


AMA Guides: Understanding Their History and Application

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National Workers' Compensation Judicial College
August 19, 2025


The AMA Guides play an integral role in workers' compensation cases. This comprehensive session will provide workers' compensation judges with essential knowledge about the historical context, latest developments, and practical application of the AMA Guides, with particular emphasis on its implications for judicial decision making.



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Judge David Langham


David W. Langham is Florida Deputy Chief Judge of Compensation Claims, a position he has held since 2006. His legal experience includes workers compensation, employment litigation, and medical malpractice. He has delivered thousands of professional lectures/presentations, published over 40 articles in professional publications and has published over 1,900 blog posts regarding the law, technology, and professionalism. He is the author and editor of Florida Workers' Compensation: Its History, Evolution, and Function (2023); The Mock Trial Performance (2023); Floridiana and the Workers' Compensation Adjudicators (2024), and Litigation 'Strategy' (2025). David is a student, a teacher, a critic, a coach, and a leader. He lives in Pensacola, Florida with his wife Pamela Langham, Esq.



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Christopher R. Brigham, MD


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



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Kenneth Eichler

Ken Eichler is a Workers Comp and healthcare expert with over 30 years in the industry. His career has spanned licensure as a NY Adjustor and IME company owner, leading to his pathway as a Treatment Guidelines & Drug Formulary expert with Reed Group / MDGuidelines and ODG/MCG Health. He was with the AMA from 2022 to 2025 responsible for AMA Guides advocacy and product development. Ken is privileged to collaborate with Physicians and jurisdictional stakeholders, Regulators and Legislators throughout the US, Canada and abroad.



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American Medical Association (AMA) Guests




Erin Kalitowski
Director, Print, Digital and Guides Impairment

Ron Caperton
Key Account Manager / Program Manager

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AMA Guides®



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Learning Goals

- Articulate the difference between impairment and disability
- Explain the evolution of the AMA Guides
- Discuss the AMA Guides 2024 Update
- Explain a structured analytical framework
- Explain how to ensure consistent application of standards
- Answer the questions you have about the AMA Guides.



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Learning Approach

- Establish a foundation about impairment and disability
- Explore the AMA Guides, history, and recent updates
- Answer frequently asked questions.
- Questions posed and discussions moderated by Judge David Langham
- Responses by Chris Brigham, MD, with active discussion with Judge Langham and Ken and Ken Eichler.

Slides and full presentation




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Qualifications

- Are physicians trained in medical school and residency to use the AMA Guides? What training is available?
- Who should perform a rating, the treating physician or an independent evaluator?
- Who is qualified to perform a rating?
- Why are patients sometimes referred to physical therapists or for FCEs to determine impairment?

Pain, Impairment, and Disability


- Are the Guides purely objective, or do they involve subjective elements?
- How can differing opinions arise about impairment?


Differences Among Editions

- Why were the Guides developed?
- Ideally, what Edition should be used?
- What are some examples of differences among Editions?

Specific Issues

- Why might a minor hand injury result in a higher rating than a back fusion?
- Can a second injury to the same body part lead to a new impairment rating?
- How do I discern impairment with challenging cases such as TBI and CRPS?





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SECTION 1 |

Foundation







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Question


Why can one person with a small impairment rating be considered disabled, while another with a larger impairment is not?







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Low Back Pain: 3% to 8% WPI (Depending on Edition)

