Decoding AMA Guides Digital Edition

One Small Step for Mankind

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My Title was Assigned by

One Small Step for Mankind

AMA Guides Sixth 2025

Thank you

Rhode Island Workers' Compensation Court

International Workers' Compensation Foundation

The goal of the Guides is to provide
fair and equitable impairments
based on functional loss.

AMA Guides Sixth 2025

Thank you for attending

The goal of the Guides is to provide
fair and equitable impairments
based on functional loss.

AMA Guides Sixth 2025

Topics
Housekeeping
Why Updates
Impact
Sixth Background
Vignettes
Questions

AI only created divider slides – can you find them?

Housekeeping

Disclaimers

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- Dr. Melhorn served as Co-Chair of the AMA Guides® Editorial Panel through its conclusion in December 2025 and remains actively involved in AMA Guides activities as a volunteer.
- The AMA requests that their materials not be duplicated or reproduced. These resources are provided exclusively to attendees for use in connection with this educational event.

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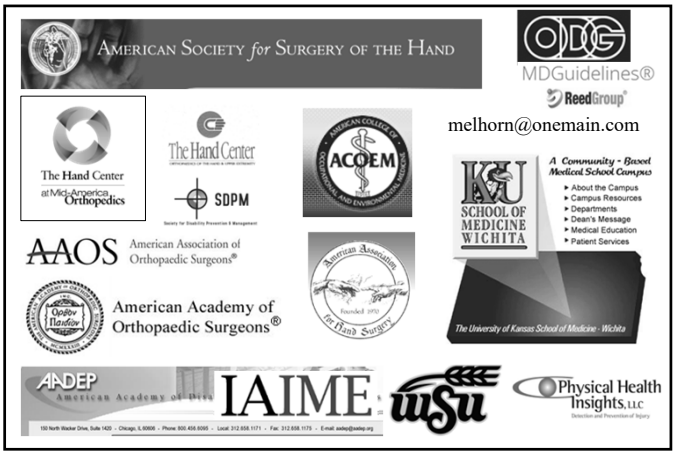
- Goal: Improve the quality of life for patients and injured workers.



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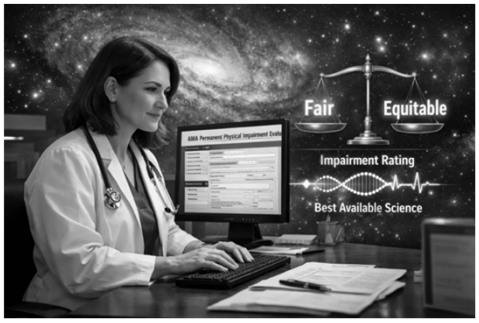
AMA Guides Sixth

- Rhode Island General Laws § 28-29-2 defines "functional impairment" as being based on the Sixth (6th) edition of the AMA Guides (or "comparable" AMA publications).
- Administrative form refers to latest "AMA guidelines"
- Impairment is determined as a percentage of the whole person?
- Based on the 2000 science, the 5th edition is not "comparable"

Why Change?



The Two WHY Questions

Updates

Digital

WHY Update?

2008

2025

Fair and Equitable Impairment Ratings

Founded on the Best Available Science

WHY Digital?

2008

2025

Integrates supplemental information to enhance evaluator use

May include references to current literature

May include clinical vignettes as illustrative educational examples

Improves comprehension

Promotes more consistent application

Enhances inter-rater and intra-rater reliability

AMA Guides Sixth 2025

The 2025 Digital Impairment Content is fixed

The 2024 MSK Digital Impairment Content was not rewritten in 2025

AMA Guides Sixth 2025

BUT

How do I find out what changed between "versions"?

AMA Guides Sixth

- Just like previous editions there may be content that needs to be corrected or grammar clarified.

This is called ERRATA

- Errata is defined as a list of corrected errors appended to a book or published document (digital)

