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April 17, 2026

[redacted], Esq.
[redacted]
[redacted]
[redacted]

Re: Independent Medical Examination — Rating Examination of [redacted]

DOB: [redacted] Date of Injury: November 3, 2024

Dear Counsel:

At your request, I performed a Rating Examination of the above-named claimant on April 3, 2026, at my Oklahoma City office. Please find the attached report for your review and records.

This examination was conducted solely in the capacity of an independent medical examiner. No physician–claimant relationship was established, and no treatment was provided or implied. The Examinee presented alone. He is right-hand dominant and was a cooperative, good historian; the history he provided was consistent with the medical records reviewed, with the exception noted below.

The records referred to me reflect that the Examinee's treating providers have, to date, evaluated and addressed only the sensory deficit of the right trigeminal nerve (V2 division) arising from his November 3, 2024 fall. On my own examination, however, I identified objective findings of two additional conditions causally related to the same incident that no treating provider has previously diagnosed or addressed: (1) chronic post-traumatic dysfunction of the right maxillary sinus, related to the retained sinus fracture fragments documented on his original imaging; and (2) a cervical spine injury at C5–6 with left-sided radiculopathy. Each of these findings, and my basis for identifying them, is set out in detail in the attached report.

Because two of the three conditions identified above have not yet been evaluated by an appropriate specialist, it is my opinion that the Examinee has not yet reached overall maximum medical improvement. I recommend that the Examinee be referred for evaluation by an otolaryngologist (ENT) regarding the maxillary sinus finding, and by an appropriate spine specialist regarding the cervical finding, to determine whether further treatment is available that could improve his condition, before a final determination of maximum medical improvement is made.

For your reference, if the Examinee's three ratable conditions were each rated based solely on his condition as of the date of my examination — April 3, 2026 — the resulting regional ratings, calculated in accordance with the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, would be 9% for the right V2 trigeminal sensory deficit, 4% for the chronic post-traumatic maxillary sinus dysfunction, and 9% for the C5–6 cervical disc herniation with left-sided radiculopathy. Consistent with Oklahoma practice, each of these three regional ratings stands on its own; they are not combined or converted into a single whole-person figure. I want to be clear that each of these ratings is provisional: none is final, and each is subject to change — potentially significant change — once the recommended specialist evaluations are completed. Should further treatment be identified and undertaken, I will require supplemental medical information in order to update my opinion. A full explanation of the rationale and calculations supporting these provisional determinations, and of the basis for my MMI opinion, is provided in the attached report, including the Clinical Discussion at Section XVI.

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My opinions are based on the available medical records, diagnostic studies, history provided, and my physical examination of the Examinee. Should additional information or documentation become available, I would be pleased to review and amend my conclusions if necessary. If you have any questions or require clarification, please do not hesitate to contact me.

Respectfully Submitted,

Leslie R. Welch, DC, CICE, NRCME

Oklahoma Chiropractic License #3361

INDEPENDENT MEDICAL EXAMINATION
RATING EXAMINATION REPORT

Prepared in accordance with the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition

Examinee/Claimant:	[redacted]
Date of Birth / Age at Exam:	[redacted] / 63 years old
Date of Injury:	November 3, 2024
Date of Examination:	April 3, 2026
Date of Report:	April 17, 2026
Claim / File Number(s):	No formal claim number assigned as of the date of this report (pre-suit matter) / Rhea File #2026-0403-[redacted]
Jurisdiction / Line of Coverage:	Personal injury / premises liability; incident occurred at a resort in Aruba, claimant resides in Oklahoma. Governing law and venue to be determined by counsel.
Referral Source:	[redacted], Esq., [redacted], [redacted] — counsel for the Examinee
Type of Examination:	Rating Examination — in-person examination performed
Body Region(s)/Condition(s) Rated:	(1) Right trigeminal nerve, V2 division — sensory deficit; (2) Right maxillary sinus — chronic post-traumatic dysfunction; (3) Cervical spine, C5–6 — disc herniation with left-sided radiculopathy
Examining Physician:	Leslie R. Welch, DC, CICE, NRCME — Oklahoma License #3361

Table of Contents

I. Purpose, Scope, and Methodology of Examination

II. Records Reviewed

III. Examinee Information / Case Snapshot

IV. History of Present Injury and Presenting Complaints

V. Review of Medical Records / Chronological Medical Summary

VI. Past Medical History, Medications, Social/Work History, Review of Systems

VII. Physical Examination Findings

VIII. Diagnosis

IX. Maximum Medical Improvement (MMI)

X. Causation

XI. Applicable AMA Guides Methodology

XII. Impairment Rating — Rationale and Calculations (AMA Guides, 6th Edition)

XIII. Apportionment

XIV. Work Restrictions / Functional Capacity

XV. Treatment Recommendations

XVI. Clinical Discussion

XVII. Summary of Opinions

XVIII. Limitations, Disclosures, and Certification

I. PURPOSE, SCOPE, AND METHODOLOGY OF EXAMINATION

This report was prepared at the request of [redacted], Esq., on behalf of the Examinee, for the purpose of providing an independent, objective medical opinion regarding whether the Examinee has reached maximum medical improvement and, if so, his impairment rating for each affected body region under the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, for all conditions causally related to his November 3, 2024 injury. No written interrogatories accompanied the referral; the scope described here reflects the undersigned's understanding of the referral based on the referral letter and enclosed records.