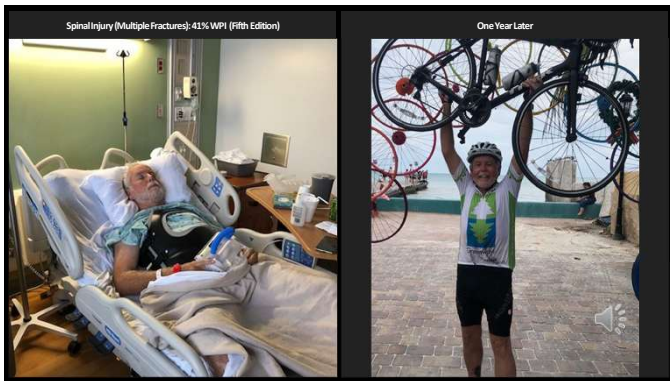


Digit Amputation: 90% digit, 5% WPI

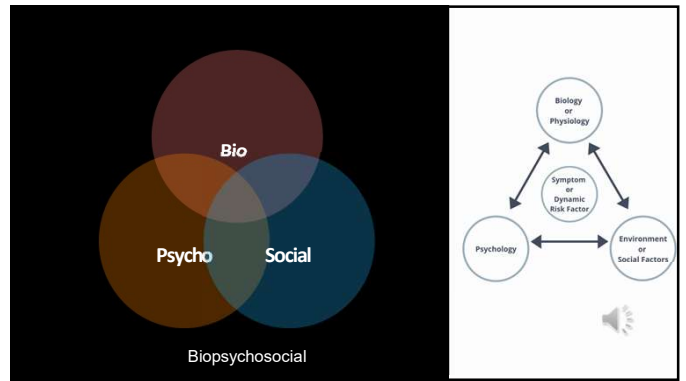




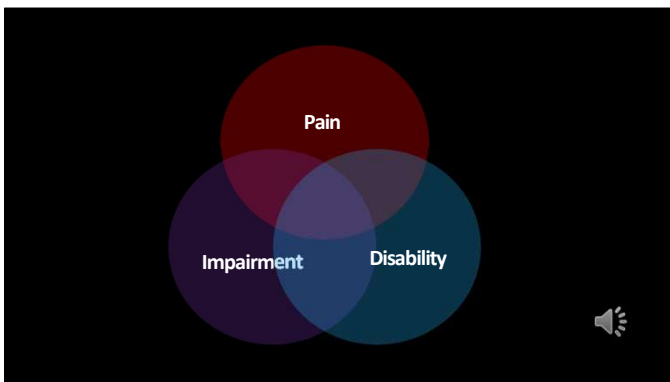
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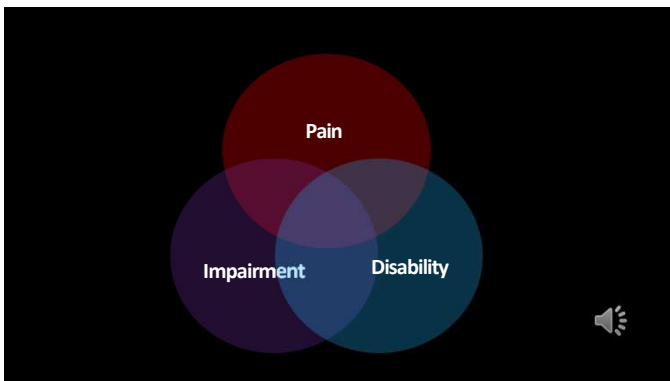


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Understanding Pain, Impairment, and Disability

Pain An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.	Impairment A significant deviation, loss, or or loss of use of any body structure or function in an individual with a health condition, condition, disorder, or disease.	Disability An umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder, or disease.
Pain vs Impairment Pain is a subjective experience, while impairment is an objective measure of a significant deviation or loss of body structure or function.		Impairment vs Disability Impairment is a medical condition, while disability refers to the limitations and restrictions an individual experiences in their daily life as a result of that condition.

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Question

Should impairment be expected for most work-related injuries?

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Impairment in Perspective

<p>Failure to Prevent Injury Impairment reflects a failure to prevent an injury in the first place</p>	<p>Failure to Assess Work-Relatedness Impairment may reflect a failure to accurately assess if a condition is work-related, e.g., a condition may reflect aging</p>
<p>Failure to Mitigate Impact Impairment may reflect a failure to effectively mitigate mitigate the impact of an injury and restore function</p>	<p>Failure to Base on Functional Result vs. Treatment Impairment rating should be about the end result, not the treatment the claimant received</p>

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Question


What should be the goals of an impairment assessment?



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Goal


Provide an assessment that is accurate and unbiased, resulting in a fair and equitable rating that is supported by the facts, evidence-based medicine, and appropriate application of the AMA Guides.



