October 15, 2007

William Client
xxx
xxx
xxx

E-mail: xxx

RE:		
	Individual:	Sam Smith
	File Number:	12345
	Date of Incident:	December 13, 2005
	Our file number:	11091

Dear Mr. Client

Thank you for providing us with the opportunity to perform this independent medical evaluation. Attached is a copy of our report. We strive to provide high quality service, efficiently and cost-effectively. Referrals can be made online at http://www.impairment.com/referral. Please visit our website at www.impairment.com to learn more about how we can assist you. We would appreciate the opportunity of performing all of your impairment evaluations.

Our invoice for this case is attached and a printed copy will be sent with the report by mail. We provide services promptly and we request the same courtesy with payment. Payment is due upon receipt and invoices not paid within 30 days are considered past due; our Fee and Payment Policy is available at www.impairment.com/fees. We appreciate the opportunity to be of service.

If you have any questions, or if we can be of further service on this case or other cases, please do not hesitate to contact us.

Sincerely,

Kerry Tockarshewsky

Kerry Tockarshewsky
Client Service Representative

Enclosure

Independent Medical Evaluation Report

Examinee:	Sam Smith
BA Number:	11091
Date of Birth:	September 2, 1955
Date of Report:	November 9, 2007
Date of Examination:	October 15, 2007
Examining Physician:	Christopher Brigham, MD, CIME, FAADEP, FACOEM, CIR
Examination Location:	Suite C312, Pali Palms Plaza, 970 North Kalaheo Avenue, Kailua, HI 96734
Date of Injury:	December 13, 2005
Type of Evaluation:	Independent Medical and Impairment Evaluation
Referral Source:	William Client, xxxx
Diagnosis (Primary):	Cubital Tunnel Syndrome
Permanent Impairment:	2% upper extremity (2% hand)

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INTRODUCTION

Mr. Smith is a 52-year-old, right-handed man with a reported injury of December 13, 2005, an event occuring nearly two years ago. He was referred for an independent medical and impairment evaluation (IME) by the above client. This evaluation focused on case evaluation and impairment evaluation, according to the AMA *Guides to the Evaluation of Permanent Impairment*, Fifth Edition.

The independent medical evaluation process was explained to the examinee, and the examinee understands that no patient/treating physician relationship was established. The examinee was advised that the information provided will not be confidential and a report will be sent to the requesting client. Informed consent was obtained with the examinee providing written permission to proceed with the evaluation, including the physical examination. The individual was advised not to do anything during the examination that would result in harm and agreed to notify us immediately of any difficulties during the examination.

Mr. Smith arrived thirty minutes early. The examinee was advised of the evaluation process, provided consent to proceed, and then completed a questionnaire and a series of pain inventories. The interview and examination involved approximately one and a half hours. Mr. Smith was very cooperative. History was provided by the examinee who was an adequate historian, although initially had not reported an injury to his right arm that occurred within a week prior to the reported workplace history; on inquiring he did discuss that event. There are some inconsistencies among the reported workplace injury and the prior motor vehicle accident. The entire process, inclusive of the medical record review, analysis of the pain inventories, interview, physical examination, case analysis, and preparation of the report, took approximately five hours.

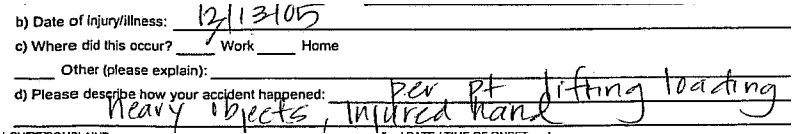
A questionnaire and pain inventories were completed by Mr. Smith. To ensure accuracy, the clinical history as reported on pages 10 and 11 of this report was reviewed by him. The examinee reported no difficulties occurring during the examination. At the conclusion of the evaluation Mr. Smith completed a Satisfaction Survey and agreed to the following four statements:

1. I was treated with dignity and respect by the staff
2. The physician appeared thoughtful and thorough
3. I did NOT sustain any new or further difficulties during the exam.
4. Overall, I was pleased with the quality of today's visit.

I carefully reviewed and analyzed the medical records you provided; these are cited in Medical Record Review. These medical records will be returned to you upon request, otherwise they will be purged from this file in approximately one year. The report, questionnaires, pain inventories, and other material specific to this evaluation will be retained.

MEDICAL RECORD REVIEW

The following are pertinent excerpts from these medical records:

Date	Provider	Type[1]	Summary
	Injury / Illness Report Form		 b) Date of injury/illness: 12/13/05 c) Where did this occur? ___ Work ___ Home ___ Other (please explain): d) Please describe how your accident happened: Heavy objects, injured hand per pt lifting loading
12/13/05	Xxx Medical Center	ER	CHIEF COMPLAINT: (R) HAND NUMBNESS; DATE/TIME OF ONSET: 12/13/05; SUBJECTIVE HISTORY: Pt states falling off his bike on Sat onto his (R) elbow. ~2° PTA, pt c/o (R) 4th & 5th finger numbness & pain; TIME IN RM: 2245; ROOM #: 3; mean pain in R hand + R arm pain, numbness ~3-3/10. EKG. ROS C, C, T, V, D Fell 3d ago bike; Pt ambulated to Rm 13 accompanied by Girlfriend. Alert, skin WD. c/o pain to (R) arm & numbness to 4th & 5th finger. States fell off bike about 3days ago. and + numbness hand, pain to RA diff having to do a lot of heavy lifting today. 2+ radial pulse. Cap <2sec. awaiting ED md to evaluate pt.
			Pt states falling off his bike on Saturday onto his right elbow, around 2◦ PTA, pt c/o right 4th and 5th finger numbness and pain Right arm ulna paresthesias
12/13/05	Urgent, Mark MD xxxxx Medical Center		HISTORY OF PRESENT ILLNESS: The patient is a 50-year-old who presents in the department at 2130 **reporting that he fell off his bike on Saturday onto his right arm. He tells me that he has had some persistent pain in his arm and his hand and now he notes some numbness.** He does not recall specifically whether he injured his wrist or not. The pain started initially and the numbness has been there since 2:00- 3:00 p.m. today, he denies having any recollection of waking up lying on his arm in a crooked position or with his elbow in a flexed position. He has not had similar symptoms in the past. He denies alcohol consumption. REVIEW OF SYSTEMS: No cough or cold. He is uncertain about fever. He has not had any vomiting, diarrhea or dysuria. ALLERGIES: None. CURRENT MEDICATIONS: None. PAST MEDICAL HISTORY: The patient is here with girlfriend. PHYSICAL EXAM: VITAL SIGNS: Temperature 99, pulse 70, respiratory rate 18, BP 112/81. 02 saturation is normal at 100%. GENERAL: On exam, the patient is awake, attentive and in no acute