AMA Guides Sixth 2008

Corrections and Clarifications

SIXTH EDITION

Guides to the Evaluation of Permanent Impairment

This is called ERRATA

PDF was 54 pages with multiple Errata per page

9th printing April 2023

AMA Guides Sixth 2024-2025

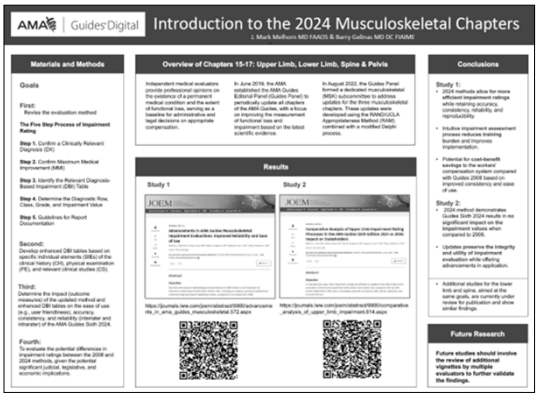
This is called ERRATA

AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition, 2024

Corrections and Clarifications – Published January 14, 2025

Impact

AMA Guides Sixth 2024-2025 MSK Financial Impact and Easy of Use



Introduction to the 2024 Musculoskeletal Chapters

J. Mark Melhorn MD FAAOS & Barry Gelinas MD DC FIAME

Materials and Methods

Overview of Chapters 15-17: Upper Limb, Lower Limb, Spine & Pelvis

Conclusions

Results

Study 1

Study 2

Future Research

Poster available on AMA Guides Digital

These articles do not imply that pre-med students are capable of independently completing appropriate impairment ratings. For these research projects, the students were given specific individual elements (SIEs) of the clinical history, physical examination, and relevant clinical studies that were pre-aligned with the 2008 and 2024 impairment criteria. However, a qualified evaluator is necessary to gather comprehensive information and determine which SIEs are relevant and applicable to the diagnosis for the specific individual being evaluated for an impairment

AMA Guides Sixth 2024-2025 MSK Financial Impact and Easy of Use

Journal of AAOS

Global Research & Reviews

Reliability and Methodological Advancements in the 2024 AMA Guides for Rating Lower Limb Impairment

Journal of Clinical Medicine

an Open Access Journal by MDPI

Comparative Analysis of Lower Limb Impairment Ratings in the AMA Guides Sixth Edition 2024 vs. 2008: Implications for Stakeholders

J. Mark Melhorn; Barry Gelinas; Douglas W. Martin; Kurt T. Hegmann; Matthew S. Thiese

J. Clin. Med. **2025**, Volume 14, Issue 19, 7033

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AMA Guides Sixth 2024-2025 MSK Financial Impact and Easy of Use


Journal of Clinical Medicine
an Open Access Journal by MDPI
Reliability of the 2024 AMA Guides' Enhanced Methodology for Rating Spine and Pelvis Impairment
J. Mark Melhorn; Barry Gelinas; Douglas W. Martin; Kurt T. Hegmann; Matthew S. Thiese
J. Clin. Med. **2025**, Volume 14, Issue 8, 2702


Journal of Clinical Medicine
an Open Access Journal by MDPI
Comparative Analysis of Spine and Pelvis Impairment Rating Using the *AMA Guides* Sixth Edition 2024 vs. 2008: Impact on Stakeholders
J. Mark Melhorn; Barry Gelinas; Douglas W. Martin; Kurt T. Hegmann; Matthew S. Thiese
J. Clin. Med. **2025**, Volume 14, Issue 6, 1919

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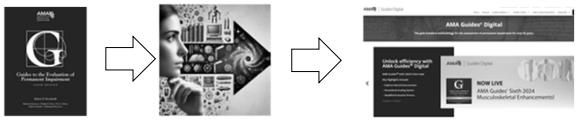
Why AMA Guides Sixth 2025?

If the scientific evidence demonstrates only minimal differences in impairment values or economic impact between the 2024 guidelines and the 2008 version, what is the justification for making the change?



Background + Current Science

AAOS 1962
AMA
1st 1971
2nd 1984
3rd 1988
3rd revised 1990
4th 1993
5th 2000

6th 2008-2021


AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition, 2025

6th 2021, 2022, 2023, 2024, 2025

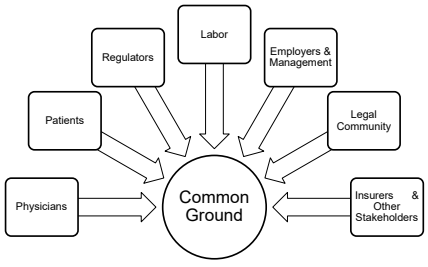
AMA Guides Sixth Panel

The Panel Process - Established June 2019

- Fair and Equitable
- Improved easy of use
- Improved reliability & reproducibility
- Reduce training required / learning curve
- Retained accuracy & consistency
- Economic impact studies provided

AMA Guides Sixth Panel

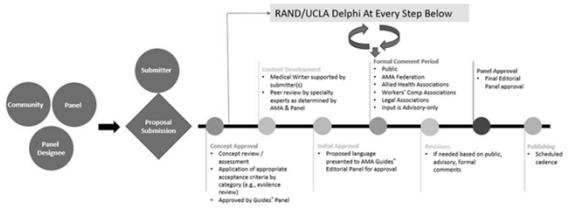
more-efficient impairment ratings while retaining accuracy, consistency, reliability, and reproducibility