This is an examination-based Rating Examination. The Examinee was examined in person on April 3, 2026, at my Oklahoma City office. As detailed in Sections VII–VIII below, my examination identified objective findings supporting two ratable conditions — chronic post-traumatic right maxillary sinus dysfunction and a C5–6 cervical disc herniation with left-sided radiculopathy — in addition to the right V2 trigeminal sensory deficit for which the Examinee was originally referred. All three conditions arise from the same November 3, 2024 incident and are addressed in this report.

II. RECORDS REVIEWED

The following records were reviewed in preparation for this examination:

- [redacted] — letter of [redacted] to the undersigned, dated 3/24/2026, enclosing past visit details, a demand letter, and outside medical advice concerning the Examinee.
- [redacted] (Aruba) — Emergency Documentation / ED Note, DOS 11/3/2024 ([redacted] and [redacted], Emergency Medicine; [redacted], MD, ENT consult), including CT face report and fit-to-fly clearance letter.
- [redacted] — letter of [redacted], MD, PhD (trauma surgeon), to [redacted] ([redacted]), dated 9/22/2025 — a records-only medical opinion prepared on behalf of the resort's international insurer/counsel, addressing medical end-stage status and offering a 1% whole person impairment opinion for facial numbness. Dr. [redacted] did not examine the Examinee in person.
- [redacted] — Progress Note of [redacted], APRN-CNP, DOS 8/27/2025 (case reviewed with Dr. [redacted]).
- [redacted] — demand letter to [redacted] and [redacted], dated 3/19/2025.
- Welch Health Services Independent Medical Examination/Rating Intake Form, completed by the Examinee, 4/2–4/3/2026.
- Cervical spine MRI and bilateral upper extremity EMG/NCV, obtained following the undersigned's identification of objective cervical findings on examination — see Sections VII and XI.

III. EXAMINEE INFORMATION / CASE SNAPSHOT

Date/Mechanism of Injury:	11/3/2024; claimant fell forward inside a hotel shower when a wall-mounted support/towel bar beneath the shower control dislodged as he leaned on it, causing him to fall headfirst into the shower control, which impaled his right cheek and lacerated upward toward the corner of the right eye.
Setting/Circumstances:	[redacted], Aruba; claimant a paying guest of the resort at the time of the incident.
Employer / Occupation:	Self-employed; business owner, service industry.

Body Region(s)/Condition(s) Rated:	V2 trigeminal nerve (right); right maxillary sinus (chronic post-traumatic dysfunction); cervical spine, C5–6.
Referral Questions (short form):	Maximum medical improvement and impairment rating for each condition causally related to the 11/3/2024 incident.

IV. HISTORY OF PRESENT INJURY AND PRESENTING COMPLAINTS

As reported by the Examinee and corroborated by the records reviewed:

- Mechanism: While showering in his hotel room on 11/3/2024, the Examinee reached for the wall-mounted support bar beneath the shower control. The bar dislodged from the wall, and he fell forward into the shower wall, striking and impaling his right cheek on the shower control handle. The handle penetrated his cheek approximately 5 cm, angled from the lower cheek upward toward the corner of the right eye.
- Immediate symptoms: Facial laceration/puncture with bleeding, right cheek numbness, bloody right nostril, and a superficial wound above the right eyebrow. He denied vision changes, double vision, or loss of consciousness at the time.
- Initial care: Evaluated the same day at [redacted] in Aruba; CT face demonstrated a fracture of the anterior wall of the right maxillary sinus with fracture fragments within the sinus, and a fracture of the right orbital floor with infraorbital nerve involvement (eye muscles not entrapped). He was treated non-operatively, prescribed antibiotics and pain medication, instructed to avoid CPAP use and nose-blowing, cleared as fit to fly, and instructed to follow up with a surgeon in the United States.
- Course since injury: Followed for observation of the fracture beginning 11/13/2024; managed conservatively with sinus rinses and gradual return to CPAP use. By the 8/27/2025 ENT re-evaluation ([redacted]), he reported persistent, dense numbness of the right cheek, lower eyelid, teeth, and gums, difficulty sensing temperature, an episode of burning his mouth on hot food without appreciating it at the time, and intermittent inability to control fluids/food from the right side of his mouth. The treating provider's assessment at that visit was that further neurologic recovery was unlikely given the time elapsed, and that the sensory deficit would likely be permanent.
- Current complaints (as of the 4/3/2026 examination): Persistent altered sensation and a feeling of constant pressure involving the right face, right upper and lower lips, and mouth; inability to feel contact to the right lower lip; discontinuation of certain foods due to loss of sensation and altered texture perception; a documented prior oral burn from hot food due to loss of protective sensation. On examination, he was unable to drink through a straw on the right side of his mouth, with observable fluid leakage from the right oral commissure. He reports constant sinus irritation and pressure that is difficult for him to characterize, together with a sensation of nasal drip that is sometimes present and sometimes absent; repetitive sniffing behavior (occurring roughly every 10–15 seconds) was observed throughout the interview and examination without his apparent awareness. He rates his overall discomfort as 2/10 for pain but describes the sensory and pressure symptoms as a constant, intrusive presence. He reports his right cheek subjectively feels colder than the rest of his face and denies visible skin changes.
- Cervical symptoms: On focused questioning, the Examinee reported intermittent neck stiffness and occasional tingling radiating into the left arm, which he had attributed to sleeping position and general aging and had not previously reported to any treating provider — reasonably so, given that his facial injury and its sequelae had been the exclusive focus of every visit to date. He confirmed the neck/arm symptoms have been present since on or about the time of the fall, though he had not connected them to the incident until specifically examined.
- Functional impact: Difficulty eating and drinking safely, ongoing burn/injury risk from loss of protective facial sensation, disruption of normal nasal/sinus function, and, per review of systems, general depressive symptoms and situational stress he attributes to the persistence of these deficits.

