced rating physician, Verne Backus, MD, to help develop a range of possible ratings.

Individual whole person permanent impairment ratings were converted to a permanent disability rating, with adjustments for future earning capacity, occupational variant, and age. Multiple disabilities were combined using the PDRS Combined Values Chart.

Ninety four percent (250) of the cases reviewed (a total of 267) provided adequate information to rate impairment. Of these cases that provided adequate information, ninety seven (37%) were not associated with any ratable impairment per the *AMA Guides*, and therefore would not have any ratable permanent disability. The average PD rating, including those with no impairment was 22.0% under the old schedule and 6.4% under the new schedule.

It is probable that:

- A significant percentage of cases that previously associated with a Permanent disability Rating will have no ratable impairment using the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* and the new schedule.
- Many permanent disability ratings will be significantly reduced by the new schedule.
- The extent of the actual decrease will be significantly less than suggested by this re-rating process.

Purpose

SB 899 required the Division of Workers' Compensation (DWC) to adopt a permanent disability rating schedule based on the AMA Guides that takes into account the impact of diminished future earning capacity as defined by prior RAND studies.

The Insurance Commissioner is required to promulgate advisory pure premium rates based, in part, on recommendations by the Workers' Compensation Insurance Rating Bureau of California (WCIRB). In order for the Insurance Commissioner and WCIRB to calculate appropriate rates, it is necessary to estimate the impact of changes to the permanent disability rating schedule on benefit payments. In this case, the effort targets a mid-year pure premium adjustment effective July of 2005.

There are several efforts underway meant to offer alternative estimates for the impact of the newly adopted permanent disability schedule. This paper describes the re-rating of reports previously evaluated under the prior schedule. A study is also being performed that involves mapping pre-2005 CPDRS maximum ratings by disability category to maximum potential ratings in accordance with the new schedule and based on that relationship estimate potential changes in the distributions of ratings. In addition, a study is being undertaken that compares actual ratings computed in accordance with the new schedule to ratings for similar claims computed under the earlier California schedule.

This study, together with the additional alternative studies, are intended to provide the WCIRB a basis upon which to reasonably estimate the impact of the new schedule on permanent disability costs.

Process

A sample of cases from the Disability Evaluation Unit (DEU) was used as the empirical data set. These cases reflected ratings performed between 1997 and 2002 and were provided by seventeen (17) DEU Offices. The sample was gathered on a random basis by DEU staff from claim files that primarily involved summary ratings from 17 DEU offices in the state with the proportion generally consistent with the number of ratings completed in that office. The sample rating information gathered by the DEU was forwarded to by the Staff of the Commission on Health and Safety and Workers' Compensation (CHSWC). For each sampled DEU file, any claimant, employer or provider identification information was redacted by the CHSWC staff. The redacted medical-legal reports were then sent by the CHSWC staff electronically to the WCIRB staff, who then forwarded the medical-legal reports to Brigham and Associates, Inc. with the DEU rating information excluded.

An initial one hundred and fifty cases were randomly selected, and subsequently an additional one hundred cases were selected for a total of two hundred and fifty (250) cases. Each case consisted of a report prepared by the treating physician (a Permanent and Stationary Report), a Qualified Medical Examiner or an Agreed Medical Examiner, and other supplemental reports from the physician who produced the report on permanent disability, as appropriate. Basic demographic data

was provided for each case, including an arbitrary sequential number, DEU office location, age, body part(s) involved, occupational group and occupational variant.

The reports were provided in delivery groups each case as a separate electronic document. The case was analyzed and rated by Christopher R. Brigham, MD, a physician nationally recognized for his experience in the use of the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*. He utilized the report(s) provided to independently rate whole person permanent impairment(s), according to the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*. If inadequate data was available to rate impairment, the case was rejected and replaced with another randomly selected case. In some cases interpretation was necessary to provide a reasonable basis for defining impairment.

For each case analyzed, the date of injury (if available) and gender were recorded. The date of the rating examination, the type of rating examination (treating physician, qualified medical examiner or agreed medical examiner), and length of report were noted. Judgments were made in terms of the overall quality of the report, in general and specifically in terms of the adequacy for rating with the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*. A case summary was prepared and comments were noted.