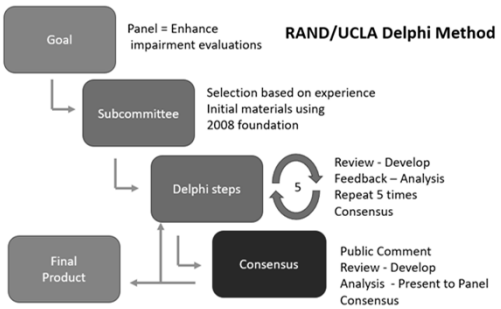
AMA Guides Sixth 2025 MSK

From: Musculoskeletal. In: Martin DW, Melhorn JM. ***AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition, 2024th. American Medical Association; 2024.***

DOI: https://doi.org/10.1001/amaguides.6th2024.msk

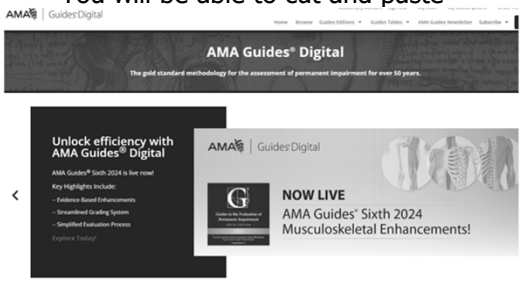


AMA Guides Sixth 2025 MSK



AMA Guides Sixth 2025 MSK

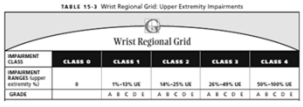
Available Exclusively on Digital Platform
There will not be a print version or book
You will be able to cut and paste



AMA Guides Sixth 2008 MSK

Review the Steps

1. MMI
2. DX
3. Regional Grid
4. Adjustment Grid
5. Class and Grade



AMA Guides Sixth 2008 MSK

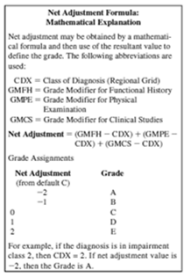
- Gone are Adjustment Grid and Modifiers, Non-Key Factors
- Gone are undefined terms like mild, moderate, severe, or very severe

TABLE 15-6
Adjustment Grid: Summary

	Specific Adjustment Grid	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Functional History	Table 15-7	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Physical Examination	Table 15-8	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Clinical Studies	Table 15-9	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem

AMA Guides Sixth 2008 MSK

- Gone are Net Adjustment



Net Adjustment Formula: Mathematical Explanation

Net adjustment may be obtained by a mathematical formula and then use of the resultant value to define the grade. The following abbreviations are used:

CDX = Class of Diagnosis (Regional Grid)
GMFH = Grade Modifier for Functional History
GMPE = Grade Modifier for Physical Examination
GMCS = Grade Modifier for Clinical Studies

Net Adjustment = (GMFH − CDX) + (GMPE − CDX) + (GMCS − CDX)

Grade Assignments

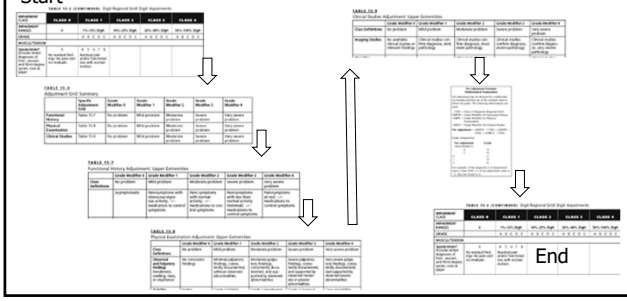
Net Adjustment (from default C)	Grade
−2	A
−1	B
0	C
1	D
2	E

For example, if the diagnosis is in impairment class 2, then CDX = 2. If net adjustment value is −2, then the Grade is A.

AMA Guides Sixth 2008 MSK

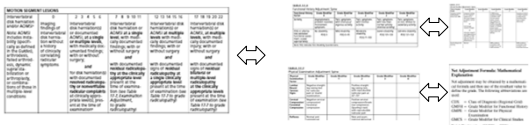
- Gone is the need to "flip back and forth" between multiple tables

Start

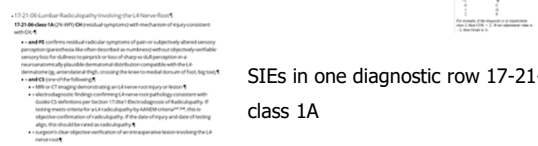


AMA Guides 2008 to 2025

2008 horizonal = across a row



2025 vertical = down a column



SIEs in one diagnostic row 17-21-06

class 1A

AMA Guides Sixth 2008 MSK

Based on 2008 Science

Do the Math

Three modifier tables,
each with five grades,
result in 125 possible permutations to arrive at an impairment value.

