



November 5, 2009

ImpairmentExpert™
Sample Report

Claims Examiner
Perfect Insurance Co.
P.O. Box 1000
Splendidville, USA 12222

RE: Examinee: Maxwell Knot
Claim Number: WC-5552222

Fax: (999)222-1111
E-mail: claims.examiner@perfect_insurance.com

Dear Mr. Examiner:

Thank you for providing us with the opportunity to review this case. Our review focused on the assessment of impairment according to the *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition. In this report, we will review the October 6, 2009 report prepared by Walter Physician, M.D., discuss the process of assessing impairment, and provide an independent assessment of impairment. Our Permanent Impairment Review Summary is below.

PERMANENT IMPAIRMENT REVIEW SUMMARY

Impairments (Values Combined, Unapportioned)	
Evaluator Original Rating: 16% whole person	Impairment Resources' Rating: 2% whole person

Impairment Components by Body Part				
Body Parts	Original Rating	Rating Units	Final Rating (Standard)	Rating Units
Shoulder – Range of Motion - Right	2%	WP	2%	WP
Shoulder – Strength - Right	13%	WP	0%	WP
Shoulder – Strength - Left	1%	WP	0%	WP

<i>AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition</i>			
Date of Incident:	August 9, 2007	Original Rater:	Walter Physician, M.D.
Date of Birth:	November 16, 1946	Original Rater Role:	Treating Physician
Occupation:	Grip, Stage Construction	Date of Report:	October 6, 2009
Code:	482	Months Post Injury:	25 months



NARRATIVE SUMMARY

In summary, the key issues identified in the review of the impairment evaluation by Walter Physician, M.D. of Mr. Knot are:

1. Based on the objective evidence, there is ratable impairment to the right shoulder based on range of motion deficits.
2. The *Guides* do not support an additional rating for pain in regards to the right shoulder. The *Guides* do not support a rating for pain in the left shoulder.
3. There is no ratable impairment for the right shoulder for distal clavicle resection, as this is not described in the operative report.
4. The *Guides* do not support a rating based on strength loss for the right shoulder in the presence of pain and/or loss of motion.

In this report, we will provide detailed rationale for our conclusions. It is our hope that this will result in a better understanding of the appropriate application of the AMA *Guides*.

MEDICAL REVIEW

The medical documentation you provided was carefully reviewed. It is our understanding that this material was a copy of documents and will be purged from our files. We have made and retain an electronic image of this material. Mr. Knot is 62-years of age with a reported injury of August 9, 2007. This history is presented in the medical records.

Walter Physician, M.D. reported the following in the report dated October 6, 2009:

Mr. Knot was initially examined by me on 11/20/08 for an industrial injury he sustained on 8/7/07 and his presenting complaints of right shoulder pain. He stated that on 8/7/07 he was using two wrenches to close a lid on an old 50-gallon drum when the bolt locked down and he felt and heard a crack at his right shoulder, accompanied by pain. He subsequently reported the right shoulder injury and was examined by a Dr. XXX, on the set, who diagnosed a sprain and sent him back to work. The symptoms increased as he continued to work and a month later the same physician prescribed physical therapy, and he was given work restrictions. He had an MRI of the right shoulder that revealed a tear and in November of 2007 he was placed on temporary total disability. He was subsequently examined by Dr. YYYY at SCOI, who reviewed the MRI and recommended surgery. The patient was status post right shoulder arthroscopy with arthroscopic rotator cuff repair, long head biceps tenodesis, side-to-side repair of the subscapularis tendon, extensive debridement of the glenohumeral joint and subacromial space, and mini-Mumford procedure on 2/29/08, performed by YYYY, M.D. He subsequently received physical therapy, and on subsequent therapy visits he noticed a pulling sensation at his right shoulder, which he reported to Dr. VVV. Dr. VVV told him his symptoms were probably due to scar tissue, and advised continued physical therapy. He then consulted Dr. SSS, and he was referred for a right shoulder MRI scan. He had an MRI with dye contrast, which was reviewed by Dr. YYYY and he was told he could return to work. Dr. YYYY also advised additional physical therapy, which the patient indicated was too painful.

Mr. Knot subsequently presented to this office for orthopaedic evaluation and treatment. Following my initial examination on 11/20/08, the diagnosis was: Right shoulder pain, rotator cuff syndrome with a tear. I requested the postoperative MRI of the right shoulder for review.