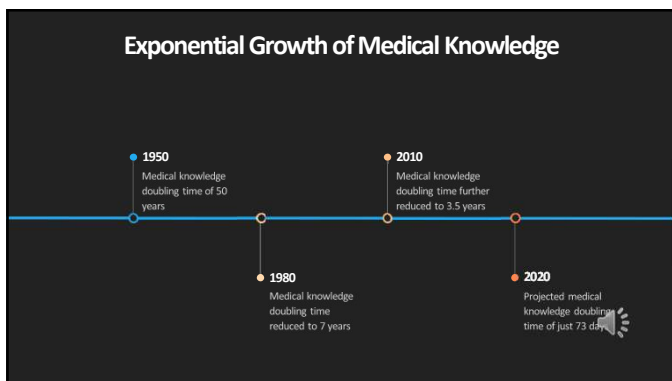
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Question

What is the history of the AMA Guides, and why are there so many Editions?




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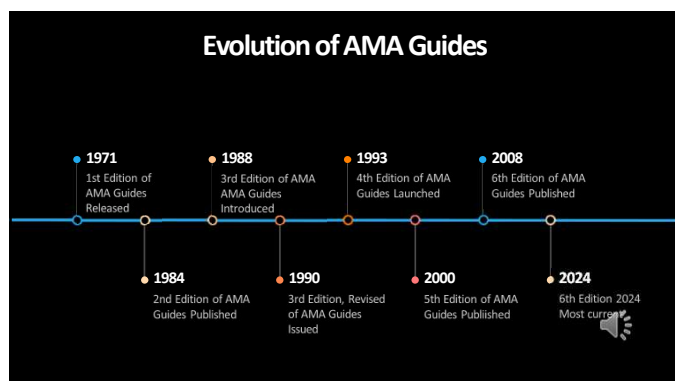
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SECTION 2 |

History of AMA Guides



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Use of AMA Guides Editions in Workers' Compensation

- Sixth Edition, 2024**
Alaska, Arizona, Illinois, Louisiana, New Mexico, and Wyoming.
- Fourth Edition, 1993 - 32 years ago**
Alabama, Arkansas, Maine, Maryland, Pennsylvania, Texas, and West Virginia.
- Sixth Edition, 2008 - 17 years ago**
Connecticut, District of Columbia, Idaho, Indiana, Mississippi, Montana, Oklahoma, North Dakota, Pennsylvania, Rhode Island, South Dakota, Tennessee, Puerto Rico, the Department of Labor Division of Federal Employee's Compensation, the Federal Employees Compensation Act, and the Longshore and Harbor Workers' Compensation Act.
- Third Edition, rev., 1988 - 37 years ago**
Colorado and Oregon.
- Fifth Edition, 2000 - 25 years ago**
California, Delaware, Georgia, Hawaii, Iowa, Kentucky, Massachusetts, Nevada, New Hampshire, Ohio, Vermont, and Washington (except spine).

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Question

What determines the Edition of the AMA Guides that should be used?

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Determining the AMA Guides Edition

- Legislation (Statutory Law)**
The use of a specific edition of the AMA Guides may be mandated by state or federal laws.
- Case Law (Judicial Interpretation)**
Courts may interpret the appropriate edition of the AMA Guides to be used based on past legal precedents.
- Administrative Regulation (Rules)**
Government agencies may establish rules or regulations requiring the use of a particular edition of the AMA Guides.
- Administration Bulletins, Policy/Manuals, and Guidance Documents**
Government agencies may issue bulletins, manuals, or guidance documents specifying the edition of the AMA Guides to be utilized.

The use of a specific edition of the AMA Guides is defined by a combination of statutory law, administrative regulations, judicial interpretations, and government policy documents.

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Question

If a system is familiar with an Edition and it is useful for claims resolution, why change?

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1993 (Fourth Edition) vs. Present

- In 1993, 32 years ago, the AMA Guides Fourth Edition orthopedic impairment evaluation relied heavily on physician judgment, basic imaging, and consensus-based Guides criteria.
- In orthopedics, in 2025, we have approximately five hundred times more knowledge than in 1993. Surgical robotics, AI-assisted imaging, biologics, and global outcome registries have transformed the field. Markedly improved outcomes.

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1993 vs. Present

- In 2025, the process to musculoskeletal disorders and other conditions is evidence-rich, technology-assisted, and data-driven — yet still requires expert interpretation to navigate complexity. Without integrating today’s tools, you’re working with less than a fraction of the available knowledge base.
- Using the AMA Guides, Sixth Edition (2024) ensures impairment ratings reflect current medical science, standardized methodology, and evidence-based outcomes. The Fourth Edition (1993) is based on a vastly smaller knowledge base, outdated diagnostic capabilities, and less reliable rating methods.
- In today’s medico-legal environment, relying on 30-year-old standards risks inaccurate ratings, greater variability, and reduced defensibility.