distress. SKIN: Warm and dry, well-hydrated. NECK: Supple. LUNGS: Clear to auscultation. HEART: Regular with no murmur. ABDOMEN: Soft. There is no rebound, no guarding.
NEUROLOGIC: The patient has use of both upper and lower extremities. He has a very well-defined area of light-touch deficit corresponding to the ulnar nerve distribution in the right hand. This is less discrete proximal to the wrist. The motor function is normal. There is both tenderness in the ulnar region of the wrist, on the flexor side, and there is tenderness iii the region of the ulnar nerve at the elbow. This makes assessing the location for the injury difficult. There is some area of swelling on the elbow but it is not truly overlying the ulnar area. Hand motor function is normal. Motor function of the other extremities is normal.

EMERGENCY DEPARTMENT COURSE: The patient was evaluated and we discussed his numbness and the fall. I doubt fracture. He does have a contusion. I also considered other possible explanations for the numbness other than the contusion and acute injury. This could include overuse syndrome related to work or sleeping position. Because of the new onset of numbness I recommended steroids. He was also given a shot of Demerol and Phenergan for pain. A long arm splint was requested and was directed and inspected by myself. He has normal vascular status following that, with unchanged neurologic status, The patient was discharged with written aftercare instructions and recommendations to see his doctor. He left the department in satisfactory condition with a prescription.

DIAGNOSIS: Right arm Ulnar neuropathy.

<Note: No reference is made to a work-place injury on December 13, 2005, only to a non work-related event, a bicycle accident, on the preceding Saturday, December 10, 2005, 3 days prior to the emergency room visit.>

12/22/05	Primary, Frank MD	M	SUBJECTIVE:

The patient is a 50-year-old male, who was **injured at work nine days ago. He reports the onset of right forearm and hand pain following the repetitive lifting of heavy objects at work.** Symptoms were further aggravated after he went home and had to ride his bike to the store. He has continued working but symptoms have not improved. He was initially evaluated in the emergency room, referred to his private physician, who referred him to Dr. Calvin Specialist. Unfortunately, Dr. Specialist no longer except workers compensation and has referred the patient here.

Current complaints include pain in the right hand and little finger with milder symptoms in the ring finger. Anesthesia is present over the ulnar side of the distal forearm, wrist, hand and little finger. Symptoms increase when performing grasping or gripping activities with the hand.

At the time of the injury, the patient was working as a pipefitter. He has continued to work since the injury.

Prior Injury: unknown
Surgeries: none
Medical Problems: none
Allergies: none
Medications: none
Activities/hobbies: unknown

REVIEW OF SYSTEMS: negative

OBJECTIVE:
Vital Signs: BP 128/80 P 59 Pain Level 5/10
The patient appears well nourished and is in no acute distress.
On physical examination there is no tenderness around the elbow. Tinels is negative at the cubital tunnel and ulnar groove and there is no evidence of subluxation of the ulnar nerve with elbow flexion. Wrist compression test is negative. Pain is present over the third and fourth metacarpals at the carpal metacarpal joints. The right little finger is swollen and there is an extensor lag at the DIP joint. Palpation of the joint is painful.
Spurlings is negative at the neck and there is no focal neck tenderness.

DIAGNOSIS: mallet finger, ulnar neuropathy

TREATMENT: x-rays of the right wrist, hand and little finger, consult with Dr. Daniel Jones

MED REFILLS: Celebrex 200 mg one bld. (samples)

<Note: No reference is made to the bicycle accident, on the preceding Saturday, December 10, 2005 or to an acute injury on December 13, 2005, rather attributed to repetitive lifting of heavy objects .>