5 x 5 x 5

AMA Guides 2008 to 2025

De Quervain's

2025 = one step = apply SIEs to one table = 1 consideration

One diagnostic row is applicable to this diagnosis, as defined in the DBI table = 15-20-05 Wrist Sprain, Strain, Specific Traumatic Event, de Quervain's, Intersection Syndrome, Tendonitis, Tendinosis, Nonspecific Tendonitis of Wrist and/or Forearm

2008 = five steps = 4 tables & 1 calculation = 125 considerations

Five grades within Class 1 Table 15-3 Wrist Table 15-7 Functional History (5 grades), Table 15-8 PE (5 grades), and Table 15-9 Clinical Studies (5 grades) applied to net adjustment formula

AMA Guides 2008 to 2025

Full Rotator Cuff Disease

2025 = one step = apply SIEs to one table = 9 considerations

Nine diagnostic rows are applicable to this diagnosis, as defined in the DBI table 15-22-10 Full Rotator Cuff Disease = reflects current best science = fair impairment

2008 = five steps = 4 tables & 1 calculation = 125 considerations

Seven grades within Class 1 Table 15-5 Shoulder, Table 15-7 Functional History (5 grades), Table 15-8 PE (5 grades), and Table 15-9 Clinical Studies (5 grades) applied to net adjustment formula

AMA Guides 2008 to 2025

Medial Meniscal Tear

2025 = one step = apply SIEs to one table = 1 consideration

One diagnostic row is applicable to this diagnosis, as defined in the DBI table = 16-20-09 Meniscal Injury

2008 = five steps = 4 tables & 1 calculation = 125 considerations

Eighteen grades within Two Classes Table 16-3 Knee DBI Table, Table 16-6 Functional History (5 grades), Table 16-7 PE (5 grades), and Table 16-8 Clinical Studies (5 grades) applied to net adjustment formula

AMA Guides 2008 to 2025

Lumbar Radiculopathy Involving the L4 Nerve Root

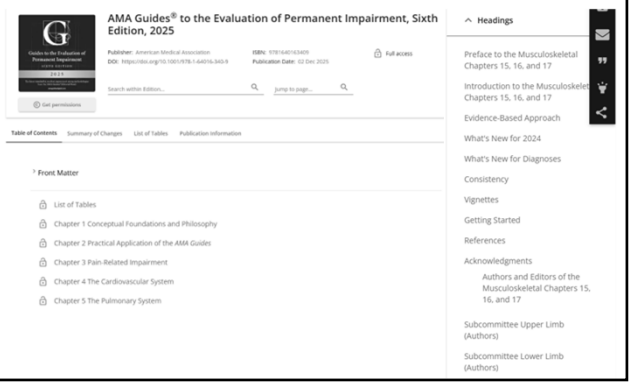
2025 = one step = apply SIEs to one table = 7 considerations

Seven diagnostic rows are applicable to this diagnosis, as defined in the DBI table 17-21-06 Lumbar Radiculopathy Involving the L4 Nerve Root = specific objective criteria

2008 = five steps = 4 tables & 1 calculation = 125 considerations

Twenty grades within Class 1 to 4 Table 17-4 Lumbar Spine, Table 17-6 Functional History (5 grades), Table 17-7 PE (5 grades), and Table 17-9 Clinical Studies (5 grades) applied to net adjustment formula = vague terms

AMA Guides Sixth 2025

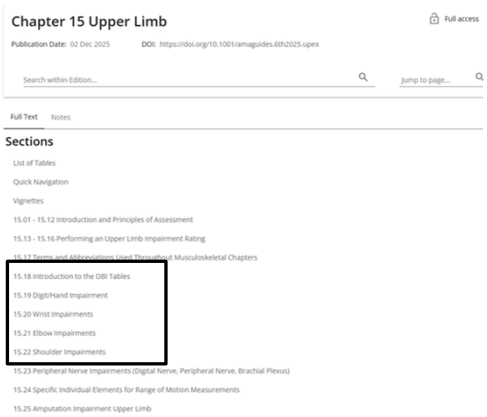


AMA Guides Sixth 2025 MSK

Updated, enhanced, accurate, consistent, reproducible resulting in

Fair and Equitable Impairments

- Musculoskeletal
- Chapter 15: Upper Limb
- Chapter 16: Lower Limb
- Chapter 17: Spine and Pelvis