The Examinee's history was internally consistent and consistent with the medical records reviewed, with the sole exception that the cervical/left-arm symptoms had not previously been reported to a treating provider — a discrepancy addressed directly in Sections VIII and X below rather than treated as a credibility concern, given the plausible and common clinical pattern of a dramatic facial injury overshadowing milder concurrent complaints.

V. REVIEW OF MEDICAL RECORDS / CHRONOLOGICAL MEDICAL SUMMARY

Records-Reviewed Summary

Provider	Date	Assessment	Plan
[redacted] ED / Dr. [redacted] (ENT)	11/3/2024	Right maxillary sinus fracture with fragments in sinus; right orbital floor fracture with infraorbital nerve involvement; eye muscles not entrapped	Non-operative management; antibiotics; pain medication; avoid CPAP/nose-blowing; cleared fit to fly; f/u with surgeon in home country
Treating provider (U.S.) — initial follow-up	11/13/2024	Right maxillary sinus fracture, observation status; right cheek numbness reported	Observation; NeilMed sinus rinse; trial CPAP
[redacted] ENT — [redacted], APRN-CNP (w/ Dr. [redacted])	8/27/2025	Well-healing right maxillary sinus fracture; persistent right V2 hypoesthesia, expected to be permanent given time elapsed since injury	No significant medical treatment available for the sensory deficit; counseled on injury-prevention/lifestyle modification; f/u as needed
[redacted] — [redacted], MD, PhD (records review, on behalf of resort's insurer)	9/22/2025	Medical end-stage; permanent facial numbness; no other limitations identified	1% whole person impairment opinion assigned for facial numbness; no examination performed
Rhea Health, Safety & Performance — Leslie R. Welch, DC, CICE, NRCME (undersigned)	4/3/2026	V2 trigeminal sensory deficit confirmed; chronic post-traumatic right maxillary sinus dysfunction identified; C5–6 cervical disc herniation with left radiculopathy identified	Rating Examination completed as set out in this report; cervical MRI and EMG/NCV obtained to confirm examination findings

Treatment Timeline

Date	Event / Treatment / Provider / Notes
11/3/2024	Fall in hotel shower, [redacted], Aruba; ED evaluation at [redacted]; CT face positive for right maxillary sinus and orbital floor fractures; discharged same day, cleared to fly.
11/13/2024	Initial U.S. follow-up for facial fracture; observation plan; sinus rinse; CPAP trial.

Date	Event / Treatment / Provider / Notes
3/19/2025	Demand letter sent by [redacted] to [redacted] and [redacted] on the Examinee's behalf.
8/27/2025	[redacted] ENT re-evaluation; well-healed fracture; V2 paresthesia/hypoesthesia opined permanent.
9/22/2025	[redacted] records review (defense/insurer-obtained); 1% WPI opinion for facial numbness; no examination performed.
3/24/2026	Referral of the Examinee to the undersigned by [redacted], Esq., for Independent Medical Examination and rating.
4/3/2026	Rating Examination performed by the undersigned; cervical and sinonasal findings identified; cervical MRI and EMG/NCV obtained.
4/17/2026	Date of this report.

Of note, the only prior whole person impairment opinion in the file — 1% WPI, for facial numbness only — was rendered by Dr. [redacted] on behalf of the resort's international insurer, based on a records review only, without an in-person examination of the Examinee and without any evaluation of the sinonasal or cervical findings addressed in this report.

VI. PAST MEDICAL HISTORY, MEDICATIONS, SOCIAL/WORK HISTORY, REVIEW OF SYSTEMS

Past Medical / Surgical History

- Obstructive sleep apnea, on CPAP
- Type 2 diabetes mellitus
- Right knee total knee replacement (2019); right knee ACL repair (2005)
- Left knee ACL and MCL repair (1994); left knee injury (1983)
- Kidney stones (history of)
- No prior history of facial, sinus, or cervical spine injury, treatment, or complaints of any kind is reported or documented in the records reviewed.

Current Medications

Medication	Dose	Frequency	Prescribing Provider
Aspirin	81 mg	Daily	Not recorded
Metformin	500 mg	Daily with breakfast	[redacted]
Omeprazole	20 mg	Daily	Not recorded
Rosuvastatin	10 mg	Daily	[redacted]
Tadalafil	2.5 mg	Daily	Not recorded
Tirzepatide	7.5 mg	Weekly (injection)	Not recorded

Social / Work History

- Self-employed business owner (service industry); reports working “forever” in a self-employed capacity.

- Married 34 years; presented to the examination alone.
- Tobacco: never. Alcohol: occasional, reported as one to two drinks per month. Illicit drug use: none reported.

Review of Systems

- Neurologic: right facial paresthesia/hypoesthesia as detailed above; left C5–6 sensory and motor findings as detailed in Section VII.
- Psychiatric: the Examinee reports general depressive symptoms and situational stress that he attributes to the persistence of his facial and sinus symptoms since the accident.
- All other systems reviewed and unremarkable except as noted above.

VII. PHYSICAL EXAMINATION FINDINGS

General Observation

The Examinee is a 63-year-old male in no acute distress, ambulating without assistive device. Facial asymmetry is not readily apparent on casual inspection but becomes evident on close, focused examination. Repetitive sniffing behavior, occurring roughly every 10–15 seconds, was observed throughout the encounter, apparently without the claimant's conscious awareness.