If there was no ratable impairment per the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* this was noted. Individual ratings were computed, with a summary explanation process for each rating, associated impairment number, per the PDRS, and impairment standard were identified. Based on the information provided, the PD formula was applied, adjusting the impairment standard for future earning capacity (FEC), occupational variant and age. If the evaluator felt it was medically probable that a reasonable, non-conservative, rating physician would provide additional impairment for pain, this was incorporated into the Impairment Standard up to 3% whole person permanent impairment. Each rating component was associated with an ICD9 diagnostic code. Permanent disability was apportioned only if apportioned under the current California system, although apportionment would also be appropriate several other cases under the new California law.

Cases with a defined psychiatric component were reviewed by an experienced evaluating psychologist, Terry Beuret, Ph.D., to determine a probable GAF score and therefore the corresponding permanent impairment rating, as defined in the PDRS (pages I-12 to I-15).

Forty two cases (17%) were independently reviewed by a second experienced rating physician, Verne Backus, MD, to help assess the potential range of possible ratings. Dr. Backus determined the whole person impairment in accordance with the *AMA Guides* without access to the original DEU rating or to the new rating computed by Brigham and Associates. The results were presented in a Microsoft Access database, with individual case reports and summary report.

Individual whole person permanent impairment ratings were converted to a permanent disability rating (PDR), with adjustments as appropriate for Future Earning Capacity, occupational variant, and age. Multiple disabilities were combined using the Combined Values Chart. The results were presented in a Microsoft Access database, with individual case reports and summary reports. Following the completion of the review of the cases Dr. Brigham was provided with the data of the original permanent disability ratings (PDR) for analysis.

Results

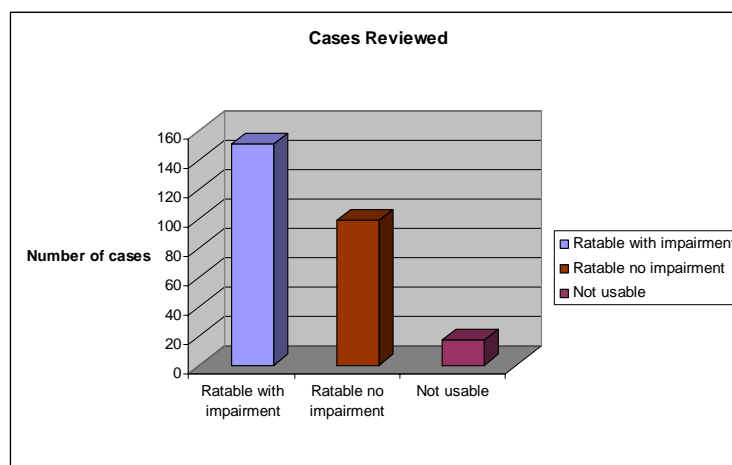
Cases Reviewed

Two hundred and sixty seven (267) cases were reviewed, of these 250 cases were ratable and 17 were rejected due to inadequate information upon which to base an impairment rating. Ninety four percent (250) of the cases reviewed (a total of 267) provided adequate information to rate impairment.

The information for rating was marginal in 21 of these 250 cases, however judged adequate to provide a reasonable basis for impairment. In some cases interpretation was necessary to provide a reasonable basis for defining impairment. For example, in reviewing examination findings in a spine impairment case the evaluating physician may report findings that were judged to reflect the ratable terms of “spasm” or “guarding,” although this precise methodology was not used in a report. An examiner may not report all measurements of motion for a joint, however based on the information provided reasonable estimates for the missing values could be made. For lower extremity ratings criteria to assess by all possible methods may not be available, however adequate data was provided to assess by the probable rating methodologies.

The cases that were rejected were replaced with other cases. Of the 250 cases that were useable, ninety-seven (97) of the cases, 39%, had no ratable impairment according to *AMA Guides* criteria. Typically these cases were of subjective reports with no objective ratable basis for defining impairment.

Category	Number of Cases Analyzed
Cases with impairment	153
Cases with no impairment	97
Non-usable cases	17
Total Cases	267



Demographics

Of the 250 ratable cases, 127 (51%) were female and 123 (49%) were male. The mean age was 42.9 years and the dates of injury range from February 1, 1997 through October 15, 2002.