AMA Guides Sixth 2025 MSK

Step 1. Confirm a Clinically Relevant Diagnosis (DX)

Step 2. Confirm Maximum Medical Improvement (MMI)

Step 3. Identify the Relevant Diagnosis-Based Impairment (DBI) Table

Step 4. Determine the Diagnostic Row, Class, Grade, and Impairment Value

Step 5. Guidelines for Report Documentation

AMA Guides Sixth 2025 MSK

Clinically Relevant Diagnosis (DX)

Based on objectively verifiable specific individual elements (SIEs) of the:

- Clinical History (CH) and (MOI)
- Physical Examination (PE)
- Relevant Clinical Studies (CS)

Establishes the "ONE" diagnostic row, class, grade, and impairment value

AMA Guides Sixth 2025 MSK

In the 2025 DBI Tables, the diagnostic rows are displayed vertically, making them easier to read on a web platform. This layout enhances readability compared to the previous horizontal format, which was suitable for printed materials but required smaller fonts and excessive scrolling on a web interface.

2025 Diagnostic Row

Diagnostic Row = 1. Clinical History (CH) 2. Physical Examination (PE) 3. Relevant Clinical Studies (CS)

15-20-09 Posttraumatic Arthritis Wrist Without ROM Loss

DBI Table 15-20-09 class 1C (7% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (two of the following) documented by imaging
  - demonstrates osteophyte (hypertrophy)
  - joint space narrowing with asymmetric arthritic changes (joint deformity) compared to opposite side

2025 Diagnostic Row

Diagnostic Row = 1. Clinical History (CH) 2. Physical Examination (PE) 3. Relevant Clinical Studies (CS)

15-20-09 Posttraumatic Arthritis Wrist Without ROM Loss

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2025 Diagnostic Row

Diagnostic Row = 1. Clinical History (CH) 2. Physical Examination (PE) 3. Relevant Clinical Studies (CS)

There are 3 Classes
for this diagnosis =
15-20-09
class 1A
but still based on
SIEs of
CH, PE, CS

15-20-09 Posttraumatic Arthritis Wrist Without ROM Loss

15-20-09 class 1A (4% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1B (5% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1C (7% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (all of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing asymmetric arthritic changes (joint deformity) compared to opposite side

2025 Diagnostic Row

Diagnostic Row = 1. Clinical History (CH) 2. Physical Examination (PE) 3. Relevant Clinical Studies (CS)

There are 3 Classes
for this diagnosis =
15-20-09
class 1B
but still based on
SIEs of
CH, PE, CS

15-20-09 Posttraumatic Arthritis Wrist Without ROM Loss

15-20-09 class 1A (4% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1B (5% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1C (7% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (all of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing asymmetric arthritic changes (joint deformity) compared to opposite side

2025 Diagnostic Row

Diagnostic Row = 1. Clinical History (CH) 2. Physical Examination (PE) 3. Relevant Clinical Studies (CS)

There are 3 Classes
for this diagnosis =
15-20-09
class 1C
but still based on
SIEs of
CH, PE, CS

15-20-09 Posttraumatic Arthritis Wrist Without ROM Loss

15-20-09 class 1A (4% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1B (5% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - swelling
  - crepitus
  - positive grind test;
- **and CS** (one of the following) imaging or findings at surgery consistent with DX
  - osteophyte (hypertrophy)
  - joint space narrowing
  - asymmetric arthritic changes (joint deformity) compared to opposite side

15-20-09 class 1C (7% ULI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

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  - osteophyte (hypertrophy)
  - joint space narrowing asymmetric arthritic changes (joint deformity) compared to opposite side

AMA Guides Sixth 2025 MSK

All three musculoskeletal chapters follow the same format and approach in the DBI tables. Sections and Tables are specifically numbered to facilitate easy identification of the diagnostic row in the evaluator's report, establishing the specific individual elements of the clinical history (CH), physical examination (PE), and relevant clinical studies (CS) used to match the diagnostic row criteria.