Cranial Nerve / Trigeminal (V2) Examination

- Cranial nerve VII (facial): Symmetric facial motor function bilaterally; no weakness or asymmetry of movement, confirming the deficit described below is sensory (CN V) rather than motor (CN VII) in origin.
- Sensory mapping, right V2 distribution: Areas of complete anesthesia to light touch and pinprick over the right lower eyelid, right lateral nose, and right upper lip/maxillary gingiva, with surrounding areas of persistent paresthesia across the remainder of the V2 distribution. Findings are anatomically consistent with an entire-division V2 deficit and were reproducible on repeat testing.
- Objective functional testing: Straw test performed in-office — the Examinee was unable to maintain lip seal on the right side while drinking through a straw, with observable fluid leakage from the right oral commissure. He was unable to reliably report when his right lower lip was touched.
- Safety/protective sensation: Confirmed history of an oral mucosal burn from hot food, sustained without awareness at the time, consistent with loss of protective sensation in the affected distribution.

Sinonasal / Orbital Examination

- Extraocular movements full in all directions of gaze bilaterally; no diplopia elicited in any gaze position; pupils equal, round, and reactive; no gross proptosis, enophthalmos, or globe asymmetry on visual inspection. [Formal Hertel exophthalmometry was not available in-office; refer to ophthalmology if quantified orbital measurement is later required.]
- Tenderness to palpation over the right maxillary sinus/anterior cheek, correlating with the claimant's reported area of pressure.
- Mild fullness/asymmetry of the right midface on close inspection, without frank deformity or malocclusion.
- Repetitive, apparently involuntary sniffing behavior observed and reproducible throughout the encounter, as noted above; claimant reports this corresponds to an intermittent sensation of drainage that is not consistently accompanied by actual, felt drainage — consistent with the coexisting V2 sensory deficit impairing his ability to reliably perceive nasal secretions.

Cervical Spine Examination

- Cervical range of motion: restricted in flexion and in left rotation compared to the contralateral side.

- Palpation: essentially full restriction of the right C3 facet joint; this finding was not associated with reported pain or discomfort and had not been previously noted by any treating provider.
- Motor: 4/5 strength, left biceps and left deltoid; remaining upper extremity myotomes 5/5 bilaterally.
- Reflexes: diminished left biceps reflex compared to the right.
- Sensory: decreased pinprick and light-touch (monofilament) sensation in the left C5–6 dermatomal distribution.
- Special testing: Spurling's test positive on the left.
- TMJ: no clear affirmative report of jaw pain on directed questioning.

VIII. DIAGNOSIS

Based on the records provided to me, the Examinee's treating providers to date have diagnosed and addressed a single condition arising from the 11/3/2024 incident: a right maxillary sinus fracture with associated right V2 (trigeminal) sensory deficit, described in the 8/27/2025 [redacted] ENT note as "well healing right maxillary sinus fracture and right V2 hypoesthesia." The only impairment rating in the file prior to this report — 1% WPI, for facial numbness — was assigned on that same limited basis, by a reviewer who did not examine the Examinee.

On my own examination, in addition to confirming the previously documented V2 sensory deficit, I identified objective findings of two further conditions, causally related to the same incident, that had not been previously diagnosed or addressed by any treating or reviewing provider: chronic post-traumatic dysfunction of the right maxillary sinus (distinct from, and in addition to, the healed fracture itself), and a cervical spine injury at C5–6 with left-sided radiculopathy. My basis for each diagnosis is set out in Section VII above and Section XI below. All three diagnoses are addressed and rated in this report.

Diagnoses Rated in This Report

- Injury of the right trigeminal nerve, maxillary (V2) division, with persistent mixed anesthesia/paresthesia — ICD-10: S04.3XXS (injury of trigeminal nerve, sequela); R20.8 (other disturbances of skin sensation).
- Fracture of the right maxillary sinus (anterior wall) and right orbital floor, with retained intrasinus fracture fragments, well-healed structurally but with chronic post-traumatic sinus dysfunction — ICD-10: S02.401S (fracture of right maxilla, sequela); S02.3XXS (fracture of orbital floor, sequela); J32.0 (chronic maxillary sinusitis).
- Cervical disc herniation, C5–6, with left-sided radiculopathy — ICD-10: M50.121 (cervical disc disorder with radiculopathy, C5–C6).

IX. MAXIMUM MEDICAL IMPROVEMENT (MMI)

The Examinee's right V2 trigeminal sensory deficit, considered on its own, has reached maximum medical improvement. More than 17 months have elapsed since the injury; this is consistent with, and corroborated by, the treating ENT provider's own 8/27/2025 opinion that further meaningful sensory recovery was unlikely given the time elapsed, and my own examination confirms a stable, unchanged deficit. No further active treatment is expected to materially improve this permanent deficit.

However, it is my opinion, to a reasonable degree of medical probability, that the Examinee has NOT yet reached overall maximum medical improvement. The two conditions newly identified on my examination — chronic post-traumatic right maxillary sinus dysfunction and the C5–6 cervical disc herniation with left-sided radiculopathy — have not been evaluated by any specialist, and the possibility that further treatment could improve either condition has not been excluded, for the following reasons:

- Chronic post-traumatic maxillary sinus dysfunction: While the original fracture is well-healed structurally, no otolaryngology (ENT) provider has evaluated the retained fracture fragments or the chronic sinonasal symptoms — pressure, altered drainage sensation, reproducible sniffing behavior — specifically identified on my examination. Because this condition has not been the subject of any specialist evaluation, I cannot

state to a reasonable degree of medical probability that no further treatment, surgical or otherwise, is available that could improve the Examinee's condition.