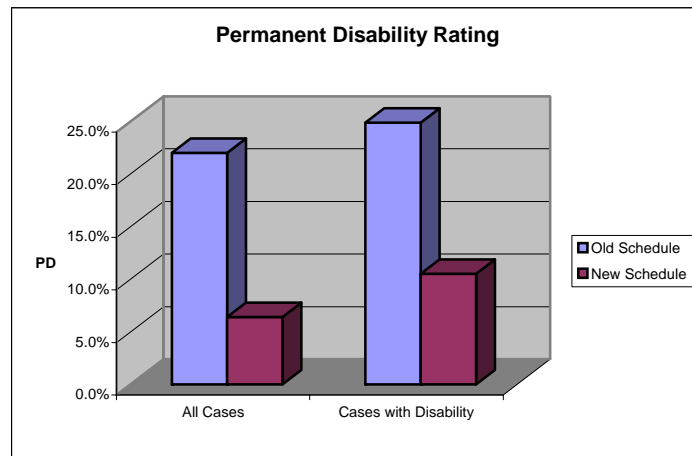
The majority of the reports reviewed were rated by the treating physician. In thirteen of the reports the role of the rating physician was not clear; of the remaining 237, 133 of the ratings (56%) were performed by the treating physician, 100 by a Qualified Medical Examiner (42%), and 4 by an Agreed Medical Examiner (2%). The average length of a report was 7.3 pages, with the range being between 1 and 47 pages and the quality of the reports varied widely.

Of the 151 cases with ratable impairment, the majority (122, 81%) of the cases had the permanent disability based on a single impairment number. Twenty nine (19%) of the cases involved the use of the Combined Values Chart; two impairment numbers were used to rate 21 cases (14%), three impairment numbers for 7 cases (5%), and one case involved six impairment numbers.

Permanent Disability Ratings

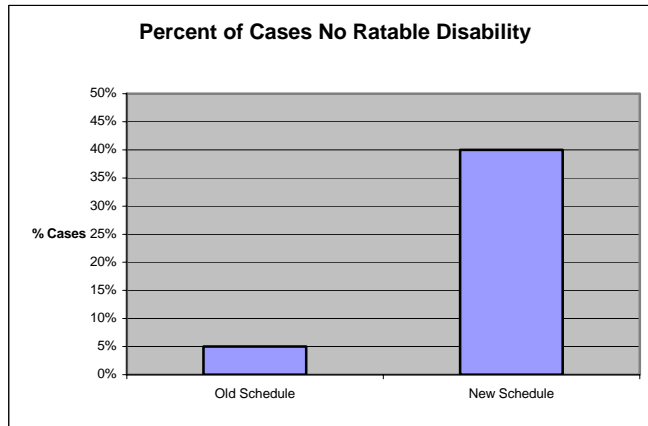
Of the total 250 cases, including those with no ratable impairment, the mean final permanent disability rating under the new schedule was 6.4%, with a range of 0% to 67%. The mean PD rating under the old schedule was 22.0%, with a range of 0 to 100%. This reflects a decrease of 71%.

One hundred fifty one (60%) of the 250 cases had ratable permanent disability according to the AMA Guides. Of these cases, the original mean PD rating was 24.9% with a range of 0% to 100%. Of the 153 cases with ratable impairment, the mean final Permanent disability Rating was 10.5% with a range of 1% to 67%.