2025 Diagnostic Row

Upper Limb

15-19-06·Digital·Stenosing·Tenosynovitis,·Trigger·Digit¶

15-19-06·class·1A·(4%·digit)·**CH**·(residual·symptoms)·with·mechanism·of·injury·consistent·with·DX;¶ • → **and·PE**·consistent·with·DX¶
15-19-06·class·1B·(5%·digit)·**CH**·(residual·symptoms)·with·mechanism·of·injury·consistent·with·DX;¶ • → **and·PE**·(one·of·the·following)¶ • → palpable·nodule·over·A1·pulley¶ • → persistent·digit·triggering¶
15-19-06·class·1C·(7%·digit)·**CH**·(residual·symptoms)·with·mechanism·of·injury·consistent·with·DX;¶ • → **and·PE**·(two·of·the·following)¶ • → palpable·nodule·over·A1·pully¶ • → persistent·digit·triggering·¶

Notice: no SIE for CS

2025 Diagnostic Row

Lower limb

16-20-08 Myositis Ossificans (hypertrophic ossification)

16-20-08 class 1A (1% LLI) **CH** (residual symptoms) with mechanism of injury consistent with DX; • **and PE** flexion 0° to 120° and no contracture • **and CS** imaging or findings at surgery consistent with DX of ≤1 cm mass
16-20-08 class 1B (2% LLI) **CH** (residual symptoms) with mechanism of injury consistent with DX; • **and PE** (all of the following) • flexion 0° to 120° and no contracture • palpable mass; • **and CS** imaging or findings at surgery consistent with DX of >1 to 2 cm mass

2025 Diagnostic Row

Spine

17-19-03 Cervical Radiculopathy Involving the C1 Nerve Root (Very Rare)

Due to the unique anatomical position and function of the C1 nerve root, radiculopathy is extremely rare. When affected, it often overlaps with upper cervical or occipital conditions.

17-19-03 class 1A (2% WPI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** confirms residual radicular symptoms of pain or subjectively altered sensory perception (paresthesia-like often described as numbness) without objectively verifiable sensory loss for dullness to pinprick or loss of sharp vs dull perception in a neuroanatomically plausible dermatomal distribution compatible with the C1 dermatome (ie, occipital or upper neck region, radiating from the back of the head toward the crown or forehead, with no significant limb symptoms);
- **and CS** (one of the following)
  - MRI or CT imaging demonstrating a C1 nerve root injury or lesion
  - electrodiagnostic findings confirming C1 nerve root pathology consistent with *Guides* CS definitions per Section 17.06e1 Electrodiagnosis of Radiculopathy. Although this test can assist in supporting the diagnosis, it is rarely performed and often fails to provide definitive confirmation. The primary reason lies in the technical challenges involved, as the nerve root primarily innervates muscles in the neck region and, unlike lower cervical nerve roots, lacks representation in limb muscles.
  - surgeon's clear objective verification of an intraoperative lesion involving the C1 nerve root

2008 to 2025 AMA Guides

How to transition? By clinical vignettes.

AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition, 2025

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Publication Date: 02 Dec 2025
Full access

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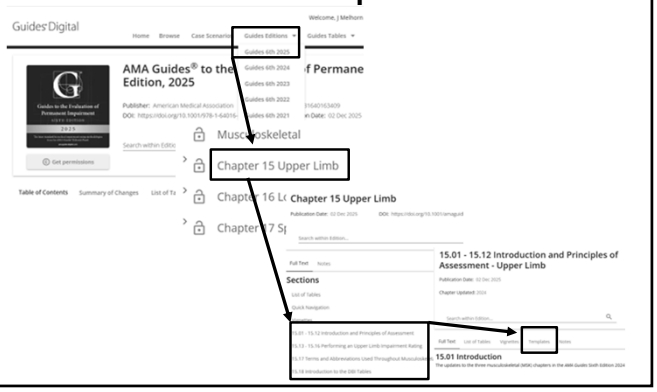
Training Vignettes 2008 to 2025

Using the same clinical data, the following Vignettes are provided with the 2008 method followed by the 2025 to help with the transition.

2025 Templates



2025 Templates

Print Templates for guidance

- Table 15-01g Upper Limb Impairment Evaluation Record Template PDF Download
- Table 16-01g Lower Limb Impairment Evaluation Record Template PDF Download
- Table 17-01g Spine and Pelvis Impairment Evaluation Record Template PDF Download

Table 15-01g Upper Limb Impairment Evaluation Record Template

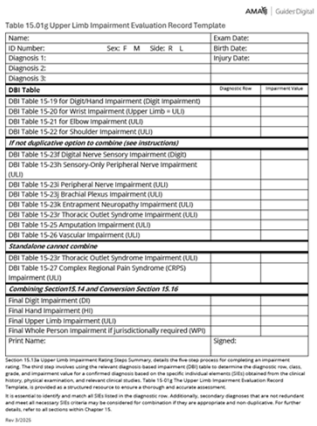


Table 15.01g Upper Limb Impairment Evaluation Record Template

Name:	Exam Date:
ID Number: Sex: F M Side: R L	Birth Date:
Diagnosis 1:	Injury Date:
Diagnosis 2:	
Diagnosis 3:	