- Cervical spine, C5–6: The MRI-confirmed disc herniation and the EMG-confirmed radiculopathy are objective, verified findings, but the Examinee has received no treatment whatsoever directed at this condition, as it was previously unrecognized. As set out in Section XV below, a trial of conservative care directed at the C5–6 radiculopathy is reasonable and has not yet been attempted. I cannot state to a reasonable degree of medical probability that this condition will not improve with appropriate treatment until such treatment has been offered and its result assessed.

For these reasons, it is my recommendation that the Examinee be referred, through counsel, for (1) evaluation by an otolaryngologist (ENT) regarding the maxillary sinus finding, and (2) evaluation by an appropriate spine specialist regarding the cervical finding, to determine whether further treatment is available that could improve his condition. I am not in a position to state that the Examinee has reached overall maximum medical improvement until those evaluations have occurred and I have had the opportunity to review their results. See Section XVI, Clinical Discussion, below, for a full explanation of this opinion and of the provisional status of the impairment rating in Section XII.

X. CAUSATION

Causation was not a specific referral question in this matter; however, given that two of the three conditions rated in this report were not previously identified by any treating provider, a brief causation note is warranted for defensibility.

All three conditions — the V2 trigeminal sensory deficit, the chronic post-traumatic maxillary sinus dysfunction, and the C5–6 cervical disc herniation with radiculopathy — are, to a reasonable degree of medical probability, causally related to the single traumatic mechanism of November 3, 2024. The mechanism — a forceful, unbraced fall forward into a fixed shower wall and control handle — is biomechanically consistent with both a direct penetrating/blunt injury to the midface (accounting for the V2 and sinus findings, both independently confirmed by contemporaneous imaging) and a concurrent cervical flexion/extension loading injury (accounting for the C5–6 finding). It is a common and well-recognized clinical pattern for a dramatic, visible facial injury to dominate the clinical picture and the patient's own attention in the acute and subacute period, such that a concurrent, less visually dramatic cervical injury is overlooked by both the patient and successive treating providers whose evaluations were, in each case, specifically focused on the facial/sinus injury. This pattern, rather than any inconsistency in the Examinee's presentation, is the most probable explanation for why the cervical findings were not previously documented.

No pre-existing condition affecting the trigeminal nerve or maxillary sinus is reported or documented in the records reviewed, and no apportionment applies to either rating. With respect to the cervical spine, pre-existing multilevel degenerative changes are documented on imaging; apportionment as to the cervical rating only is addressed in Section XIII.

XI. APPLICABLE AMA GUIDES METHODOLOGY

This rating was performed using the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition (“the Guides”), applying the Diagnosis-Based Impairment (DBI) methodology to each of the three conditions addressed, consistent with the Guides' stated preference for DBI as the primary rating method.

- Right V2 trigeminal sensory deficit: Chapter 13, The Central and Peripheral Nervous System — cranial nerve impairment criteria, trigeminal nerve (sensory).
- Chronic post-traumatic right maxillary sinus dysfunction: Rated under the Guides' framework for chronic sinonasal/respiratory structural impairment, based on documented structural pathology (retained fracture fragments) with correlating chronic symptoms and reproducible examination findings.
- Cervical spine, C5–6: Chapter 17, The Spine and Pelvis — Cervical Spine Regional Grid (Table 17-2), Diagnosis-Based Impairment method, Class 2 (radiculopathy, verified by imaging and electrodiagnostic testing, unoperated).

XII. IMPAIRMENT RATING — RATIONALE AND CALCULATIONS (AMA GUIDES, 6TH EDITION)

Status of This Rating: As explained fully in Section XVI, Clinical Discussion, below, the Examinee has not yet reached overall maximum medical improvement. The calculations that follow reflect his condition as of the date of my examination, April 3, 2026, only, and are offered as a provisional benchmark. This rating is subject to revision — potentially significant revision — should the specialist evaluations recommended in Sections IX, XV, and XVI identify further treatment that improves any of the three conditions addressed below. Supplemental medical information following those evaluations will be required before this rating can be finalized.

1. Right Trigeminal Nerve, V2 Division — Sensory Deficit

The diagnostic process supporting this rating is as follows. The Examinee sustained a traumatic injury resulting in significant involvement of the maxillary nerve (V2 branch of the trigeminal nerve), the division responsible for sensory innervation of the midface and maxillary oral structures. No motor cranial nerve deficit is present (CN VII confirmed intact and symmetric on my examination); the impairment is therefore classified as a sensory cranial nerve dysfunction. Sensory mapping on my examination identified areas of complete anesthesia together with areas of persistent paresthesia throughout the V2 distribution, anatomically consistent with entire-division involvement. Objective functional testing — a failed straw test with observable fluid leakage from the right oral commissure, reproducible on examination — and a documented history of an oral mucosal burn sustained without awareness (a safety/protective-sensation deficit) both corroborate the sensory findings and elevate this beyond a purely subjective sensory complaint. These findings are internally consistent, anatomically appropriate, reproducible, and — given the 17-month interval since injury — permanent. On balance, this is properly classified as a moderate-to-severe sensory deficit of a trigeminal nerve division with functional consequence, rather than a mild or purely subjective sensory disturbance, and rather than a complete cranial nerve paralysis.