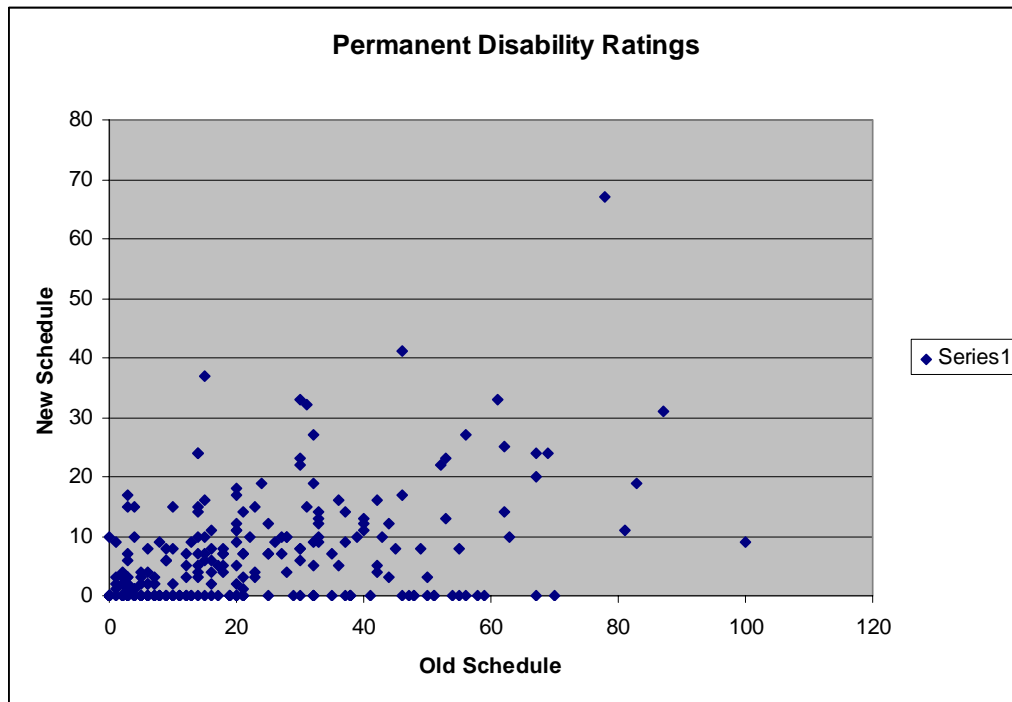


Of the total 250 cases that were ratable, per the original rating, 12 cases (5%) had no ratable PD. One of these cases that had no ratable permanent disability under the old schedule had ratable disability with the use of the *AMA Guides*. Ninety seven (37%) of the 250 cases had no ratable permanent disability according to the *AMA Guides*; 88 of these cases previously had ratable permanent disability. Therefore, 88 (37%) of the 238 cases that previously had ratable PD, did not

have ratable PD according to the *AMA Guides*. Of these 88 cases now with no ratable PD, the mean original PD rating was 19.7% with a range of 1% to 70%.



The following chart illustrates the relationships between permanent disability ratings by the old schedule compared to the new schedule.

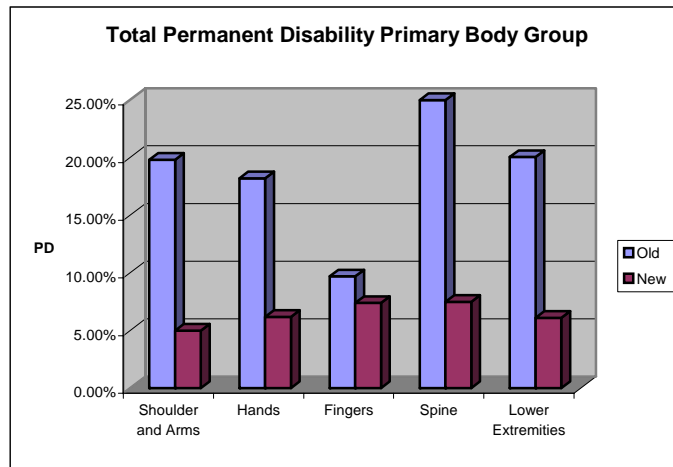


The mean combined whole person permanent impairment by AMA Guides conventional approaches was 4.1% whole person permanent impairment for all cases and 6.7% whole person permanent impairment for the cases with ratable impairment. The mean PD rating under the new schedule was 6.4% for all cases and 10.5% for cases with ratable impairment. Therefore, after the application of FEC, occupation and age adjustments, per the Permanent Disability Rating Schedule,

the Permanent Disability rating average was 1.6 times greater than the initial Impairment Standard; this was true for both all cases (6.4/4.1) and those with ratable impairments (10.5/6.7).

The cases were sorted by primary body group and then the average rating was given for the body group, including any cases with multiple impairments. Total PD based on the Primary Body Group (not all body groups) for the cases revealed the following:

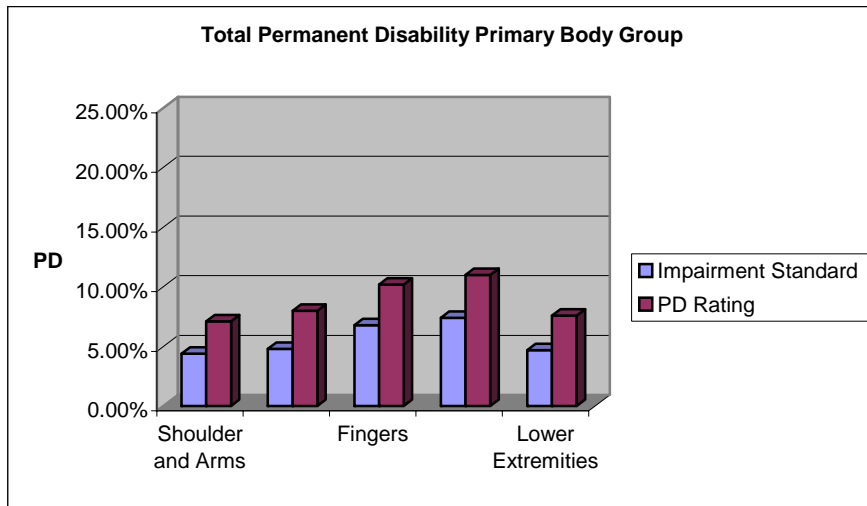
Primary Body Region	Disability Number	Cases	Cases (multiple)	Old PD Rating (Average)	New PD Rating (Average)
Shoulders and Arms	7	64	12	19.8%	5.0%
Hands	10	30	7	18.2%	6.2%
Fingers	8 and 9	15	4	9.7%	7.4%
Spine	12	77	16	27.7	7.5
Lower Extremities	14	41	2	20.4%	6.1%



The above provides a relative comparison between the old and new schedule. This reflects the overall combined PD rating of cases based on the primary body region rated, it does not reflect the actual average PD ratings for specific body regions since many of these cases contain multiple components.

For cases with ratable impairment, PD ratings for specific regions, reflected in both ratings with single and multiple components, were analyzed. This resulted in somewhat different averages, since the average PD ratings sorted by primary body group does not reflect necessarily the same distribution of case elements.

Body Region	Disability Number	Impairment Standard (Average)	New PD Rating (Average)
Shoulders and Arms	7	4.4%	7.1%
Hands	10	4.8%	8%
Fingers	8 and 9	6.8%	10.2%
Spine	12	7.4%	11.0%
Lower Extremities	14	4.7%	7.6%



Of the 250 cases reviewed, six (2.4%) had a PD rating under the old schedule over 70%. By the new schedule no cases had a rating over 70%; the mean by the new schedule for these cases is 22.8%. No cases were over 70% by the new schedule. The highest rating under the new schedule for the sampled claims was 67%, previously rated at 78%.

Peer Review

Forty two cases (17%) were peer reviewed. Eleven of these peer review ratings (26%) resulted in slightly different values. Of the differing ratings, the mean impairment rating under the Peer Reviewer was 3.5% whole person permanent impairment and by Dr. Brigham was 6.5% whole person permanent impairment. The differences related to variables in providing additional impairment for pain, and judgments in spinal impairment DRE categorization, placement of impairment within a DRE range, and other clinical judgment.

Psychiatric Impairment

Ten cases had previous psychological assessments. On the basis of the information in these reports a GAF score was derived. The average GAF score was 68.9 with a range of 59 to 80.

Discussion

The *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition* uses a specific methodology to define permanent impairment. The goal of the *Guides* is provide a mechanism for “consistent and reliable acquisition of medical information through a single set of standards.” (5th ed., 17) The approach used is based primarily on objective, verifiable findings that are applied against criteria in the *Guides*. The goal is such that “Two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions.” (5th ed., 17) The *Guides* explain that “if the clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria.” (5th ed., 17) The *Guides* provide a detailed methodology for acquiring and analyzing data, with the goal of providing an independent and unbiased rating.

The processes defined in the *Guides* are different than the processes previously used in the State of California, both in philosophy and approach. The previous system based impairment on a different set of standards, including factors that are typically not considered in the *AMA Guides* in rating impairment, i.e. subjective reports, opinions on work restrictions, and grip strength loss. Therefore, differences in ratings were expected.