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Digital Platforms: The New Paradigm

Real-Time Updates and Evidence-Based Practice

Platforms like UpToDate, DynaMed, BMJ Best Practice, and ClinicalKey offer continuously updated content, peer-reviewed summaries, and links to the latest studies and guidelines. These platforms allow physicians and trainees to access living documents that evolve with emerging evidence.

Interactivity and Personalization

Digital platforms allow adaptive learning, including Anki with spaced repetition systems (SRS), AI-driven tutors (e.g., Osmosis, Amboss), and integration with electronic health records (EHRs) to offer point-of-care decision support.

Accessibility and Portability

Mobile apps and cloud-based platforms provide instant access to content anytime and anywhere—a critical asset in busy clinical settings or for global health practitioners in resource-limited areas.

Digital learning resources are becoming a necessity, offering real-time updates, interactivity, multimodal learning, and unparalleled accessibility. These advancements revolutionize medical education and clinical practice, empowering healthcare professionals to stay at the forefront of evidence-based care.

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Credit: <https://ama-guides.ama-assn.org>

AMA Guides Digital

The gold standard methodology for the assessment of permanent impairment for over 50 years.

AMA Guides® Sixth 2024 highlights include:

- Evidence-based enhancements supporting accurate, relevant impairment assessments.
- Streamlined three-grade rating system improving reliability and adding regulatory oversight.
- Streamlined evaluation process with the ICR grid reducing rating variation.

Unlock Efficiency With AMA Guides Sixth™ 2024 Musculoskeletal Enhancements!

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Question

Why is there resistance to change?

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Perceptions and Barriers to Change

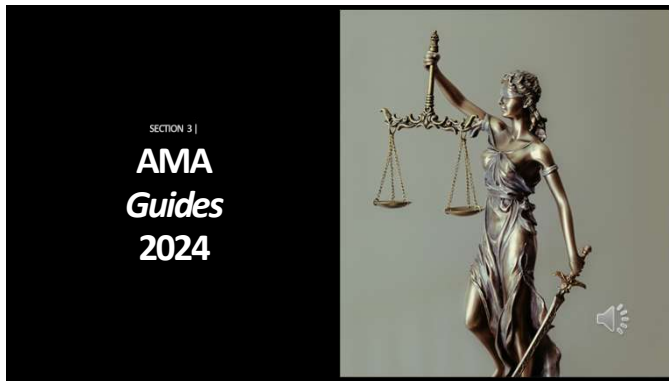
- **Legislative change complex**
A political, negotiated process that may involve multiple issues.
- **Concerns for lower rating values**
No significant change, other than values increased with the Fifth Edition, particularly for spinal surgery. No difference with the Fourth, Sixth (2008) and Sixth (2024).
- **Ethical advocacy (e.g., patients with pain and subjective complaints)**
Bias and confusion among concepts of pain, impairment, and disability.
- **Training and certification burden**
Implementing new approaches requires additional training and certification, which can be perceived as a burden by healthcare professionals.
- **Concerns about evolving editorial control by AMA**
Editorial process was transparent; however, concerns about relinquishing the update process to another entity.

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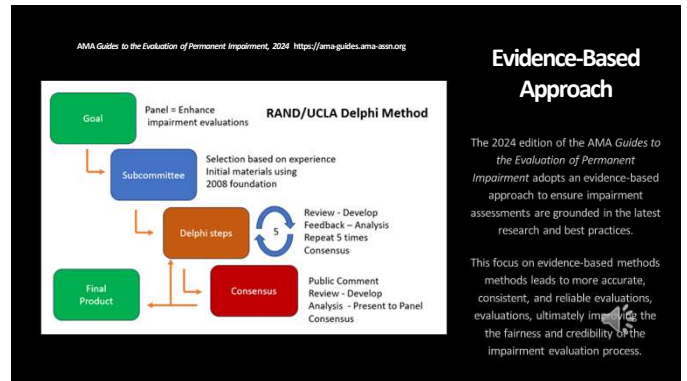
Question

Why were the musculoskeletal chapters updated in 2024 and what were these changes?

