


**AMA Guides:
Understanding Their
History and Application**

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National Workers' Compensation Judicial College
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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

Slides and full presentation

- 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, IVD, with active discussion with Judge Langham and Ken and Ken Echler.



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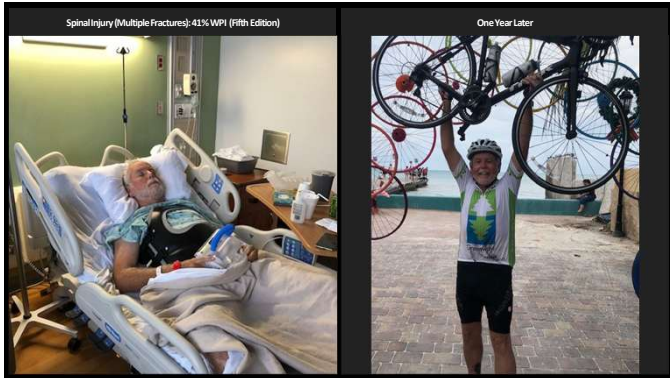
Low Back Pain: 3% to 8% WPI (Depending on Edition)



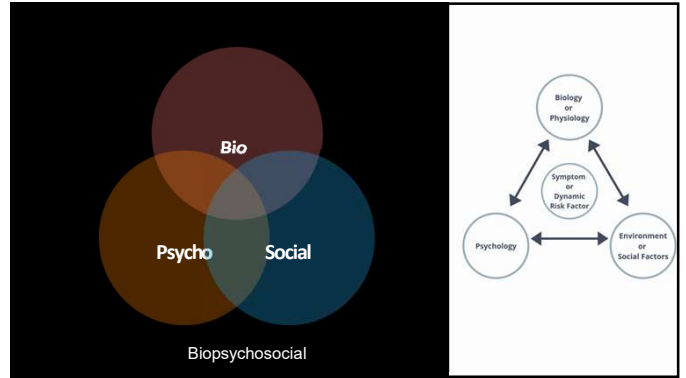
Digit Amputation: 90% digit, 5% WPI



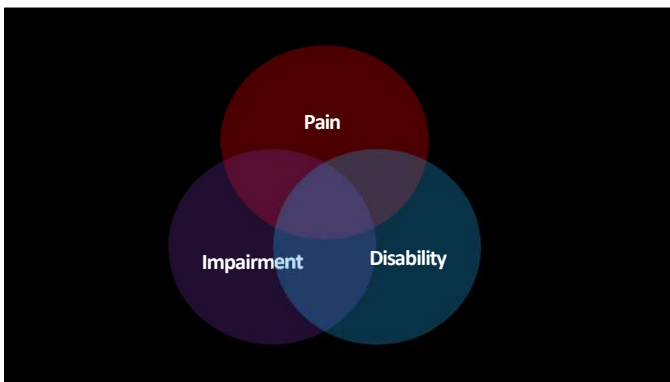
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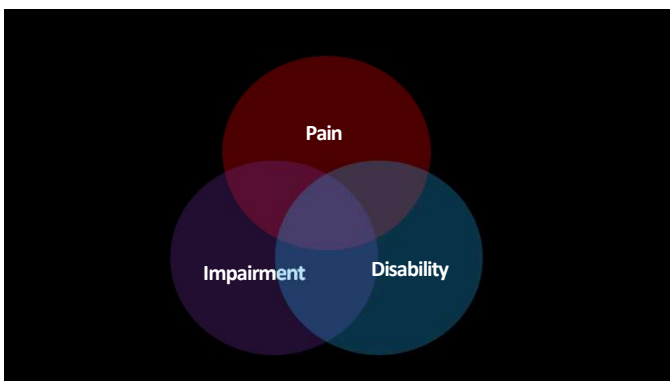


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Understanding Pain, Impairment, and Disability

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

Failure to Prevent Injury Impairment reflects a failure to prevent an injury in the first place	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
Failure to Mitigate Impact Impairment may reflect a failure to effectively mitigate mitigate the impact of an injury and restore function	Failure to Base on Functional Result vs. Treatment Impairment rating should be about the end result, not the treatment the claimant had

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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.



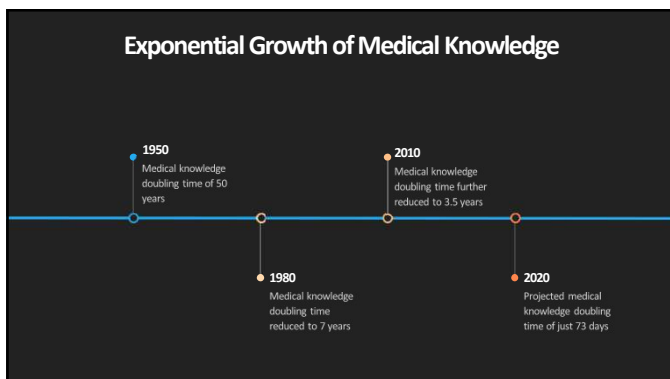
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Question