Ninety four percent (250) of the cases reviewed (a total of 267) provided adequate information to rate impairment. Of these cases that were reviewable, ninety seven (39%) were not associated with any ratable impairment per the *AMA Guides*, and therefore would not have any ratable permanent disability. Of these cases with no ratable PD by the new schedule, 89% had PD by the old schedule. The average PD ratings, including those with no impairment were 22.0% under the old schedule and 6.4% under the new schedule. The reasons for these findings are multifold, including:

- The *AMA Guides* base impairment primarily on objective data, as opposed to subjective complaints and opinions on work restrictions. It is recognized that subjective complaints often do not directly correlate with objective findings, and reflect many issues, particularly in the context of litigation. It is also recognized that many physicians have difficulty in accurately identifying work capability, particularly “prophylactic” work restrictions.
- For ratings that were based on objective findings in the past, the criteria and threshold for ratable impairment in the *Guides* are often different. For example, with range of motion findings the *AMA Guides* may define a value as normal whereas the prior system would define the finding as abnormal and associate it with ratable disability.
- Grip and other measures of strength loss were methods commonly used in the past to define disability; however it is rarely used to define impairment in the *Guides*.

There were limitations to the study. The information available to the reviewer was limited (in most cases) to a single medical-legal report; therefore it was not possible to determine if the data presented was reliable. This, however, was the same information used in the prior rating process, therefore this should not have an adverse effect the comparisons. It is possible that other clinical information not present in the report would impact the rating, e.g. there may be clinical findings that were not reported that would have altered the impairment rating.

Additionally, the sample was based primarily on DEU information on summary ratings, which may not be fully representative of all ratings computed in the system. In particular, it is likely that this process under-samples certain types of claims such as psychiatric and multiple body part claims, which are frequently litigated. To the extent the results for these types of claims vary from those sampled, the actual impact could differ from that suggested by the study.

Finally, as noted the results of the study were based on the interpretation of the AMA Guides by experts truly proficient in their application. Experience has shown that there can be significant differences in those interpretations and interpretations applied by practitioners that are less proficient in the use of the Guides. In particular, this is a concern inasmuch as (a) during this transitional period most practitioners producing the reports will be relatively unfamiliar with the Guides and (b) many of the ratings produced by the Guides will be very different from the “typical” rating that had been generated by the California system for similar injuries.

It is useful to review this data in the context of other studies on impairment ratings seen with the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*. The following represents overall average whole person permanent impairment ratings.

Source	Average Whole Person Impairment	Cases
Brigham – National – Observed ¹	14.3%	862
Brigham – National – Expert Re-Rating	7.2%	862
Brigham – California – Observed	13.0%	104
Brigham – California – Expert Re-Rating	6.3%	104
State of Colorado, Workers Compensation Study ²	9.4%	250
Texas Impairment Rating Study – Designated Doctor* ³	12.4%	129
Texas Impairment Rating Study – Panel Doctor*	11.6%	129
Texas Impairment Rating Study – Treating Doctor*	13.7%	129
WCIRB / DEU Study** ⁴	6.7%	250

* Fourth Edition ratings

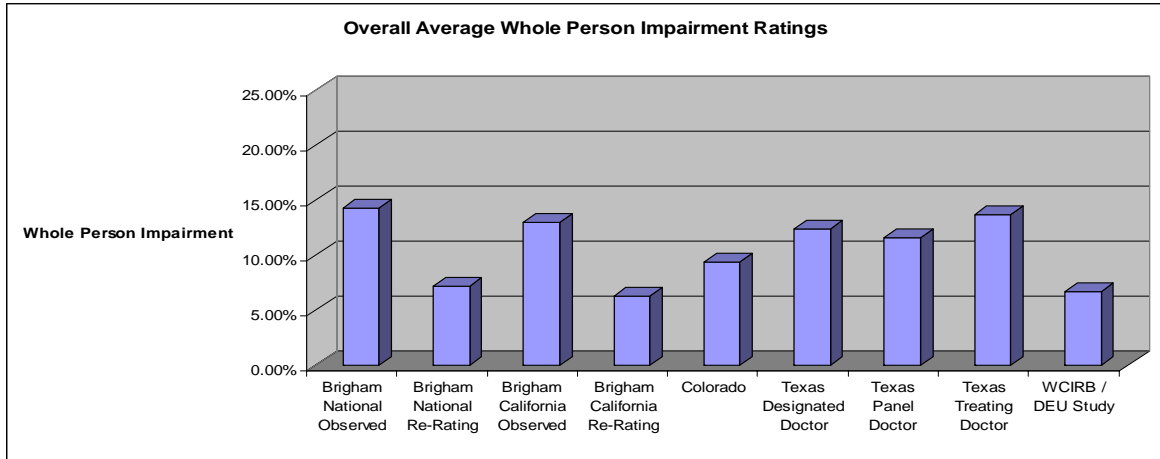
** Excluding cases with no ratable impairment

1 Based on database of reviews performed by Brigham and Associates, Inc. upon request of clients. Note these referrals are often made based on concern that a rating is erroneous, therefore this may not reflect all ratings performed. “Observed” refers to the values provided by the original rating physician and “Expert Re-Rating” refers to values obtained based on expert review of the clinical data and application of *AMA Guides* criteria.