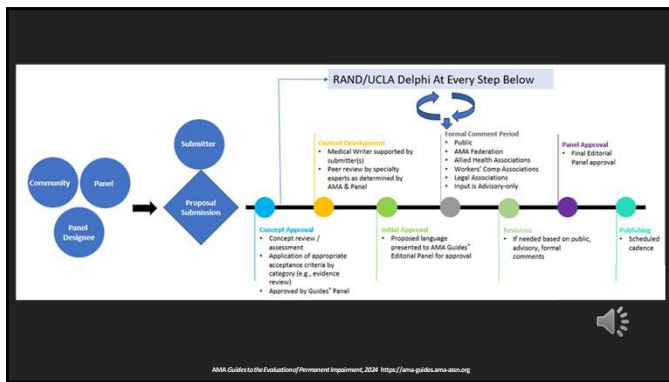
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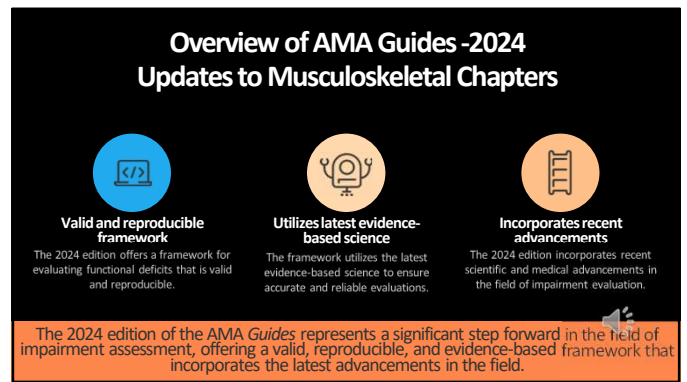
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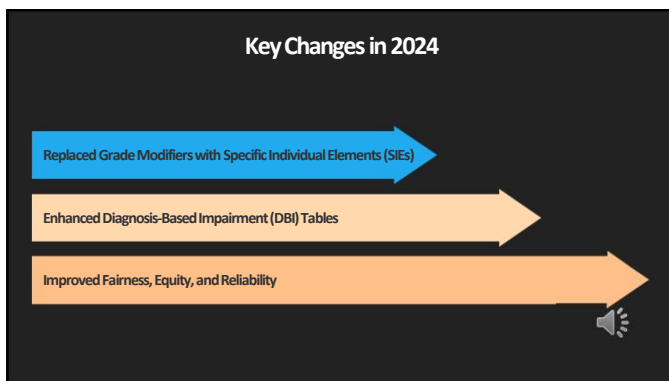
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Meniscal Injury: 16-20-09 Class 1A (1% LLI)

AMA Guides to the Evaluation of Permanent Impairment, 2024 <https://ama-guides.ama-assn.org>

- Meniscal Injury**
16-20-09 class 1A (1% LLI) - Meniscal injury diagnosed on 16-20-09, classified as class 1A with 1% lower limb impairment.
- Residual Symptoms**
CH (residual symptoms) - Patient is experiencing residual symptoms related to the meniscal injury
- Mechanism of Injury**
Mechanism of injury consistent with diagnosis
- Physical Examination**
Physical examination (PE) consistent with condition, including flexion >110°
- Imaging or Surgical Findings**
Imaging or findings at surgery consistent with diagnosis, including partial (central or inner two-thirds or white zone) medial meniscal tear, meniscectomy, or repair, or partial (peripheral or outer third or red zone) lateral meniscal tear, meniscectomy, or repair




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Consistency and Ease of Use

- Consistent format and approach across musculoskeletal chapters**
The 2024 AMA Guides maintain a consistent format and approach in the diagnosis-based impairment (DBI) tables across all musculoskeletal chapters, ensuring a standardized evaluation process.
- Streamlined evaluation process**
The consistent format and approach in the 2024 Guides reduces the need for frequent referencing between sections and tables, streamlining the overall impairment evaluation process.
- Reduced need for referencing**
The 2024 Guides provide clear instructions and guidance within the DBI tables, minimizing the need to flip back and forth through the book during an impairment evaluation.

The consistent format and approach in the 2024 AMA Guides streamline the impairment evaluation process, reducing the need for frequent referencing and improving the overall ease of use for evaluators.