DBI Table	Diagnostic Row	Impairment Value
DBI Table 15-19 for Digit/Hand Impairment (Digit Impairment)		
DBI Table 15-20 for Wrist Impairment (Upper Limb + ULI)		
DBI Table 15-21 for Elbow Impairment (ULI)		
DBI Table 15-22 for Shoulder Impairment (ULI)		
If not duplicative option to combine (see instructions)		
DBI Table 15-23f Digital Nerve Sensory Impairment (Digit)		
DBI Table 15-23h Sensory-Only Peripheral Nerve Impairment (ULI)		
DBI Table 15-23i Peripheral Nerve Impairment (ULI)		
DBI Table 15-23j Brachial Plexus Impairment (ULI)		
DBI Table 15-23k Entrapment Neuropathy Impairment (ULI)		
DBI Table 15-23r Thoracic Outlet Syndrome Impairment (ULI)		
DBI Table 15-25 Amputation Impairment (ULI)		
DBI Table 15-26 Vascular Impairment (ULI)		
Standalone cannot combine		
DBI Table 15-23r Thoracic Outlet Syndrome Impairment (ULI)		
DBI Table 15-27 Complex Regional Pain Syndrome (CRPS) Impairment (ULI)		
Combining Section15.14 and Conversion Section 15.16		
Final Digit Impairment (DI)		
Final Hand Impairment (HI)		
Final Upper Limb Impairment (ULI)		
Final Whole Person Impairment if jurisdictionally required (WPI)		
Print Name:	Signed:	

Section 15.13a Upper Limb Impairment Rating Steps Summary, details the five-step process for completing an impairment rating. The third step involves using the relevant diagnosis-based impairment (DBI) table to determine the diagnostic row, class, grade, and impairment value for a confirmed diagnosis based on the specific individual elements (SIEs) obtained from the clinical history, physical examination, and relevant clinical studies. Table 15-01g The Upper Limb Impairment Evaluation Record Template, is provided as a structured resource to ensure a thorough and accurate assessment.

It is essential to identify and match all SIEs listed in the diagnostic row. Additionally, secondary diagnoses that are not redundant and meet all necessary SIEs criteria may be considered for combination if they are appropriate and non-duplicative. For further details, refer to all sections within Chapter 15.

Rev. 9/2025

Table 16-01g Lower Limb Impairment Evaluation Record Template

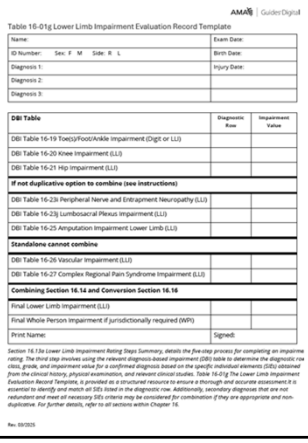


Table 16-01g Lower Limb Impairment Evaluation Record Template

Name:	Exam Date:
ID Number: Sex: F M Side: R L	Birth Date:
Diagnosis 1:	Injury Date:
Diagnosis 2:	
Diagnosis 3:	

DBI Table	Diagnostic Row	Impairment Value
DBI Table 16-19 Toe(s)/Foot/Ankle Impairment (Digit or LLI)		
DBI Table 16-20 Knee Impairment (LLI)		
DBI Table 16-21 Hip Impairment (LLI)		
If not duplicative option to combine (see instructions)		
DBI Table 16-23i Peripheral Nerve and Entrapment Neuropathy (LLI)		
DBI Table 16-23j Lumbosacral Plexus Impairment (LLI)		
DBI Table 16-25 Amputation Impairment Lower Limb (LLI)		
Standalone cannot combine		
DBI Table 16-26 Vascular Impairment (LLI)		
DBI Table 16-27 Complex Regional Pain Syndrome Impairment (LLI)		
Combining Section 16.14 and Conversion Section 16.16		
Final Lower Limb Impairment (LLI)		
Final Whole Person Impairment if jurisdictionally required (WPI)		
Print Name:	Signed:	

Section 16.13a Lower Limb Impairment Rating Steps Summary, details the five-step process for completing an impairme rating. The third step involves using the relevant diagnosis-based impairment (DBI) table to determine the diagnostic ro class, grade, and impairment value for a confirmed diagnosis based on the specific individual elements (SIEs) obtained from the clinical history, physical examination, and relevant clinical studies. Table 16-01g The Lower Limb Impairment Evaluation Record Template, is provided as a structured resource to ensure a thorough and accurate assessment.It is essential to identify and match all SIEs listed in the diagnostic row. Additionally, secondary diagnoses that are not redundant and meet all necessary SIEs criteria may be considered for combination if they are appropriate and non-duplicative. For further details, refer to all sections within Chapter 16.