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




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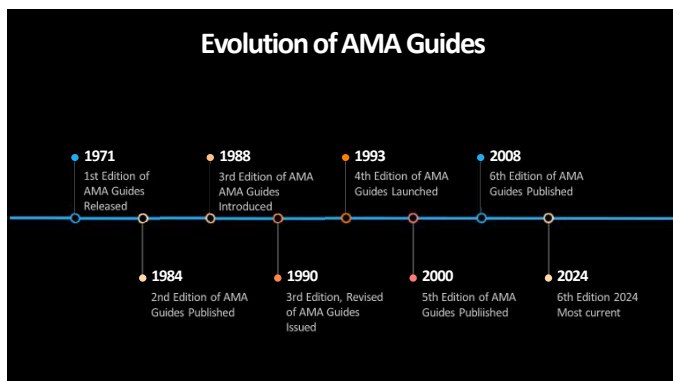


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SECTION 2 | History of AMA Guides



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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

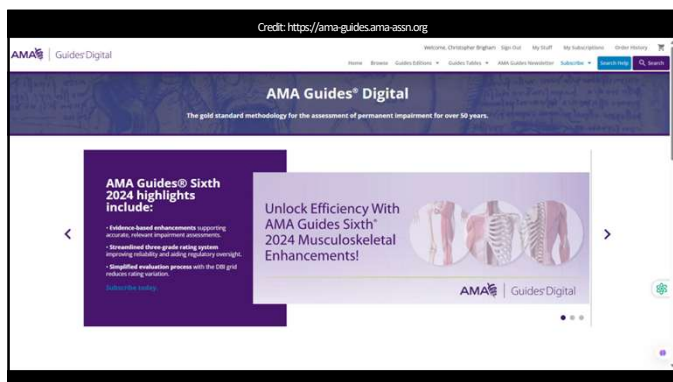
Digital platforms allow adaptive learning, including Anki with spaced repetition systems (SRS), AI-driven tutors (e.g., Osmosis, Amboss), and integration with electronic health records (EHRs) to offer point-of-care decision support.

Accessibility and Portability

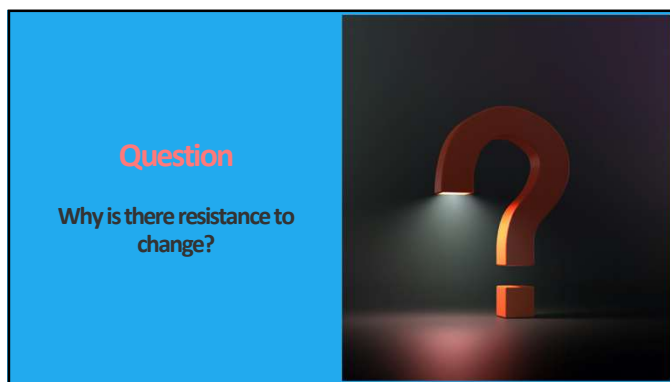
Mobile apps and cloud-based platforms provide instant access to content anytime and anywhere—a critical asset in busy clinical settings or for global health practitioners in resource-limited areas.

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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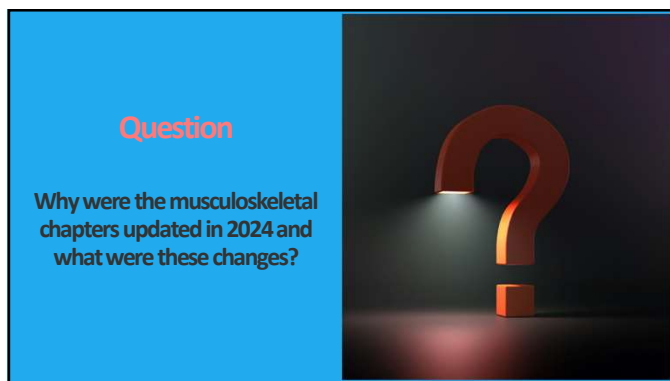


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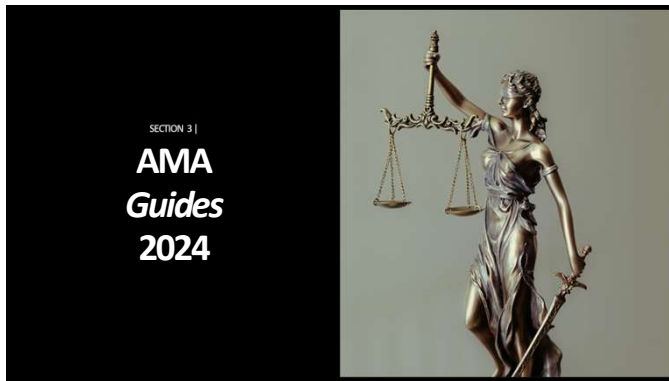
Perceptions and Barriers to Change

- **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.