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Research Findings

- Reduced time required to complete the evaluation**
The 2024 method reduced the time required to complete the evaluation, thereby enhancing ease of use and reducing learning or training time.
- Enhanced consistency, reliability, and reproducibility**
Consistency, reliability, and reproducibility were enhanced, improving both interrater and intrarater performance.
- Improved impairment value accuracy**
Impairment value accuracy was improved, resulting in fairer and more equitable evaluations.
- Values unchanged**
No significant change in the values associated with common musculoskeletal conditions.

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Reliability of the 2024 AMA Guides' Enhanced Methodology for Rating Spine and Pelvis Impairment


Methodological Advancements in the Guides for Rating Lower Limb Impairment

Pelvis Impairment Rating in 2024 vs. 2008: Impact

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Question

Are physicians trained in the use of the AMA Guides in medical school and residency? How are they trained?



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AMA Guides Training

- Training not provided in medical school or residency.**
- Self-taught by reading the AMA Guides or using companion learning resources.**
- Courses: virtual and live**
AMAGuides.com
American Board of Independent Medical Examiners
American College of Occupational and Environmental Medicine
International Academy of Independent Medical Evaluators
Other professional organizations
- Certification**
Certified Impairment Rater (CIR)
Certified Independent Medical Examiner (CIME)
Certified Medical Legal Evaluator (CMLLE)

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Question

Who should perform ratings? Who is more appropriate, e.g., treating physician or independent medical evaluator?



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Who performs evaluations?

- Physician**
Physician assessments are performed within the scope of practice. May utilize information from physical therapy assessment and FCEs.
- Clinical, medicolegal, and impairment assessment abilities all required.**
Knowledge, skills and experience required. Must be unbiased and use best practices.
- Musculoskeletal assessment specialties**
Orthopedics
 Physical medicine and rehabilitation
 Occupational medicine
- Treating physician vs. independent medical evaluator**
Treating physicians must be patient advocates and are often unfamiliar with impairment assessment.
- Non-physicians may critique ratings.**
If clinical information provided, may be able to assess impairment.

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Question

How often are ratings ratings incorrect and why?




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How often are impairment ratings wrong?



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




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


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

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Why are impairment rating errors so prevalent?



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



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



Lack of standardization
Failure to follow best practices for evaluations and managing ratings.

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

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What are the root causes of erroneous ratings?

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

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Analogy – Impairment Ratings and Taxes

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

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Question

What are common mistakes and "red flags"?

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What are common mistakes in impairment ratings?

Confusion among pain, impairment, disability, and restrictions

Differentiating between these concepts is crucial for accurate impairment ratings.

Faulty clinical reasoning and improper use of the AMA Guides

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

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

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

Sixth Edition: Misdiagnosis, invalid use of multiple diagnoses

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

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

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Red Flags

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

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Rating by Treating Physician or Known Biased Evaluator

Treating physician reports

Treating physicians inherently possess therapeutic allegiance, compromising impartiality.

Evaluator with known litigation bias

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

Flag for secondary review

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

Track evaluator patterns

Analyze evaluator data longitudinally to identify systemic bias.

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

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Evaluation Performed Outside Specialty Scope

Evaluator lacks clinical training in the condition assessed

For example, a chiropractor rating internal organ damage.

Verify the evaluator's clinical appropriateness

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

Ratings demand specialized knowledge in the pathology and functional consequences

Evaluators must have the necessary expertise to accurately assess the condition.

Reject reports outside the evaluator's domain of competence

Do not accept impairment ratings from evaluators without the proper expertise.

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

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Inadequately Trained and Non-Credentialed Evaluator



No formal training or certification in AMA Guides, medicolegal evaluation, or impairment rating

Ratings accuracy depends on the evaluator's technical understanding of the AMA Guides methodology.



Prioritize reports from certified professionals (e.g., CR, CIME, CMLE)

Certified professionals have the necessary training and expertise to provide accurate and reliable impairment ratings.




Scrutinize ratings from uncertified sources

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

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


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Poorly Constructed or Unprofessional Report




Disorganized, unformatted report

Lack of structure and formatting may indicate low evaluative quality.




Missing essential elements

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



Use formatting as a surrogate marker

Sloppy presentation can be a proxy for lack of analytic rigor.




Apply high scrutiny or request re-evaluation

Poorly constructed reports warrant closer examination or re-evaluation.