12/28/05	Primary, Frank MD	M	The patient returns for a recheck of his right hand and little finger injuries. On physical examination the right little finger remains swollen and there is a mallet deformity. Anesthesia is reported along the ulnar side of the wrist and hand. DIAGNOSIS: mallet finger ulnar neuropathy PLAN: waiting on approval to proceed with diagnostic testing and orthopedic surgery consult
2/16/06	Jones, Daniel MD	C	Dear Doctor Primary: Thank you for consulting me on Mr. Smith. As you know he is a 50-year-old, pipefitter, who presents with a number of complaints. **He injured himself on 12/13/05, when trying to lift a long heavy iron. He rotated his finger.** He was in a splint, however, he is complaining of severe pain. He complains of numbness in the ulnar 1-1/2 digits, complains especially of pain in cold weather and when he leans on the elbow it seems to hurt and he has to lift it up. He has not been wearing the splints any more. For his finger he notices it is still crooked. He denies any previous similar symptoms. PAST MEDICAL HISTORY: Allergies: None. Medications: None. He has had no other serious illnesses or surgeries. He drinks a six-pack per month and does not smoke. PHYSICAL EXAMINATION: General: Well-developed, well-nourished and in no acute distress. Musculoskeletal: Examination of the finger shows that he tends to have a slightly curl over the PIP about 20 degrees but passively I can extend it. He lags about 40 degrees at the DIP joint and passively I can fully extend it and he lacks about 1/2 cm of full fist in flexion. He does splint his ring finger with numbness ulnarly and no numbness radially. No numbness radially and he has weakness in the first dorsal interossei, and no weakness with abduction of the thumb. He has a positive Tinel's sign in the cubital tunnel and elbow flexion test is negative. X-RAYS were obtained, two views of the little finger, these show no fracture with a mild mallet deformity. DIAGNOSIS: 1) CUBITAL TUNNEL, RIGHT. 2) MALLET, RIGHT FIFTH. ASSESSMENT & PLAN: At this point, for the mallet finger he still has this so I did recommend a figure-of-eight splint, but he should be encouraged to move his PIP joint both in extension and flexion so it does not get stiff. I would probably wear the splint for one more month and then accept a lag after that. However, I am more concerned about his cubital tunnel, that seems to bothering him much more and we did given him an elbow protective brace so if he leans on it, it does not hurt as much. I would recommend nerve studies, EMG's and NCT's, to rule out significant cubital tunnel. If he does show up with significant cubital tunnel and if this does not clinically improve over the next few weeks then I would be happy to re-evaluate him for a transposition of the ulnar nerve. Thank you again for allowing me to see this nice gentleman in consultation.

<Note: No reference is made to the bicycle accident nor to repetitive lifting, rather attributed to a specific lifting event.>

4/24/06	Primary, Frank MD		numbness along the ulnar side of the right hand and in the little and ring fingers. On physical examination Tinel's is mildly positive at the cubital tunnel of the right elbow. Wrist compression testing is negative. Will proceed with EMG/NCV studies per the recommendation of Dr. Jones.
5/12/06	Neuro, Jack MD		Patient is a 50 year old gentleman who sustained injury to his right upper extremity while on the job on 12/13/2005. Patient currently reports numbness and soreness over the ulnar aspect of the right hand and small finger. INTERPRETATION Nerve Conduction Studies: 1) Bilateral median and left ulnar motor nerve action potentials revealed normal distal latencies, amplitudes and conduction velocities. Right ulnar motor nerve action potentials revealed slightly prolonged distal latencies, decreased amplitudes and slightly decreased conduction velocities. 2) Bilateral radial and left ulnar sensory nerve action potentials revealed normal peak latencies, amplitudes and conduction velocities. Right ulnar sensory nerve action potentials revealed prolonged peak latencies, normal amplitudes and decreased conduction velocities. Bilateral median sensory nerve action potentials revealed prolonged peak latencies, normal amplitudes and decreased conduction velocities. Electromyography: The above muscles were examined using a disposable, monopolar needle. No increase in insertional activities seen. No abnormal spontaneous activities present. The morphology of the motor unit action potentials observed was within normal limits with respect to amplitudes, duration as well as the number of phases. Recruitment pattern and activation were also within normal limits. IMPRESSION I) There is electrophysiologic evidence of sensorirnotor ulnar neuropathy present on the left **(sic)** side, Axonal loss present. Readings are consistent with a moderate left **(sic)** ulnar neuropathy. 2) There is electrophysiologic evidence of sensory median neuropathy present bilaterally. Findings are consistent with mild, bilateral carpal tunnel syndrome. 3) Clinical correlation suggested.
5/12/06	Primary, Frank MD	M	right little finger mallet, anesthesia over ulnar nerve distribution proceed with electrodiagnostic testing of the upper extremities per the recommendations of Dr. Daniel Jones
6/28/06	Rxxxxxxxx, Kent MD	IME	Sam Smith is a 50-year-old male who is employed by xxxxxxxxx xxxxxxxx Incorporated as a pipe-fitter. Mr. Smith **apparently fell off his bicycle on 12/10/05, injuring his right arm and hand. He went to work and on 12/13/05 and noted numbness in his right hand which began at 2 o'clock to 3 o'clock in the afternoon.** He was then seen at xxxxxxxxxx Medical Center Emergency Room by Mark xxxxxx, M.D. with a diagnosis of right arm ulnar neuropathy. He was then referred to his regular physician, Michael Fxxxxxxx, M.D. who saw him on 12/16/05. Dr. Fxxxxxxx referred Mr. Smith to Frank Primary, M.D. who examined the patient on 12/22/05 and felt that he had an ulnar neuropathy and a mallet finger. He was then referred to Daniel Jones, M.D., orthopedic surgeon, who saw him on 02/16/06 and felt that he had a cubital tunnel syndrome and a mallet finger of his right fifth finger. Dr. Jones recommended EMG and nerve conduction studies which were eventually done three months later on 05/12/06 by Jack xxxxxxxxx, M.D. These revealed a left moderate ulnar neuropathy and a mild right and left carpal tunnel syndrome. Mr. Smith is here today for further evaluation. He is a 50-year-old divorced male with three children. He moved to Hawaii in February 1982. He is originally from New York. Mr. Smith denies any prior surgical procedures. He has had no significant medical problems, other work- related injuries or

motor vehicle accidents. He has worked as a pipe-fitter for approximately the last 5 years for xxxxxxxxx xxxxxxxx which apparently changed to xxxxxxx xxxxxxxx in May 2006.

At this time, Mr. Smith complains of pain, weakness and numbness in his right fourth and fifth fingers. He has no allergies and takes no medications. He is not seeing any physicians at this time.

PHYSICAL EXAMINATION: Sam Smith is 50 years of age. He is 5' 9" tall and weighs 169 pounds. Examination of the upper extremities reveals that he is right hand dominant.