The patient was re-evaluated on 11/20/08, still with right shoulder pain. Examination revealed a positive Hawkins' test, a positive impingement sign, palpable tenderness at the right shoulder, and restricted range of motion. The MRI of the right shoulder was reviewed, which revealed evidence of a prior surgery for repair of the rotator cuff: however, the postoperative MRI demonstrated a moderate-sized full thickness tear in the mid-to-anterior portion of the supraspinatus tendon, with mild atrophy of the belly of the supraspinatus muscle. I recommended operative arthroscopy of the right shoulder with revision rotator cuff tear repair, and subacromial decompression with a longer period of post-operative physical therapy to avoid another reoccurrence of rotator cuff tear that caused his current need for revision surgery,

The patient was subsequently seen in follow-up on a number of occasions, pending authorization of the right shoulder surgery. When seen in follow-up on 4/30/09, the patient was authorized for right shoulder revision arthroscopy and repeat rotator cuff repair. However, because of his familial and financial situation, he is unable to proceed with surgery for his right shoulder at this time. He also reported left shoulder pain, relating additional history that when he was wearing a right upper extremity sling, he had a fall and tried to protect his right arm by taking the brunt of the fall onto his left upper extremity, and he continued to have left shoulder pain. He indicated that he had a history of previous biceps injury and surgery to his left shoulder, exacerbated by the fall. He also reported difficulty sleeping because of the shoulder pain. Following examination, the diagnoses were: 1) Right shoulder recurrent rotator cuff tear. 2) Left shoulder compensatory pain and impingement syndrome/rotator cuff tendonitis. 3) Chronic sleep deprivation and stress. He was indicated for physical therapy for both shoulders two times per week for six weeks. He was continued on Ultram, and he was prescribed Ambien for sleep. I also recommended an MRI of the left shoulder to assess the degree of injury from the fall.

On 5/21/09 he returned to the office, complaining of pain in both shoulders. Following examination, he was continued on physical therapy to both shoulders. The MRI of the left shoulder was still pending.

An MR arthrogram of the left shoulder was performed that revealed rotator cuff tendinosis with some degenerative joint disease of the acromioclavicular joint and signs of inferolateral tilting of the acromioli and subacromial impingement.

When seen in follow-up on 6/4/09, the results of the MR arthrogram of the left shoulder were discussed with the patient. I did not see any surgical indication for the bilateral shoulders at this point, as the patient was having some improvement with physical therapy. He was continued on his course of physical therapy and pain medication. Following examination on 7/2/09, he was continued on his course of physical therapy. He was subsequently seen in follow-up and on 9/3/09, physical therapy was continued. He remained temporarily totally disabled.

Mr. Knot was re-evaluated on 10/1/09. He reports no significant change in his condition in the interim since he was previously examined on 9/3/09. He denies any new injury or change in his general health in the interim. He is not currently receiving any physical therapy. He has not been working because he has been on temporary total disability.

Dr. Physician records the examinee's complaints as follows:

Frequent slight right shoulder pain, increasing to Intermittent slight to moderate pain, and occasional moderate pain with work at or above shoulder level and with lifting greater than 20 pounds, and pushing and pulling activities.

Intermittent slight left shoulder pain that occasionally increases to slight to moderate and at times moderate pain with work at or above shoulder level, lifting greater than 20 pounds, and pushing and pulling activities.

Dr. Physician offers this diagnostic impression:

Status post arthroscopy, right shoulder, arthroscopic rotator cuff repair, and arthroscopic long head biceps tenodesis, side to side repair of the subscapularis tendon, extensive debridement of the glenohumeral joint and the subacromial space, and Mini-Mumford resection of inferior distal clavicular spurring.

Recurrent right shoulder rotator cuff tear, with residual weakness.

Right shoulder chronic subacromial impingement.

Compensatory left shoulder subacromial bursitis and rotator cuff tendinosis.

Degenerative changes of the acromioclavicular joint with inferolateral tilting of the acromion and probable subacromial impingement secondary to subchondral cystic changes of the proximal humeral head.

PERMANENT IMPAIRMENT REVIEW

Permanent impairment evaluation must be performed in accordance with the *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition. Adequate information is provided in the medical records to analyze this case and provides the needed data for the rating criteria in the Fifth Edition.¹ The *Guides* states, “if the clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria.”² It is not necessary for us to directly examine Mr. Knot since the clinical information needed for comparison to criteria in the *Guides* has been provided.