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


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Incomplete Clinical and Rating Documentation




Missing history

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




Absence of diagnostic correlation

Missing links between diagnoses and impairment ratings calls into question the rationale for the conclusions.



Lack of causation analysis

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




Incomplete examination findings

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

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


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No MMI Statement or Premature Rating (<6 months)




Ratings prior to MMI are invalid

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



Confirm date and clinical basis of MMI

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




Delay rating if premature

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

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


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Incorrect AMA Guides Citation




Referencing the wrong edition of the AMA Guides

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



Using vague terms like "AMA Guidelines"

Ambiguous references to the AMA Guides can indicate a lack of familiarity with the proper citation format.




Verify the edition cited matches jurisdictional requirements

Ensure the edition of the AMA Guides used in the report aligns with the specific edition mandated by the jurisdiction.

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


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Unusually High or Low Impairment Values




Whole Person Impairment (WPI) >10% without strong objective basis

Ratings that are disproportionately high compared to the clinical severity should be scrutinized.



WPI <10% in cases of significant trauma

Ratings that are disproportionately low compared to the injury complexity should also be closely examined.




Assess consistency with objective findings and injury complexity

The impairment rating should be proportionate to the clinical evidence and the overall injury picture.


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

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Diagnosis-Related Rating Problems



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



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




Demand High-Level Documentation
Require high-level documentation and clear diagnostic substantiation to support impairment ratings for these problematic conditions.


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

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Multiple Diagnoses Rated



Red Flag: Multiple Diagnoses
Especially if acute injury with documentation that this involved a single region or reported as a cumulative trauma disorder.



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




Action: Scrutinize Multiple Diagnosis Cases
Especially regarding the accuracy of the diagnoses and causation.


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

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Missing Tables, Figures, or Method References



No citation of Guides Table, Figure, or section used
Lack of citations for the Guides tables, figures, or sections used to derive the impairment compromises transparency and reproducibility.



Lack of transparency in rating methodology
Without citing the specific Guides references, the process used to calculate the impairment rating is unclear.




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


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

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Use of Disallowed or Subjective Rating Methods



Strength loss ratings without clear neurologic deficit
The AMA Guides restrict the use of strength loss ratings unless there is a clear neurologic deficit, as this method is prone to subjectivity and inflation.




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


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

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Software-Based Ratings Lacking Clinical Insight



Ratings based solely on software outputs
Software outputs can be prone to errors and misuse if not accompanied by clinical reasoning.



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

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

73

Invalid or Inconsistent Clinical Findings



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



Findings not aligned with physiology
Physiologically implausible findings should raise concerns and prompt further investigation.




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


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

74


Internal Report Inconsistencies



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



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



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

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

75

Use of Non-Standard or Jurisdictionally Prohibited Methods



Ratings must be based on standardized, accepted methods
Impairment ratings should comply with both the AMA Guides and local legal standards. In California, carefully evaluate Almaraz-Guzman approaches to determine if appropriate.




Ensure pain ratings or other methods are jurisdictionally permitted
Certain pain rating methods or approaches may be prohibited in some jurisdictions


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

76


Diagnosis-Inconsistent Impairment Ratings



Impairment is often diagnosis-driven
The impairment rating must be derived from the diagnosis that matches the causally related injury.



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




In the Sixth Edition, match impairment class and category
The impairment rating must be based on the appropriate impairment class and category for the injury diagnosis.


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

77


Improper Use of Range of Motion (ROM)



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



Confirm edition-specific applicability
Confirm the edition-specific ROM applicability and documentation rigor.




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


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

78


Mathematical Errors



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



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




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


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

79


Pain Used as Standalone Impairment



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



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




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

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

80

Question

How do you evaluate an impairment evaluation and report?



81

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

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


82

IME/Impairment Rating Report Checklist

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


83

Structure and Presentation




Logical Organization

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




Professional Formatting

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



Objective Tone

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




Readable Language

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

A well-structured, professionally formatted report is more likely to reflect a thoughtful evaluation and communicate complex information in a clear, objective manner.