Maximum circumference: RIGHT LEFT
Biceps 11 inches 11-1/2 inches
Forearm 10-1/2 inches 10-1/2 inches

There is decreased sensation in the fifth and ulnar aspects of the fourth finger of the right hand. There is a positive Tinel's at the right elbow. There is a negative Tinel's and Phalen's sign at both wrists. Motor evaluation of the right hand is normal. The radial, ulnar and median nerve sensation is normal except for the right hand ulnar nerve distribution. There is a mallet finger of the right fifth digit which lacks approximately 30 degrees of extension.

IMPRESSION:
1. Right ulnar neuropathy.
2. Right fifth mallet finger not related to the work injury of 12/13/05.

DISCUSSION: Sam Smith fell off his bicycle on 12/10/05. It is most likely that this resulted in his right fifth finger mallet finger as this was a traumatic event. He complained of pain in the right hand and elbow but no numbness until he returned to work on 12/13/05.

I believe that his work on 12/13/05 aggravated his right ulnar neuropathy which persists to this day. I would suggest that he have an ulnar decompression at the elbow as suggested by Dr. Jones. I believe that the right ulnar nerve problem is as a result of the work injury of 12/13/05. However, I believe that his right fifth mallet finger was as a result of the preexisting bicycle accident.

<Note: References bicycle accident, then symptoms of numbness with onset at work.>

7/5/2006	Primary, Frank MD	M	SUBJECTIVE: The patient returns for a recheck of his right hand and little finger injuries. Complaints: anesthesia and tingling paresthesia over ulnar nerve distribution in the right upper extremity, pain in the right index finger The patient appears well nourished and is in no acute distress. He has a Band-Aid over the tip of his right index finger. When the Band-Aid is removed it is apparent that he has developed a felon. He says he cut his finger on some threaded pipe at work and it got infected. I told him he needed to report the accident and get treatment right away. His EMG/NCV study was reviewed and though the report indicates he has a left ulnar neuropathy, I believe it is an error and is supposed to say right ulnar neuropathy. He will be sent back to Dr. Daniel Jones. DIAGNOSIS: mallet finger ulnar neuropathy
8/31/06	Jones, Daniel MD	M	Mr. Smith returns. He would like to go ahead with surgery. On EXAMINATION, chest clear to P&A. Cardiovascular system - regular rhythm, S1 and S2, without murmurs or gallops. Extremity examination shows negative Tinel's or weakness in the first dorsal interossei and numbness in the ulnar nerve distribution. ASSESSMENT & PLAN: At this point, I told him that usually people do not get completely better after surgery. Sometimes the pain goes away. Gradually, the numbness can go away as can the weakness but it is obviously not guaranteed. There are risks of surgery, including but not limited to anesthesia, infection, nerve damage, worsening of symptoms, and unforeseen complications. I also

			told him to expect some numbness behind the elbow from the little nerves that run across the field. He knowingly consents to the surgery, which will be performed in the near future as an outpatient.
9/22/06	Jones, Daniel MD	M	Mr. Smith returns. He would like to go ahead with surgery. On EXAMINATION, chest clear to P&A. Cardiovascular system - regular rhythm, S1 and S2, without murmurs or gallops. Extremity examination shows negative Tinel's or weakness in the first dorsal interossei and numbness in the ulnar nerve distribution. ASSESSMENT & PLAN: At this point, I told him that usually people do not get completely better after surgery. Sometimes the pain goes away. Gradually, the numbness can go away as can the weakness but it is obviously not guaranteed. There are risks of surgery, including but not limited to anesthesia, infection, nerve damage, worsening of symptoms, and unforeseen complications. I also told him to expect some numbness behind the elbow from the little nerves that run across the field. He knowingly consents to the surgery, which will be performed in the near future as an outpatient.
9/27/06	Jones, Daniel MD	O	PREOPERATIVE DIAGNOSIS: Cubital tunnel, right. POSTOPERATIVE DIAGNOSIS: Cubital tunnel, right. **OPERATION: Anterior subcutaneous transposition of ulnar nerve, right elbow.** . . . Then we followed it through the cubital tunnel. We followed it through the two heads of the flexor carpi ulnaris. The nerve was very sensitive here. By just touching it, he had pain, and this may have been the area of compression. . . .
10/25/06	Jones, Daniel MD	M	Mr. Smith returns, overall, he is doing a little better and has less numbness in the ring, but still numb along the ulnar aspect of the hand. The wound is healing well and not really bothering him much. On EXAMINATION elbow motion is good and he has fairly good strength in the first dorsal interossel. ASSESSMENT & PLAN: At this point, he can return to work on Monday and I will see him back in a month for a clinical recheck. I told him sometimes it takes up to six months to a year to get the final results from this type of surgery.
11/4/06	Jones, Daniel MD	M	Mr. Smith returns. He feels a little less numb in the finger and is status post anterior transposition of the ulnar nerve. On EXAMINATION his wounds are clean and moving the fingers well. Of note, he has bilateral swelling of his feet. ASSESSMENT & PLAN: At this point, he is on some Vicodin and Phenergan. I do not think that would cause swelling in the feet, with both sides, it is unlikely he has any type of occlusion, the surgery was quick in the upper extremities, therefore I referred him back to his PCP, Dr. Fxxxxxxxx for the swelling in the feet, because I am not really sure what is causing this. I will see him back in three weeks and determine if he can return to work then.
11/21/06	Jones, Daniel MD	M	Mr. Smith returns, overall, he has gotten considerably better and less numbness. The numbness is ulnar through the finger. On EXAMINATION he is moving his elbow and fingers well, the wound is well healed and still weak but present in the first dorsal interossei. ASSESSMENT & PLAN: At this point, he is definitely improving see him back in two months to monitor his improvement. from his surgery.

1 Type of Encounter: C = Consult, H = Hospital, I = IME / Impairment Assessment, M = Medical Visit, O = Operation, R = Report / Letter, P = PT/OT Visit, S = Diagnostic Study, X = X-ray (Imaging) Study, * = Other

HISTORY (PER EXAMINEE)

Pre-Existing Status

Mr. Smith denies any previous problems or injuries, including any other work- or liability-related injuries. He also denies having any difficulties similar to those that he is now experiencing until the injury.