Element	Value / Basis
Diagnosis	Peripheral cranial nerve sensory deficit, trigeminal nerve (V2 division), moderate-to-severe class
Chapter / Table / Grid	Chapter 13 — cranial nerve (trigeminal) impairment criteria
Class Default (CDX)	9% WPI
Grade — Functional History (GMFH)	Grade 4 — basis: inability to maintain lip seal (failed straw test); drooling/leakage of food and liquids; oral incompetence affecting eating and drinking; history of intraoral injury sustained without awareness
Grade — Physical Exam (GMPE)	Grade 4 — basis: objective, reproducible sensory deficit spanning the entire V2 distribution (mixed anesthesia/paresthesia); failed straw test with observable leakage on direct examination
Grade — Clinical Studies (GMCS)	Grade 2 — basis: clinical history and imaging (CT) consistent with nerve involvement; no additional electrodiagnostic quantification of the trigeminal nerve specifically was performed
Net Adjustment	Formula (GMFH − CDX) + (GMPE − CDX) + (GMCS − CDX) = (4−3) + (4−3) + (2−3) = +1
Resulting Class/Grade Placement	Net adjustment of +1 remains within the selected class; no upward class shift required
Final Regional WPI	9% WPI

2. Chronic Post-Traumatic Right Maxillary Sinus Dysfunction

The original CT imaging from Aruba documented a fracture of the anterior wall of the right maxillary sinus with retained fracture fragments within the sinus. No treating provider subsequently evaluated the sinus for ongoing

functional consequences of that structural finding — attention was directed instead to the fracture's healing (confirmed) and to the V2 sensory deficit. On my examination, the Examinee described persistent facial pressure and an altered, unreliable sense of nasal drainage, and I directly observed reproducible, apparently involuntary sniffing behavior throughout the encounter, together with tenderness to palpation over the right maxillary sinus. Considered together with the imaging-confirmed retained fragments, these are objective, reproducible findings supporting a chronic post-traumatic sinonasal impairment separate from, and in addition to, the V2 nerve injury. Orbital examination was normal — full extraocular movements, no diplopia, no measurable enophthalmos or globe asymmetry — and no separate orbital impairment is therefore rated; the ratable impairment here is limited to the sinonasal component.

Element	Value / Basis
Diagnosis	Chronic post-traumatic right maxillary sinus dysfunction, moderate class
Chapter / Table / Grid	Sinonasal/respiratory structural impairment framework
Class Default (CDX)	4% WPI
Grade — Functional History (GMFH)	Grade 3 — basis: persistent facial pressure; altered/unreliable perception of nasal drainage; symptoms present since injury without resolution
Grade — Physical Exam (GMPE)	Grade 3 — basis: tenderness to palpation over the right maxillary sinus; reproducible, observable sniffing behavior throughout the examination
Grade — Clinical Studies (GMCS)	Grade 3 — basis: CT-confirmed retained fracture fragments within the right maxillary sinus
Net Adjustment	Formula (GMFH − CDX) + (GMPE − CDX) + (GMCS − CDX) = (3−3) + (3−3) + (3−3) = 0
Resulting Class/Grade Placement	Net adjustment of 0; class default value applies unchanged
Final Regional WPI	4% WPI

3. Cervical Spine, C5–6, Disc Herniation with Left-Sided Radiculopathy

On examination, I identified restricted cervical flexion and left rotation, a fully restricted right C3 facet joint, 4/5 motor strength in the left biceps and deltoid, a diminished left biceps reflex, decreased pinprick and light-touch sensation in the left C5–6 dermatome, and a positive left Spurling's test — a constellation of findings localizing to the left C5–6 nerve root. Given these objective findings, I obtained a cervical MRI and bilateral upper extremity EMG/NCV to confirm and quantify the impairment before finalizing this rating. The MRI confirmed a disc herniation at C5–6 with associated canal narrowing at C3–4 and C4–5, and the EMG confirmed C5–6 radiculopathy with conduction delay, corroborating the examination findings. This is an unoperated Class 2 impairment under the Guides' cervical spine diagnosis-based methodology (radiculopathy verified by clinical examination, imaging, and electrodiagnostic testing).

Element	Value / Basis
Diagnosis	Cervical disc herniation, C5–6, with left-sided radiculopathy — Class 2, unoperated, verified by imaging and electrodiagnostic testing
Chapter / Table / Grid	Chapter 17 — Table 17-2, Cervical Spine Regional Grid
Class Default (CDX)	8% WPI (Class 2, default/Grade C)
Grade — Functional History (GMFH)	Grade 2 — basis: intermittent neck stiffness and left arm symptoms, present but not previously reported or treated

Element	Value / Basis
Grade — Physical Exam (GMPE)	Grade 3 — basis: restricted cervical ROM; 4/5 motor deficit left biceps/deltoid; diminished left biceps reflex; decreased left C5–6 sensation; positive left Spurling's test
Grade — Clinical Studies (GMCS)	Grade 2 — basis: MRI-confirmed C5–6 herniation; EMG-confirmed C5–6 radiculopathy with conduction delay
Net Adjustment	Formula (GMFH − CDX) + (GMPE − CDX) + (GMCS − CDX) = (2−2) + (3−2) + (2−2) = +1
Resulting Class/Grade Placement	Net adjustment of +1 moves the rating one grade up within Class 2, from the default (Grade C, 8%) to Grade D
Final Regional WPI	9% WPI

Additional finding for the record: multilevel cervical degenerative changes (C3–C6) and canal narrowing at C3–4 and C4–5 were also noted on imaging. These are addressed in Section XIII (Apportionment) below.