The report by Walter Physician, M.D. was reviewed in terms of standards defined in the *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition. The relationship of Walter Physician, M.D. to Mr. Knot is that of Treating Physician. He authored this impairment rating:

Right shoulder: The patient is status post mini-Mumford procedure with distal clavicle resection, indicating 10% upper extremity impairment per Table 16-27. Range of motion is restricted, including loss of flexion indicating 2% upper extremity impairment, 1 % for loss of abduction, and 1% for loss of extension, totaling 4% upper extremity impairment for loss of motion. There is 4+ out of 5 weakness in the left shoulder, 3% upper extremity impairment for loss of strength on flexion, 2% for strength deficit on abduction, 1% for extension, 1% for adduction, 1% for internal rotation and 1% for external rotation, totaling 9% upper extremity impairment for loss of strength. Combining the 10% for the distal clavicle resection with 4% for loss of motion and 9% for loss of strength results in 21 % upper extremity impairment, which converts to 13% whole person impairment for the right shoulder. In addition, I would assign 2% whole person impairment for pain affecting activities of daily living, resulting in 15% whole person impairment for the right shoulder.

Left shoulder: External rotation is slightly restricted, though unratable. I would assign 1 % whole person impairment for pain in the left shoulder affecting activities of daily living, including lifting, pushing, pulling and activities at and above shoulder level.

Combining the 15% for the right shoulder with 1% for the left shoulder results in 16% whole person impairment.

As will be explained in the following discussion, the objective findings do not fully support the impairment rating.

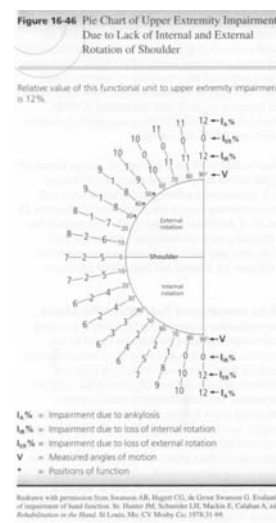
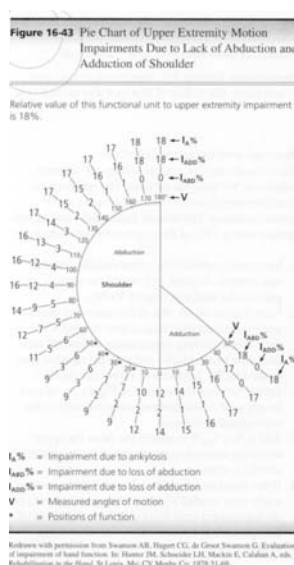
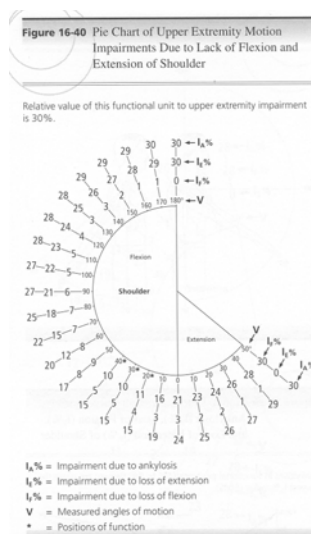
¹ Question and Answer. *The Guides Newsletter*, July/August 1999.

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

Upper Extremities - Right & Left Shoulders

The process of assessing shoulder impairment is defined in Section 16.4i Shoulder (5th ed., 474-479) and was further clarified in the articles by Katz/Perraraju and Brigham that appeared in the September/October 1998 issue of *The Guides Newsletter*.^{3 4}

Shoulder range of motion impairment is determined using Figure 16-40 Upper Extremity Impairments Due to Lack of Flexion and Extension of Shoulder (5th ed., 476), Figure 16-43 Upper Extremity Impairments Due to Lack of Abduction and Adduction of Shoulder (5th ed., 477) and Figure 16-46 Upper Extremity Impairments Due to Lack of Internal and External Rotation of Shoulder (5th ed., 479). 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.” In this case the opposite shoulder does not serve as a basis for normal due to a previous injury of the left shoulder.



³ Katz RT, Perraraju S. Evaluating Shoulder Impairment. *The Guides Newsletter*, September/October 1998, 1-3.
⁴ Brigham CR. Measuring Shoulder Joint Motion. *The Guides Newsletter*, September/October 1998, 4-5.