Injury

Mr. Smith reports on December 13, 2005 while working as a welder for xxxxxxxxx xxxxxxxxxx on the fantail of a ship he was "picking up small sections of I beams 10 feet to 20 feet in length, 4' width, with a co-worker. Another co-worker called him, he turned, wasn't watching and the I-beam turning in my hand and pinch my small finger and ring finger on the right hand"

He reports the problems at that time as "a lot of numbing, tingling feeling in the hand. Whenever cold hit it was hurting even more, couldn't grip things right with his finger locking". He states he reported this to the office.

In reviewing his history with him, I inquired about the report bicycle accident that occurred approximately 3 to 4 days prior to that event. He states he fell from his bicycle onto his right arm (elbow and hand), however had no problems with pain in his hand nor any significant difficulties until the event on December 13, 2005.

Clinical Chronology

His history was reviewed with him and consistent with that in the record review above (with the exception of reported injury, as noted).

In summary, he was seen at the Medical Center, and then by Frank Primary, MD. Dr. Primary evaluated him and referred him to Dr. Jones who saw him in consultation. Subsequently he had nerve conduction studies performed, and then following agreement in an independent medical evaluation with Dr. Rxxxxxxxx, an ulnar nerve release was performed on September 7, 2006. He states he has not seen any significant improvement with the surgery. His last visit with Dr. Jones was in November 2006.

Current Status

Mr. Smith reports that his greatest concern is "that to me is in the long run is my hand going to come paralyzed or what? To this day I still having problems even when my doctor told me it would take 6 months to year."

His difficulties include numbness, followed by pain and difficulties in making use of his right hand. He has numbness involving the little finger and the ulnar aspect of his ring finger. He also has pain in those areas. His symptoms are increased with cold, gripping, and use of tools at work. It is improved with warmth. The pain is frequent. On a scale from 0 to 10, where 0 represents no pain and 10 represent excruciating pain, he reports his current level of pain as a 5. During the past month it has averaged 7, with a low of 4 and a high of 7.

On his questionnaire he noted:

> I was told that this should be cleared up within 6 months to 1 year. I still have the problem as told by Dr. Jones. My hand, fingers (small and ring finger) still feel numbness and tingling feeling. It also gets to the point where it seems

like I can't even open my hand at points when opening or holding on to my tools or even welding. I think I should get compensation for this. It's my working hand I'm talking about.

Functional Status

The greatest difficulties are with use of his hands, in tasks such as welding, chipping, and grasping items. He reports tightness with his fingers. He estimates he can lift an occasional 50 pounds.

Occupational History

He has worked with xxxxxxxxxxxxx xxxxxxxx for 4 years as a welder. His work involves welding, cutting, grinding, and fabrication. He was initially out of work for approximately two weeks, and then returned to work. He continues to work on a full time basis. Although his initial background was welding; he is now working as a pipefitter. He went to a technical school and has a high school degree.

Social History

He lives in Waianae area with friends. He has a 7 year old son who lives with his mother. He describes a typical day as "work, eat, and sleep on weekends". He may go out with friends who have a band. He denies any involvement with significant other activities or recreational pursuits.

He does not smoke. He may drink a 6 pack of beer on a weekend.

Past Medical History

Medical: Unremarkable

Surgery: Unremarkable

Medications: None

Allergies: Denied

Review of Systems

Denies any other significant medical problems.

Family History

Non-contributory.

PHYSICAL EXAMINATION

Observations

The individual is a well-developed, well nourished male who appears in no acute distress although uncomfortable at times. Examination of the hands reveals mild callus. No assistive devices were used. He reports weighing 167 pounds and being 5 feet 9 inches tall.

<image of examinee – deleted for sample report>

Behavioral Observations

The examinee was pleasant and cooperative. Affect was normal. During the visit the examinee appeared comfortable. Pain behavior was absent. Nonphysiologic findings were absent.

All range of motion measurements in this case were performed as instructed in the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition. These measurements were reproducible within 10%, unless otherwise noted.

Upper Extremity Examination

There were no findings of antalgic posturing or display, swelling, discoloration, deformity, atrophy, thermal abnormality, nor hyperpathia. Scar is present on the right elbow, 10 cm. in length, with mild keloids, consistent with his surgery.

Shoulders

Shoulder examination was unremarkable.

Elbows

	Right	Left	Reference (5th ed.)	Normal
Flexion	140	140	Figure 16-34 (472)	140
Extension	0	0	Figure 16-34 (472)	0
Supination	70	70	Figure 16-37 (474)	70
Pronation	80	80	Figure 16-37 (474)	80

Inspection of the right elbow was normal, except for the scar as noted. Resisted and passive motions were pain-free. There were no abnormal findings.

Wrist

Wrist examination was unremarkable.

Hand

Hand examination was unremarkable.

Palpation of the Upper Extremity

Palpation of the proximal forearm tendons, distal forearm tendons, thumb tendons, digital tendons at the wrists, olecranons (medial and lateral), and bony carpus were pain-free with normal findings.

Neurological Examination of Upper Extremity

Upper Extremity Deep Tendon Reflexes

		Right	Left
Biceps	C-5	1+	1+
Triceps	C-7	1+	1+
Brachioradialis	C-5-7	1+	1+

Upper Extremity Motor Examination

Motor examination revealed normal and symmetric strength throughout the upper extremities and no muscle atrophy. There was no focal motor deficits in the distribution of the innervation of the ulnar nerve

		Right	Left
Upper arm circumference (cm.)	10 cm. above the elbow	29 cm.	29 cm.
Forearm circumference (cm.)	10 cm. below the elbow	27 cm.	26.5 cm.