2 Results of “Study of the Impact on Changing from the AMA Guides to the Evaluation of Permanent Impairment, Third Edition Revised to the Fourth or Fifth Editions in Determining Workers’ Compensation Impairment Ratings” performed at the request of Department of Labor and Employment, The State of Colorado by Christopher R. Brigham, MD (http://www.coworkforce.com/DWC/Medical%20Topics/brigham_report.pdf)

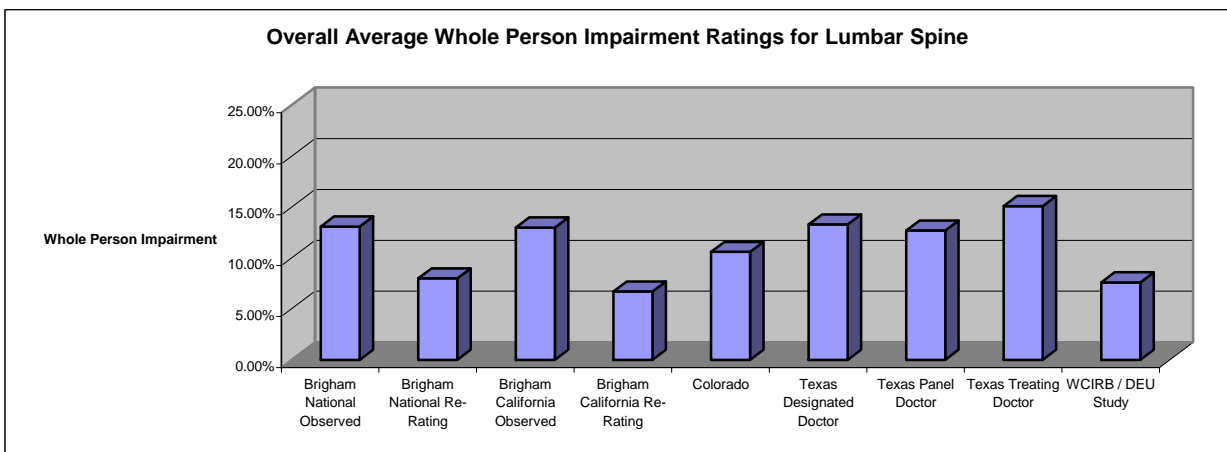
3 State of Texas Designated Doctor Study, courtesy of William Nemeth, MD. Note this is based on the use of the Fourth Edition.

4 Impairment Values for specific regions of the body were determined by assigning a specific ICD-9 code to each body portion rated and then grouping of the ICD-9 codes.



The following represents average whole person permanent impairment for the lumbar spine (low back):

Source	Average Whole Person Impairment	Cases
Brigham – National – Observed	13.1%	82
Brigham – National – Expert Re-Rating	8.0%	82
Brigham – California – Observed	13.0%	9
Brigham – California – Expert Re-Rating	6.7%	9
State of Colorado, Workers Compensation Study	10.6%	77
Texas Impairment Rating Study – Designated Doctor*	13.3%	77
Texas Impairment Rating Study – Panel Doctor*	12.7%	77
Texas Impairment Rating Study – Treating Doctor*	15.1%	77
WCIRB / DEU Study**	7.6%	38



Overall, the whole person permanent impairment ratings from this study were less than those observed in other studies, however these ratings were consistent with those of expert re-rating of

other physician's reports. The review of the data obtained by Brigham and the State of Texas demonstrate that ratings by treating physicians are often higher than ratings by independent physicians. It is recognized that it may be difficult for a treating physician to be independent and unbiased, a defined requirement in the *AMA Guides*.

It is probable that this study will reflect ratings lower than those that will be typically given by treating physicians and other examiners. It is probable that many ratings will be erroneous, and typically higher than those provided by a skilled independent rater.