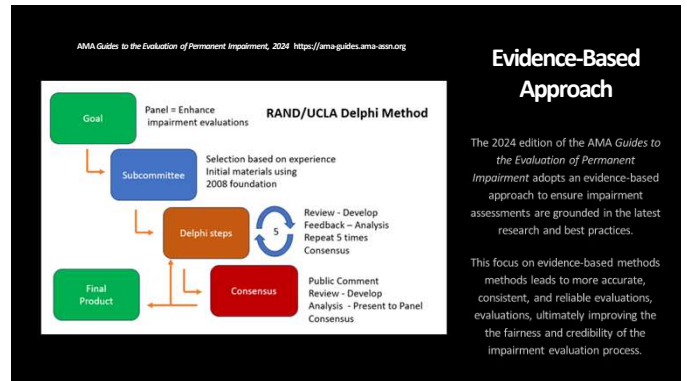
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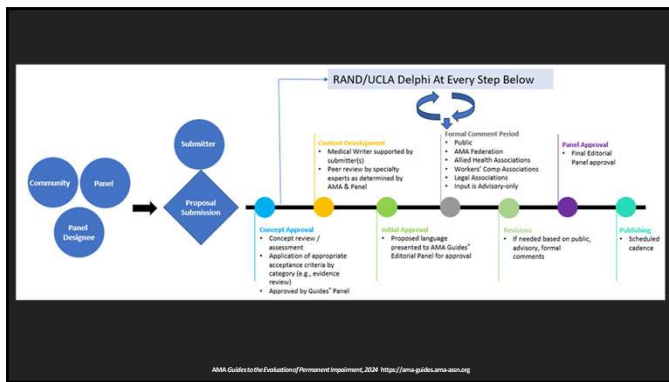
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Overview of AMA Guides -2024 Updates to Musculoskeletal Chapters

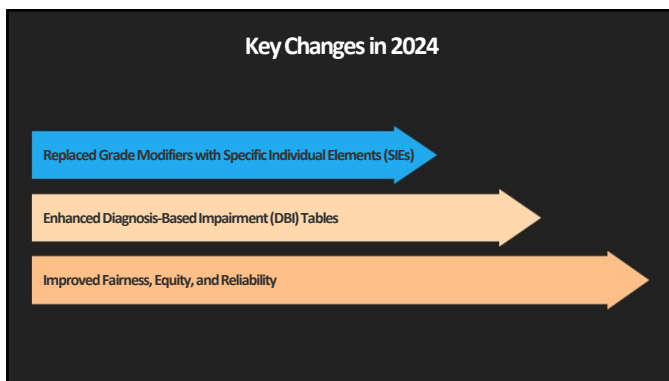
Valid and reproducible framework
The 2024 edition offers a framework for evaluating functional deficits that is valid and reproducible.

Utilizes latest evidence-based science
The framework utilizes the latest evidence-based science to ensure accurate and reliable evaluations.

Incorporates recent advancements
The 2024 edition incorporates recent scientific and medical advancements in the field of impairment evaluation.

The 2024 edition of the *AMA Guides* represents a significant step forward in the field of impairment assessment, offering a valid, reproducible, and evidence-based framework that incorporates the latest advancements in the field.

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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.

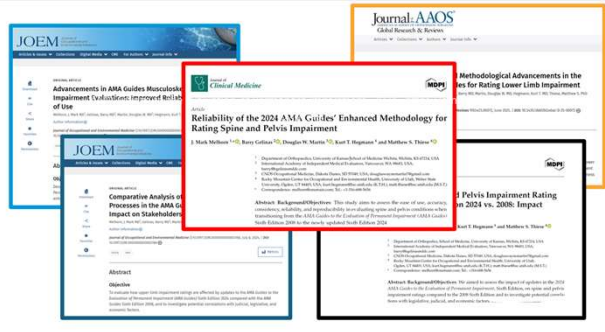
The consistent format and approach in the 2024 AMA Guides streamline the impairment evaluation process, reducing the need for frequent referencing and improving the overall ease of use for evaluators.

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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.
- Causation Errors**
Incorrect determination of the cause of the impairment, whether it's work-related or pre-existing, can lead to erroneous impairment ratings.
- Bias - Experts**
Hired experts may have a conflict of interest or predetermined biases that influence their 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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Question

How do you evaluate an impairment evaluation and report?



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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.

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Question

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



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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.

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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% LL [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 16-16a (Impairment Values Conversion for Lower Limb to Whole Person). [2]

As noted in similar cases (example 16A08), this impairment value is expected to remain stable, with any potential change not anticipated to exceed 3% in the foreseeable future. [3]

View sources >

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Speak **Unreviewable**

Can you explain how the 1% LL 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? Send message

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?




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Question

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



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What other questions do you have?

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Thank you

Click on QR Code for Slides and Full Presentation

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