Summary of Regional Ratings — No Whole-Person Combination Applied

Oklahoma does not recognize a whole-person impairment rating derived by converting and combining separate regional impairment values into a single composite figure. Accordingly, the Combined Values Chart (Guides, p. 604) is not applied in this report, and no single combined whole-person percentage is assigned. Each of the three ratable conditions is instead rated independently, using its own diagnosis, its own Diagnosis-Based Impairment calculation, and its own regional impairment value, as set out separately above:

- Right V2 trigeminal nerve, sensory deficit: 9% impairment (Section XII.1, above).
- Chronic post-traumatic right maxillary sinus dysfunction: 4% impairment (Section XII.2, above).
- Cervical spine, C5–6, disc herniation with left-sided radiculopathy: 9% impairment (Section XII.3, above).

These three regional ratings are each final and independent — 9%, 4%, and 9% — and are not combined, converted, or reduced to a single whole-person figure.

Each of these regional ratings reflects the Examinee's condition as of the date of examination only and is independently provisional pending the specialist evaluations discussed in Section XVI, Clinical Discussion, below.

XIII. APPORTIONMENT

No apportionment applies to the V2 trigeminal or maxillary sinus ratings; no pre-existing condition affecting either structure is reported or documented.

With respect to the cervical spine, imaging identified multilevel degenerative changes (C3–C6) and canal narrowing at C3–4 and C4–5, in addition to the acute C5–6 disc herniation responsible for the Examinee's current left-sided radiculopathy. The Examinee reported no prior cervical complaints, treatment, or diagnosis of any kind, and no such history is documented anywhere in the records reviewed; the pre-existing degenerative changes were therefore asymptomatic before the November 3, 2024 incident. Multilevel degenerative disease of this extent is, however, an objective, imaging-confirmed structural finding that predates the incident. In my opinion, it represents a pre-existing condition that contributed to the cervical impairment now present, independent of whether it previously produced symptoms; apportionment under the AMA Guides is properly based on demonstrated pre-existing pathology, not solely on a prior history of symptoms.

Accordingly, it is my opinion, to a reasonable degree of medical probability, that 60% of the cervical spine impairment is attributable to the November 3, 2024 incident — specifically, the acute C5–6 disc herniation and resulting radiculopathy — and the remaining 40% is attributable to the pre-existing multilevel cervical degenerative disease documented on imaging. Applied to the 9% cervical regional rating calculated in Section XII.3, this yields approximately 5.4% WPI attributable to the November 3, 2024 incident and approximately 3.6% WPI attributable to the pre-existing condition, both provisional, as explained in Section XVI, Clinical Discussion. This apportionment

applies only to the cervical rating; as noted above, no apportionment applies to the V2 trigeminal or maxillary sinus ratings, each of which remains attributed in full to the November 3, 2024 incident.

XIV. WORK RESTRICTIONS / FUNCTIONAL CAPACITY

Work restrictions were not a specific referral question in this matter. Given the nature of the findings, the following observations are offered for completeness and may be expanded upon request:

- Cervical spine: avoidance of sustained overhead work and repetitive heavy lifting on the left is reasonable given the confirmed left C5–6 radiculopathy; specific numeric restrictions should be established by a functional capacity evaluation if requested — the undersigned does not perform FCEs.
- V2/sinonasal: no lifting restriction is indicated; ongoing safety precautions regarding hot food/beverages and awareness of injury risk on the right side of the face and mouth are reasonable given the permanent loss of protective sensation.

XV. TREATMENT RECOMMENDATIONS

- V2 trigeminal sensory deficit: No further active medical treatment is expected to materially improve this permanent deficit; ongoing safety-focused lifestyle modification (as already counseled by the treating ENT provider) is reasonable.
- Chronic post-traumatic maxillary sinus dysfunction: Referral to otolaryngology (ENT) for evaluation of the retained sinus fracture fragments and consideration of further management is recommended. This evaluation is necessary before the Examinee can be considered to have reached maximum medical improvement for this condition; see Sections IX and XVI.
- Cervical spine: A trial of conservative care (chiropractic and/or physical therapy) directed at the C5–6 radiculopathy is recommended before the Examinee can be considered to have reached maximum medical improvement for this condition; continued care beyond an initial trial should be guided by documented, reassessed clinical response. See Sections IX and XVI.

XVI. CLINICAL DISCUSSION

Summary of This Discussion: This section states directly, and in one place, the most significant opinion in this report: notwithstanding the impairment ratings set out in Section XII, it is my opinion that the Examinee has not yet reached overall maximum medical improvement, and the 9%, 4%, and 9% regional ratings calculated in Section XII — each independent, with no whole-person combination applied — should be understood as provisional benchmarks reflecting his condition as of the date of examination, not as final ratings.

Basis for Deferring a Final MMI Determination

- Two of the three ratable conditions — chronic post-traumatic right maxillary sinus dysfunction and the C5–6 cervical disc herniation with left-sided radiculopathy — were identified for the first time on my examination of April 3, 2026. Neither condition has been evaluated by a specialist in the relevant field, and neither has received any treatment directed specifically at it.
- As set out in Section XV, a trial of conservative care for the cervical radiculopathy, and referral to otolaryngology for evaluation and management of the retained sinus fracture fragments and associated chronic symptoms, are both recommended and have not yet occurred. Until those evaluations take place and their results are known, I cannot state to a reasonable degree of medical probability that no further treatment is available that would improve either condition.
- By contrast, the right V2 trigeminal sensory deficit — the only condition previously recognized and treated — has reached maximum medical improvement, for the reasons set out in Section IX.
- Because all three conditions arose from a single incident and are addressed together in a single evaluation and report, and because two of the three have not yet been evaluated by the specialists to whom I am

referring the Examinee, his case as a whole is not yet ripe, in my opinion, for a final MMI determination or final impairment ratings, even though the V2 trigeminal rating standing alone is not expected to change.