Upper Extremity Sensory Examination

Sensory examination revealed normal 2 point discrimination of 6 mm. testing all digits. Sensibility assessment using monofilaments revealed diminished sensibility over the right little finger and the ulnar aspect of the right ring finger (unable to detect blue filaments, 0.2; however able to feel these with other digits).

Non-Organic Findings

Test	Negative	Positive	Result
Superficial Touch Painful	x		
Range of Motion Inconsistent	x		
Sensory Deficits Non-Organic	x		
Muscle Weakness Giveaway	x		

GRIP STRENGTH MEASUREMENTS

Right

	Kg.	Kg.	Kg.
Position 1	10		
Position 2	16, 14, 10	12, 20, 20	20
Position 3	20		
Position 4	20		
Position 5	15		

Left

	Kg.	Kg.	Kg.
Position 1	25		
Position 2	30, 30, 40	40, 42, 40	40
Position 3	38		
Position 4	36		
Position 5	30		

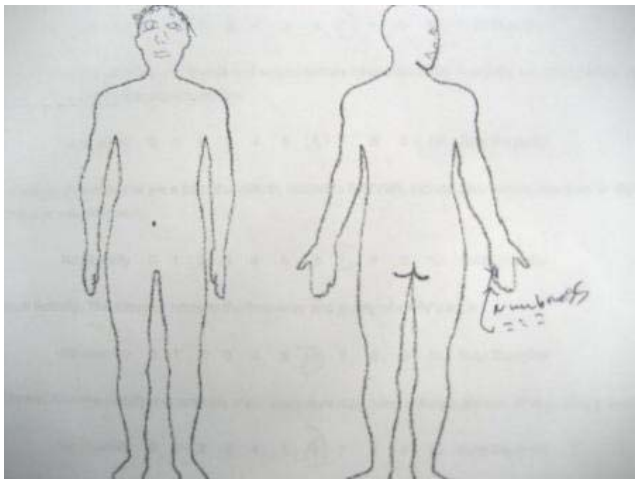
Interpretation

There appears to be diminished strength on the right compared to the left, however there is significant variability in measurements in position 2. Therefore, the reliability of the reporting finding is questionable.

PAIN STATUS INVENTORIES

Pain Drawing

Mr. Smith completed a pain drawing using symbols to describe sensations.



He indicates numbness involving his left ulnar aspect of his hand, otherwise no symbols were used.

Pain Disability Index

The Pain Disability Index uses rating scales to measure the extent of perceived disability in seven areas of life, reporting difficulties on a scale of 0 no disability to 10 total disability.

Area	Report	Percentage
1. Family / home responsibilities. Activities related to the home or family, including chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g. driving the children to school.)	7	70%
2. Recreation. Hobbies, sports and similar leisure time activities.	7	70%
3. Social activity. Participation with friends and acquaintances other than family members, including parties, theater, concert, dining out, and other social functions.	6	60%
4. Occupation. Activities that are part of or directly related to one's job, including nonpaying jobs such as that of a homemaker or voluntary work.	7	70%
5. Sexual activity. This category refers to the frequency and quality of one's sex life.	6	60%
6. Self-care. Activities of daily maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)	6	60%
7. Life-support activities. Basic life-support behaviors such as eating, sleeping and breathing.	7	70%
Average		66%

He reports a high level of perceived disability.

Examinee: Sam Smith
File Number: 12345
Date of Report: October 15, 2007

Date of Injury: December 13, 2005
BA Number: 11091

The Disabilities of the Arm, Shoulder and Hand Score(QuickDash)

Patient's name: Sam Smith

INSTRUCTIONS: This questionnaire asks about your symptoms as well as you ability to perform certain activities. Please answer *every question* , based on your condition in the **last week**. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on you ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week.	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
1. Open a tight or new jar	☐	☐	◉	☐	☐
2. Do heavy household chores (eg wash walls, wash floors)	☐	☐	◉	☐	☐
3. Carry a shopping bag or briefcase	☐	☐	◉	☐	☐
4. Wash your back	☐	☐	◉	☐	☐
5. Use a knife to cut food	☐	☐	◉	☐	☐
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	☐	☐	◉	☐	☐
	Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Extremely**
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	☐	☐	◉	☐	☐
	Not limited at all	**Slightly limited**	**Moderately limited**	**Very limited**	**Unable**
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	☐	☐	◉	☐	☐
Please rate the severity of the following symptoms in the last week	**None**	**Mild**	**Moderate**	**Severe**	**Extreme**
9. Arm, shoulder or hand pain	☐	☐	☐	◉	☐
10. Tingling (pins and needles) in your arm, shoulder or hand	☐	☐	☐	◉	☐
	No difficulty	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**So much difficulty I can't sleep**
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	☐	☐	☐	◉	☐

The Disabilities of the Arm, Shoulder and Hand (quickdash) Score 56.8 **consistent with moderate disability.**

CONCLUSIONS

Diagnoses

1. Right ulnar neuropathy (cubital tunnel syndrome), s/p release September 27, 2006
2. Mallet finger, history of, resolved

Mr. Smith has electro diagnostically documented ulnar neuropathy and underwent a release approximately thirteen months ago. At the time of surgery there were findings consistent with cubital tunnel syndrome. He continues to have sensory complaints. His physical examination reveals sensory deficits, however does not reveal any motor deficits. His reported symptoms and level of disability is greater than what would be expected on the basis of the objective findings, however he does have reproducible sensory deficits that result in ratable impairment.

Ulnar neuropathy is the second-most common upper extremity compression neuropathy. The elbow is also the most common site of ulnar nerve compression. While cubital tunnel syndrome is often used synonymously with ulnar neuropathy, the former was originally described as compression of the ulnar nerve by the humeroulnar arcade. The ulnar nerve finds itself in a flattened and narrowed canal. The nerve may slide up to 1.4 cm in extreme flexion and sublux or dislocate from the groove even in normal individuals. There are many potential sites of entrapment however studies reveal that usually a specific etiology for ulnar neuropathy cannot be identified. This issue was discussed in an article entitled "Ulnar Neuropathy at the Elbow Due to Repetition: Myth or Reality?" by Richard T. Katz, MD which was published in the September – October 2006 *Guides Newsletter*.