Based on the range of motion deficits, the following impairments were determined:

Motion	Right Measurement	Normal*	Reference (5th ed.)	Right Impairment (UE%)
Flexion	150	180 (180)	Figure 16-40. (476)	2%
Extension	40	50 (50)	Figure 16-40. (476)	1%
Adduction	50	50 (40)	Figure 16-43. (477)	0%
Abduction	150	180 (170)	Figure 16-43. (477)	1%
Internal Rotation	80	90 (80)	Figure 16-46. (479)	0%
External Rotation	80	90 (60)	Figure 16-46. (479)	0%
Total				4%

*The first measurement is normal as per the *Guides* and the second is below which there is ratable impairment per the referenced pie chart.

Based on the above measurements, there is a 4% right upper extremity impairment for range of motion deficits.

Dr. Physician provided a rating to the right shoulder based on the surgery procedure performed of a mini-mumford procedure. The operative report was reviewed and the performance of the mini-mumford procedure is not consistent with a distal clavicle arthroplasty in this case. The description is consistent with a shaving or smoothing out of the clavicle; however, there was no anatomical change to the AC joint. It remains intact and therefore, does not qualify for a rating per Table 16-27 (5th ed., 506).

Dr. Physician rated the right shoulder based on strength loss. 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. The *Guides* states in Section 16.8 Strength Evaluation, “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) This is both a painful condition and there is reduced range of motion. Therefore, the *Guides* are clear that impairment for strength cannot be included in the assessment of impairment.

In summary, there is a 4% right upper extremity impairment for the range of motion deficits. Using Table 16-3 Relationship of Impairment of the Upper Extremity to Impairment of the Whole Person (5th ed., 439), there is 2% whole-person permanent impairment for the right shoulder.

Pain

Dr. Physician rated the right and left shoulder additional whole person impairments for pain. In this case, however, no pain rating should have been applied. The pain described in this case for the shoulders was one of the expected consequences from the injury described and incorporated into the rating of the motion loss. The *Guides* in fact states that the conventional impairment ratings already have “accounted” for pain in the specific organ chapters (5th ed., 570).

In Section 18.3a, the *Guides* discuss when Chapter 18 Pain should be used (5th ed., 570-571):

When There Is Excess Pain in the Context of Verifiable Medical Conditions That Cause Pain:

Individuals in this group have pain associated with medical conditions that are verifiable by objective means. An example is an individual with a persistent lumbar radiculopathy following a lumbar discectomy. Such an individual will usually have objective findings, including atrophy of the affected leg, muscle weakness, and MRI evidence of epidural scarring. An individual with these findings would receive an impairment rating of 10% on the basis of the DRE spine impairment rating system described in Chapter 15. Although the DRE rating is usually appropriate, some individuals with persistent lumbar radiculopathies report “excess” pain. That is, they report that their pain causes severe ADL deficits, suggesting a level of impairment greater than 10%. Procedures in this chapter can be used to assess this additional impairment and to classify it as mild, moderate, moderately severe, or severe.

When There Are Well-Established Pain Syndromes Without Significant, Identifiable Organ Dysfunction to Explain the Pain:

Individuals in this group have pain syndromes that are widely accepted by physicians based on the individuals’ clinical presentation but that are not associated with definable tissue pathology. These syndromes are not ratable under the conventional rating system and also they do not fit any of the other chapters in the *Guides* since there is no measurable organ dysfunction. Individuals with these well-established pain syndromes can be evaluated on the basis of concepts elaborated in this chapter. These individuals must have symptoms and signs that can plausibly be attributed to a well-defined medical condition. Some of the most common of these syndromes are listed in Table 18-1. The list is not comprehensive and may change as the body of medical information about various pain syndromes grows. If an examiner determines that an individual has a diagnosis that is not on the list, he or she may rate the individual's pain-related impairment if he or she is convinced that the diagnosed condition is well recognized and that the pain-related impairment is a consequence of the condition. An explanation should be provided in writing.

When There Are Other Associated Pain syndromes:

Use this chapter to evaluate pain-related impairment when dealing with syndromes with the following characteristics: (a) They are associated with identifiable organ dysfunction that is ratable according to other chapters in the *Guides*; (b) they *may be* associated with well-established pain syndromes, but the occurrence or nonoccurrence of the pain syndromes is not predictable; so that (c) the impairment ratings provided in other chapters of the *Guides* do not capture the added burden of illness borne by individuals who have the associated pain syndromes.

In this case, there is motion impairment to the right shoulder. The complaints to the shoulder would be characterized as excessive for this condition based on the description provided in Dr. Physician’s report.

Dr. Physician in fact does not describe excessive pain in relationship to the diagnosis or condition. As such, in our expert opinion, no additional impairment should be considered in this case for “excess pain” that is not documented for the right shoulder.