The reasons for this are multifold:

- Treating physician effect, as noted above.
- Examining physicians, with an applicant or defense orientation, may present clinical findings or interpretations that reflect their own biases.
- Physicians not skilled in specific clinical assessment procedures defined in the *Guides* may base impairment on findings that lack validity and/or reliability.
- Evaluators not experienced in the use of *Guides* methodologies may incorrectly utilize the criteria in the *Guides*.

It is probable that physicians new to the use of the *Guides* are more likely to err in providing a rating higher, rather than lower, compared to an experienced examiner. Common problems include:

- Errors in judgment of causation and apportionment,
- Rating by duplicative methods, and less commonly failing to rate all impairments secondary to an injury,
- Rating spinal injuries using the wrong method, more common error is misapplication of the Range of Motion method when the Diagnosis-Estimated method is more appropriate,
- Rating spinal impairments in a different category or assigning a different value within a category than is appropriate,
- Not using the opposite extremity as normal for the individual,
- Incorrect grading of motor and sensory deficits of peripheral nerves,
- Incorporating grip strength inappropriately in upper extremity ratings (particularly given the history of this being a common rating methodology in the past), and
- Using multiple methods to assess lower extremity permanent impairment when a single method should be used or not considering a method that should be used.

It is difficult to project what ratings will actually be since there are several variables, including whether:

- The profile of cases seen under the old schedule will be the same as those rated under the New Schedule.
- Physicians obtain the needed knowledge, skills and abilities to appropriately rate according to the *AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*.
- Pain (which may result in up to 3% whole person permanent impairment) will be rated in addition to the conventional impairment rating.
- The *Guides* are used in a manner not typically used.
- Erroneous reports are identified and managed.
- Selected cases are rated by approaches other than the Permanent Disability Rating Schedule to define diminished future earnings capacity.

Acknowledgements

Brigham and Associates, Inc. and the Workers Compensation Insurance Rating Bureau (WCIRB) are very appreciative of the management and staff of the Division of Workers Compensation (DWC), Disability Evaluation Unit (DEU) and Commission on Health and Safety and Workers' Compensation (CHSWC) who facilitated this project by providing and redacting the medical-legal reports in a timely manner.

Brigham and Associates, Inc. greatly appreciates the opportunity to perform this study and the assistance provided by the Workers Compensation Insurance Rating Bureau (WCIRB) and by Frank Neuhauser of the University of California – Berkeley.

Background

Christopher R. Brigham, MD, FAADEP, CIME, FACOEM is President of Brigham and Associates, Inc. and is regarded as a leading physician expert on the use of the *AMA Guides to the Evaluation of Permanent Impairment*. He is the Editor of the *AMA Guides Newsletter* and the *Guides Casebook* and served on the Senior Advisory Committee to the Fifth and Sixth Editions of the *Guides*. He is co-author of the *Use of the AMA Guides in Workers Compensation* and was Associate Editor of the First Edition of the *ACOEM Occupational Medicine Practice Guidelines*.

Dr. Brigham has served as a senior consultant to several organizations, including international corporations, insurance companies, attorneys (defense and plaintiff), governmental agencies and health care organizations. As a clinician, with over twenty five years experience, he has performed several thousand independent medical and impairment examinations, providing him with excellent insight to the complexities of impairment and disability. He now devotes his efforts to consulting, training, writing, expert review of other physician's impairment ratings, and technology development. He has been very involved in California in training, consultation, and the review of ratings.

Dr. Brigham is very highly regarded professional speaker, trainer and author. He has spoken at hundreds of seminars and conferences in the United States, Canada, Australia and other countries, often serving as the featured speaker. He has published extensively, including several books and over a hundred articles on impairment assessment. He is also featured in several videotape and audiotape productions in the medicolegal field. Dr. Brigham is Chair of the Medical Advisory Board of Mitchell Medical in San Diego and Chair of the Professional Advisory Board for the Fourth Edition of the Medical Disability Advisor. He received his Medical Degree from the Washington University School of Medicine in St. Louis. He is board certified in occupational medicine, a Fellow of the American College of Occupational and Environmental Medicine and a Fellow of the American Academy of Disability Evaluating Physicians. Dr. Brigham is the Founding Director of the American Board of Independent Medical Examiners. His firm has offices in San Diego, California, Portland, Maine, and Oahu, Hawaii.