Causation

It is my understanding that administratively his cubital tunnel syndrome is being managed as a work-related injury; therefore causation analysis is not performed at this time. Inconsistencies in the reported history are noted:

Date	Physician	Report of Injury
11/8/2007	Brigham, Christopher MD	Per examinee - "Mr. Smith reports on December 13, 2005 while working as a welder for xxxxxxxxx xxxxxxxx on the fantail of a ship he was "picking up small sections of I beams 10 feet to 20 feet in length, 4' width, with a co-worker. Another co-worker called him, he turned, wasn't watching and the I-beam turning in my hand and pinch my small finger and ring finger on the right hand" He reports the problems at that time as "a lot of numbing, tingling feeling in the hand. Whenever cold hit it was hurting even more, couldn't grip things right with his finger locking". He states he reported this to the office. In reviewing his history with him, I inquired about the report bicycle accident that occurred approximately 3 to 4 days prior to that event. He states he fell from his bicycle onto his right arm (elbow and hand), however had no problems with pain in his hand nor any significant difficulties until the event on December 13, 2005.
12/13/05	Urgent, Mark MD	reporting that he fell off his bike on Saturday onto his right arm. He tells me that he has had some persistent pain in his arm and his hand and now he notes some numbness.
	Medical	*<Note: No reference is made to a work-place injury on December 13, 2005, only to a non work-related event, a*

	Center	*bicycle accident, on the preceding Saturday, December 10, 2005, 3 days prior to the emergency room visit.>*
12/22/05	Primary, Frank MD	injured at work nine days ago. He reports the onset of right forearm and hand pain following the repetitive lifting of heavy objects at work. *<Note: No reference is made to the bicycle accident, on the preceding Saturday, December 10, 2005 or to an acute injury on December 13, 2005, rather attributed to repetitive lifting of heavy objects.>*
2/16/06	Jones, Daniel MD	He injured himself on 12/13/05, when trying to lift a long heavy iron. He rotated his finger *<Note: No reference is made to the bicycle accident nor to repetitive lifting, rather attributed to a specific lifting event.>*
6/28/06	Rxxxxxxxx, Kent MD	apparently fell off his bicycle on 12/10/05, injuring his right arm and hand. He went to work and on 12/13/05 and noted numbness in his right hand which began at 2 o'clock to 3 o'clock in the afternoon. *<Note: References bicycle accident, then symptoms of numbness with onset at work.>*

Maximum Medical Improvement

It is probable that the examinee achieved maximum medical improvement (MMI) as of September 2007, approximately one year post release. Typically one year is used as a determination point for entrapment neuropathy. He reports that his symptoms have been persistent and unchanged.

MMI is defined as the date after which further recovery and restoration of function can no longer be anticipated, based upon a reasonable degree of medical probability.

Permanent Impairment Evaluation

Permanent impairment evaluation was performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition being based on the data obtained during this evaluation and the criteria provided in the *Guides.*

Impairment assessment for entrapment is discussed in the Fifth Edition in Section 16.5d Entrapment / Compression Neuropathy (5th ed., 491-495) and specifically on page 495. The *Guides* note 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 importantly, on the presence of *positive clinical findings and loss of function.* The diagnosis should be documented be electromyography as well as sensory and motor nerve conduction studies." (5th ed., 493) This diagnosis was confirmed by electrodiagnostic tests.

The *Guides* advise: "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." (5th ed., 494). The *Guides* note in Section 16.5 Impairment of the Upper Extremities Due to Peripheral Nerve Disorders that "Loss of strength relating to conditions not resulting from peripheral nerve disorders is discussed in Section 16.8. The evaluator should not apply impairment values from both sections to the same condition." Therefore the

rating is based on the neurologic (sensory) deficits present on this examination.

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 (5th ed., 492) the maximum loss for the ulnar nerve above midforearm is 7% upper extremity impairment for sensory deficits and 46% 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 (5th ed., 482). 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 (5th ed., 484).

Based on the information provided there are sensory deficits, however no motor deficits. The sensory findings revealed distorted superficial tactile sensibility with normal two point discrimination; these findings are consistent with a Grade 4 deficit associated with a range of 1% to 25% deficit. Based on his interference with activities of daily living the maximum deficit is assigned at 25% deficit. Therefore, for sensory impairment there is 25% deficit times 7% upper extremity permanent impairment resulting in 2% upper extremity permanent impairment. There are no focal ratable motor deficits, therefore there is no motor impairment. The final impairment is 2% upper extremity permanent impairment which is equivalent to 2% hand.

Although the rating must be performed by the current edition, the Fifth Edition, it is useful to determine what the rating would be if it was rated with the Sixth Edition of the AMA Guides which has not yet been published, however will serve as the basis for ratings in 2008 and subsequently. I served as Senior Contributing Editor, having authored Chapter 15 The Upper Extremities, and provide the following only for illustrative processes. The rating for this case must be performed according to the current Fifth Edition and remains at 2% hand.