84

Comprehensive Medical Report




Complete History

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




Thorough Physical Examination

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



Comprehensive Medical Documents

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



Detailed Analysis and References

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

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

85

Report Introduction




Introduction

Provides an overview of the report and its purpose




Referring source and scope of evaluation

Defines the sources used and the extent of the evaluation



Purpose of the report

Clearly states the objectives and goals of the report

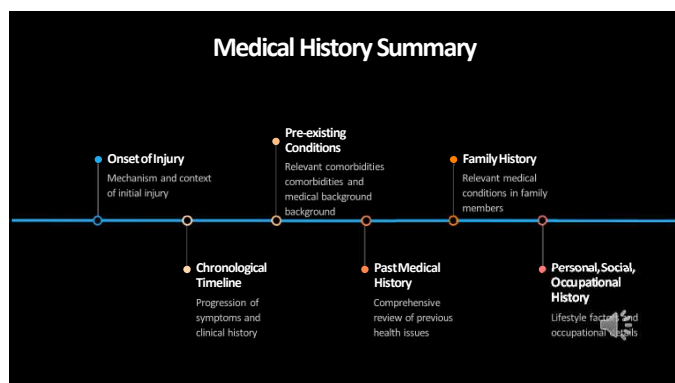


Historian identified and corroborated with medical records

Identifies the historian and verifies the information using medical records

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

86



87



88

Comprehensive Medical Evaluation

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

89

Bias and Tone Assessment

- Neutral Language**: Objective and impartial language, no emotional or subjective phrasing
- No Implicit Bias**: No references to race, gender, age, or other protected characteristics
- Professional Tone**: Formal, respectful, and courteous language towards all parties

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

90

Question

What are the roles for software and artificial intelligence (AI) in impairment assessment?

91

What is the role of AI in Impairment Evaluation?

- Improved Consistency**: AI can standardize the evaluation process, reducing variability and ensuring more consistent assessments; however, it is not yet reliable in assessing impairment.
- Early Error Detection**: AI-powered tools can analyze data and flag potential issues or errors early in the evaluation process, allowing for timely corrections.
- Nuance and Context Limitations**: AI may struggle to fully capture the nuances and contextual factors that are critical in impairment evaluations, requiring human judgment.
- Human Judgment Importance**: Ultimately, human expertise and decision-making remain essential in interpreting the complexity of impairment cases and making informed determinations.

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

92

A patient had a partial tear of his lateral meniscus and underwent a partial meniscectomy. One year later, the patient is still experiencing residual symptoms related to the work-related meniscal injury. The mechanism of injury was consistent with the physical examination. Imaging and surgical findings were consistent with the diagnosis. What is the rating?

Based on the direct information from the AMA Guides Sixth Edition - 2024, the patient's impairment rating is:

1% Lower Extremity (LE) Impairment

This is supported by the context information which shows that for a partial lateral meniscal tear with meniscectomy or repair, with residual symptoms and normal physical examination consistent with clinical studies, the appropriate rating is 1% L1, [1].

If conversion to whole person impairment is required by the jurisdiction, the 1% lower extremity impairment would convert to 0% whole person impairment using Table 16-16b (Impairment Values Conversion for Lower Limb to Whole Person). [6]

As noted in similar cases (example 16v03), this impairment value is expected to remain stable, with any potential change not anticipated to exceed 3% in the foreseeable future. [1]

View sources >

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Can you explain how the 1% LEI was determined?

What factors could potentially increase the impairment rating?


Could you provide examples of residual symptoms?

A patient had a partial tear of his lateral meniscus and underwent a partial meniscectomy. One year later, the patient is still experiencing residual symptoms related to the work-related meniscal injury. The mechanism of injury was consistent with the physical examination, imaging and surgical findings were consistent with the diagnosis. What is the rating?

93

Question

How do you resolve conflicting opinions and ratings?




94

Question

Is there a prohibition on subsequent ratings on a particular anatomical part?


If a patient sustains a shoulder injury, receives a rating, and then experiences a subsequent injury to the same shoulder, are they re-rated, and how is the impairment apportioned?



95

Question

What guidance would you provide in assessing challenging cases, e.g., traumatic brain injury (TBI) and complex regional pain syndrome (CRPS)?



96

Question


Why do the *Guides* not address future impairment and treatment?



97

Question


In a spinal impairment case, a physician rates one with radiculopathy at 3% WPI and another without radiculopathy at 19% WPI? Is this logical?



98

Question

How can a slight hand injury result in more severe impairment than a back fusion?



99



Thank you

Click on QR Code for Slides and Full Presentation

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