For the left shoulder, the additional discretionary impairment provided in Chapter 18 Pain, is allowed as an “add-on” to the conventional impairment ratings provided in the other chapters. In this case, there are no ratable objective factors of disability for the left shoulder.

Of additional note, the DEU authored a statement in August of 2005 on this issue, which can be found on their website www.dir.ca.gov/FAQ:

Q: As a primary treating physician, how do I evaluate subjective impairment under the new schedule? For example, I am evaluating a lower extremity impairment and have found no objective impairment under chapter 17. Can I give a 3% whole person impairment to this case due to the limitation of some activities of daily living?

A: No. The new schedule states that an impairment rating based on the body or organ rating system of the AMA *Guides* may be increased up to 3% for pain that is above and beyond the pain associated with the underlying impairment rating. Under the new schedule, a subjective impairment (pain) can only be used as a potential add-on to an existing impairment.

Therefore, absent any ratable impairment in the applicable chapter of the *Guides*, it is inappropriate to assign impairment for pain per Chapter 18 for the left shoulder.

CALIFORNIA PERMANENT DISABILITY RATING SCHEDULE

The whole person impairment rating(s) are used as the Impairment Standard(s), the first step in defining Permanent Disability in the State of California, as explained in the Schedule for Rating Permanent Disabilities (<http://www.dir.ca.gov/dwc/dwcpropregs/PDRS.pdf>). Based on the facts in this case, the following Impairment Numbers and Impairment Standards apply. For each impairment standard, I have provided the percentage of impairment apportioned to the referenced injury. As explained in the Rating Procedures, these standards are adjusted for diminished future earning capacity, occupation and age. If there are multiple disabilities, these are combined.

Assuming the occupation of Grip, Stage Construction and applying the impairment standard as outlined above, the following permanent disability is calculated:

Right Shoulder – Range of Motion
16.02.01.00 - 2 - [7] 3 - 482I - 5 - 6

Final PD = 6%

QUALIFICATIONS

The author of this report is a Certified Impairment Rater (CIR) and has unique knowledge, skills and experience in the use of the AMA *Guides to the Evaluation of Permanent Impairment*. Her professional background has included years of work in claims assessment, extensive training on the AMA *Guides*, and ongoing peer review by physicians distinguished in the use of the *Guides*. Further information is provided at <http://www.impairment.com/profiles.htm>.

DISCLOSURE STATEMENT

The above analysis is based upon the available information provided by the requesting party at this time; it is assumed that the information provided is correct. If more information becomes available at a later date, an additional report may be requested; such information may or may not change the opinions rendered in this report. The opinions are based on reasonable degree of medical certainty, i.e., more likely than not. Comments expressed in this report are professional opinions based upon the

specifics of the case and documentation reviewed; they should not be generalized, nor necessarily be considered supportive or critical of the involved providers or disciplines. Any recommendations offered are provided as guidance and not as medical orders. The opinions expressed in this report do not constitute a recommendation that specific claims or administrative action be made or enforced. This report reflects solely the information reviewed and an independent professional opinion.

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

Sincerely,



Patty Stevens, CIR

PEER REVIEW

The above examiner is trained in the use of the *AMA Guides to the Evaluation of Permanent Impairment*. The examiner's work is regularly reviewed under my tutelage through a stringent process of quality assurance to insure fair, accurate and reliable ratings. In addition to my position as the National Medical Director for Impairment Resources, LLC, I am a board-certified occupational medicine physician practicing as an Occupational and Disability Medicine Specialist with Sharp-Rees Stealy Medical Group, Associate Editor of the new edition of *The Guides Casebook*, reviewer of the *AMA Guides*, Sixth Edition, and an Associate Editor for the *AMA Guides Newsletter*. I have more than 15 years of experience in Occupational Medicine. I received my M.D. from the University of Southern California - Keck School of Medicine, did a residency in Occupational and Environmental Medicine at the University of California at Irvine, and received a Master's Degree in Public Health from San Diego State University. I am a Qualified Medical Evaluator with the State of California, Certified Independent Medical Examiner by the American Board of Independent Medical Examiners and a Certified Impairment Rater. I have extensive experience in the use of the *AMA Guides to the Evaluation of Permanent Impairment*, having performed and/or reviewed thousands of cases regarding impairment and causation/apportionment analyses.



Craig M. Uejo, MD, MPH, QME, CIME, CIR
National Medical Director, Impairment Resources, LLC

CMU/PS:kl