In the Sixth Edition, Section 15.4f Entrapment Neuropathy (Sixth Ed., 443 – 450) is used to assess peripheral nerve impairment secondary to entrapment. The rating would be performed using Table 15-23, Entrapment/Compression Neuropathy Impairment:

TABLE 15-23

Entrapment/Compression Neuropathy Impairment

Clinical	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
TEST FINDINGS	Normal	Conduction delay (sensory and/or motor)	Motor conduction block	Axon loss	Almost dead nerve
HISTORY	Mild intermittent symptoms	Mild intermittent symptoms	Significant intermittent Symptoms	Constant symptoms	NA
PHYSICAL FINDINGS	Normal	Normal	Decreased sensation	Atrophy or weakness	NA
FUNCTIONAL SCALE	Normal (0–20) 0 Mild (21–40) 1 Moderate (41–60) 2	Normal (0–20) 0 Mild (21–40) 1 Moderate (41–60) 2	Mild (21–40) 1 Moderate (41–60) 2 severe (61–80) 3	Mild (21–40) 1 Moderate (41–60) 2 severe (61–80) 3	NA
UE IMPAIRMENT	0	1 2 3	4 5 6	7 8 9	NA

Note: NA indicates not applicable; UE, upper extremity.

The rating methodology is specified on pages 448 – 449 in the upcoming Edition:

> **Rating Process**
> To rate the impairment for focal nerve compromise; use Table 15-23, Entrapment/Compression Neuropathy impairment. Grade modifiers are described for test findings, history, and physical findings. If test findings are grade modifier 0 (i.e., electrodiagnostic testing is normal or does not meet standards), do not use this section. The *Quick*DASH is used to further modify the grade and to choose the appropriate numerical impairment rating.
>
> 1. Determine the appropriate grade modifier for test findings, history (symptoms), and physical findings. Determine the average value for these 3 modifiers using the associated number for each grade, for example, grade 0 has a value of 0 and grade 1 has a value of 1. Round that average value to the nearest integer to determine the average grade. For example, if grade modifiers are grade 1 for history, grade 2 for physical findings, and grade 1 for tests findings, add the corresponding numerical values: 1 + 2 + 1 = 4. Then 4 divided by 3 is 1.33, which rounds to 1, so grade 1 is the final rating category.
>
> 2. Identify the row "Upper Extremity Impairments" at the bottom of the table. This contains the range of impairment values for the grade. The middle number is the default impairment value for the grade.
>
> 3. This value is modified up or down from the default value based on the functional scale grade. If the grade modifier assigned to the functional scale score is equal to the grade assigned for the condition (e.g., *Quick*DASH score of 21 to 40 is grade 1 and the condition is grade 1), the default or middle value of Upper Extremity Impairment in that grade is the appropriate rating. If the functional scale score is 1 grade lower or higher than the grade assigned to the condition, the lower or higher value, respectively, is the appropriate impairment rating.

The following clinical findings are:

- Test findings – conduction delay (Grade Modifier 1)
- History – significant intermittent symptoms (Grade Modifier 2)
- Physical findings – decreased sensation (Grade Modifier 2)

Therefore, the average grade is 1.7 which rounds to 2. His *Quick*DASH score is 57. Therefore he would be assigned moderate on a functional basis and impairment of 5% upper extremity permanent impairment if the Sixth Edition was used.

In summary, his rating using the current standard, the Fifth Edition, is 2% hand impairment.

Work Capacity

No work restrictions are required.

Future Medical Treatment

No further treatment is anticipated.

QUALIFICATIONS

Christopher R. Brigham, MD, the President of Brigham and Associates, Inc., is an internationally recognized expert on impairment and disability assessment. His credentials include board certification in Occupational Medicine (ABPM), Founding Director of the American Board of Independent Medical Examiners (ABIME), Certified Independent Medical Examiner (CIME - ABIME), Certified Impairment Rater (CIR), Fellow of the American Academy of Disability Evaluating Physicians (FAADEP), CEDIR (Certification in Evaluation of Disability and Impairment Rating – AADEP), Fellow of the American College of Occupational Environmental Medicine (FACOEM), and Master Fellow of the Academy of Independent Medical Examiners of Hawaii (AIMEHI). He is Senior Contributing Editor to the AMA *Guides to the Evaluation of Permanent Impairment,* Sixth Edition, Editor of the *Guides Newsletter* (the American Medical Association publication on the use of the *Guides* – Fourth, Fifth and Sixth Editions*)*, Editor of The *Guides Casebook* (the companion AMA textbook to the *Guides*), co-author of the text *Understanding the AMA Guides in Workers Compensation*, has authored over one hundred articles on impairment and disability evaluation and other texts, is a highly regarded professional speaker, has provided training throughout the US, Canada and internationally on the AMA *Guides*, served on the Senior Advisory Committee to the Fifth and the Sixth Edition, and has consulted for numerous organizations (including governmental jurisdictions) on the AMA *Guides*. Dr. Brigham is a graduate of the Washington University School of Medicine and Chaired the Medical Advisory Board for the Fourth Edition of *Medical Disability Advisor*, Fourth Edition, and was Associate Editor of the *ACOEM Occupational Medicine Practice Guidelines* – First Edition. He is licensed to practice medicine in Hawaii and resides on Oahu. His curriculum vitae is available at http://www.impairment.com/PDFFiles/BrighamC_CV.pdf

DISCLOSURE STATEMENTS

The above analysis is based upon the available information at this time, including the history given by the examinee, the medical records and tests provided, the results of pain status inventories, and the physical findings. It is assumed that the information provided to me 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 evaluation.

My opinions are based upon reasonable medical certainty. Medicine is both an art and a science, and although an individual may appear to be fit for work activity, there is no guarantee that the person will not be reinjured or suffer additional injury. If applicable, employers should follow the processes established in the Americans with Disabilities Act, Title I. The opinions on work capacity are to facilitate job placement and do not necessarily reflect an in-depth direct threat analysis. Comments on appropriateness of care are professional opinions based upon the specifics of the case and should not be generalized, nor necessarily be considered supportive or critical of the involved providers or disciplines. Any medical recommendations offered are provided as guidance and not as medical orders. The opinions expressed do not constitute a recommendation that specific claims or administrative action be made or enforced. 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.

Thank you for asking me to see this examinee in consultation. If you have any further questions, please do not hesitate to contact me.

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