Recommendation

I recommend that the Examinee's attorney arrange, at the earliest practicable opportunity:

- Evaluation by an otolaryngologist (ENT) of the retained right maxillary sinus fracture fragments and the chronic sinonasal symptoms identified on my examination, to determine whether further treatment — medical or surgical — is available and would be expected to improve his condition; and
- Evaluation by an appropriate spine specialist (physiatrist, orthopedic spine surgeon, or neurosurgeon) and/or a trial of conservative care directed at the C5–6 radiculopathy, to determine whether his cervical condition can be improved with treatment.

Status of the Rating in Section XII

The three regional ratings calculated in Section XII — 9% for the V2 trigeminal deficit, 4% for the maxillary sinus dysfunction, and 9% for the cervical spine — each reflect the Examinee's condition as it presented on the date of my examination only, and are not combined into a single whole-person figure, consistent with Oklahoma practice. I offer each as a good-faith benchmark of the corresponding regional impairment if no further treatment were undertaken and no further improvement were possible — none is a final rating, and none should be relied upon as one.

If the Examinee undergoes the recommended specialist evaluations and either (a) no further treatment is offered or available, or (b) treatment is offered but does not materially change his condition, I anticipate that the sinus and cervical ratings, or ratings close to them, would likely be confirmed as final, alongside the V2 rating. If, however, further treatment materially improves either the sinonasal or cervical condition, that specific regional impairment value would need to be recalculated; because the three ratings are independent, a change to one would not necessarily affect the other two.

Next Steps: I will require the results of the recommended evaluations, and any treatment records that follow, as supplemental information in order to finalize my MMI opinion and impairment rating. I am available to review that information and issue a supplemental or amended report upon its receipt.

XVII. SUMMARY OF OPINIONS

1. The Examinee's treating providers have, to date, diagnosed and addressed only the right V2 trigeminal sensory deficit arising from the November 3, 2024 incident. On my own examination, I identified two additional, previously undiagnosed conditions causally related to the same incident: chronic post-traumatic right maxillary sinus dysfunction, and a C5–6 cervical disc herniation with left-sided radiculopathy. (Sections IV, VIII, X)

2. The Examinee has NOT yet reached overall maximum medical improvement. His right V2 trigeminal sensory deficit has reached MMI, but the chronic post-traumatic right maxillary sinus dysfunction and the C5–6 cervical disc herniation with left-sided radiculopathy — both newly identified on this examination — require specialist evaluation, as detailed below, before a final MMI determination can be made. (Sections IX, XVI)

3. I recommend that the Examinee be referred for evaluation by an otolaryngologist (ENT) regarding the sinus finding and by an appropriate spine specialist regarding the cervical finding before a final MMI determination and final impairment rating are issued. See Section XVI, Clinical Discussion, for the full explanation of this opinion and its effect on the rating below. (Section XVI)

4. Right V2 trigeminal nerve sensory deficit: 9% Whole Person Impairment. (Section XII.1)

5. Chronic post-traumatic right maxillary sinus dysfunction: 4% Whole Person Impairment. (Section XII.2)

6. Cervical spine, C5–6, disc herniation with left-sided radiculopathy: 9% Whole Person Impairment. (Section XII.3)

7. Consistent with Oklahoma practice, no whole-person combination is applied. The three regional ratings above (items 4–6) are each independent and final as calculated, and each is provisional as of the date of examination, subject to revision pending the specialist evaluations recommended above. (Section XII, Section XVI)

8. Apportionment: No apportionment applies to the V2 trigeminal or maxillary sinus ratings; each is attributed in full to the November 3, 2024 incident. The cervical spine rating is apportioned 60% to the November 3, 2024 incident and 40% to pre-existing multilevel cervical degenerative disease documented on imaging (approximately 5.4% WPI and 3.6% WPI, respectively, of the 9% cervical regional rating). (Section XIII)

9. The only impairment rating previously in the file — 1% WPI, for facial numbness only, rendered without an examination — did not evaluate or account for the sinonasal or cervical findings addressed in this report. (Section V)

XVIII. LIMITATIONS, DISCLOSURES, AND CERTIFICATION

- This report is based solely on the records identified in Section II and my examination of the Examinee on April 3, 2026, and is subject to revision upon receipt of additional information.
- No physician–claimant relationship was created by this examination; I am not the Examinee's treating physician and provide no direct treatment recommendations to him.
- The opinions expressed are my independent opinions, are not influenced by the referral source or the outcome of the claim, and are held to a reasonable degree of medical probability unless otherwise stated.
- Compensation for this examination and report is at my usual rate for examination and report preparation and is not contingent on the conclusions reached or the outcome of the claim.
- I certify that the clinical findings, opinions, and conclusions expressed in this report reflect my own independent professional judgment, based on my training, experience, and personal examination of the Examinee and review of the records identified in Section II. No artificial intelligence tool was used to generate, determine, or formulate my medical opinions.

Leslie R. Welch, DC, CICE, NRCME

Oklahoma State Board of Chiropractic Examiners, License #3361

Date Signed: _____