Rev. 03/2025

Table 17-01g Spine and Pelvis Impairment Evaluation Record Template

1 of 7 pages

nerve root for cervical thoracic lumbar

pelvis

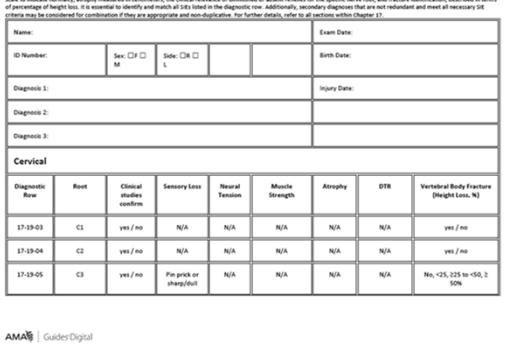


Table 17-01g Spine and Pelvis Impairment Evaluation Record Template AMA *Guides*® Sixth 2024 1/7

Section 17.13a Spine or Pelvis Impairment Rating Steps Summary, details the five-step process for completing an impairment rating. The third step involves using the relevant diagnosis-based impairment (DBI) table to determine the diagnostic row, class, grade, and impairment value for a confirmed diagnosis based on the specific individual elements (SIEs) obtained from the clinical history, physical examination, and relevant clinical studies. Table 17-01g is provided as a structured resource to ensure a thorough and accurate assessment. The spine-specific individual elements (SIEs) include sensation in a neuroanatomically plausible dermatomal distribution [1. confirms residual radicular symptoms of pain or subjectively altered sensory perception (paresthesia-like often described as numbness) without objectively verifiable sensory loss for dullness to pinprick or loss of sharp vs dull perception, 2. sensory deficit dullness to pinprick, or 3. sensory deficit loss of sharp vs dull perception (decreased protective sensibility)], the presence of tension signs specific to the nerve root, muscle strength evaluated on a 5/5 scale to indicate normalcy, atrophy measured in centimeters, the clinical relevance of diminished or absent reflexes for the specific nerve root, and fracture identification, described in terms of percentage of height loss. It is essential to identify and match all SIEs listed in the diagnostic row. Additionally, secondary diagnoses that are not redundant and meet all necessary SIE criteria may be considered for combination if they are appropriate and non-duplicative. For further details, refer to all sections within Chapter 17.

Name:							**Exam Date:**	
ID Number:		**Sex:** ☐F ☐ M	**Side:** ☐R ☐ L				**Birth Date:**	
Diagnosis 1:							**Injury Date:**	
Diagnosis 2:								
Diagnosis 3:								
Cervical								
Diagnostic Row	**Root**	**Clinical studies confirm**	**Sensory Loss**	**Neural Tension**	**Muscle Strength**	**Atrophy**	**DTR**	**Vertebral Body Fracture (Height Loss, %)**
17-19-03	C1	yes / no	N/A	N/A	N/A	N/A	N/A	yes / no
17-19-04	C2	yes / no	N/A	N/A	N/A	N/A	N/A	yes / no
17-19-05	C3	yes / no	Pin prick or sharp/dull	N/A	N/A	N/A	N/A	No, <25, 225 to <50, ≥ 50%

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Training Vignettes

15v03 Stenosing Tenosynovitis, Symptomatic, Impairment Rating, Chart Review

15v11 Status Post Rotator Cuff Repair

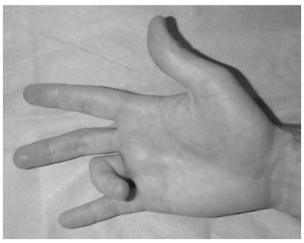
16v08 Meniscal Tear

16v10 Subluxing Patella

17v03 Intervertebral Disk Herniation or AOMSI at a Single Level (Cervical)

17v15 Intervertebral Disk Herniation or AOMSI at Multiple Levels (Lumbar)

2008 for 15v03 Trigger



2008 for 15v03 Trigger

15v03 Stenosing Tenosynovitis, Symptomatic, Impairment Rating, Chart Review (using 2025 format of 2008 data)

- **HPD:** A 24-year-old man sustained an injury to his right index finger while operating a nail gun at work. At 6 months after surgical treatment, he has moderately severe persisting pain and swelling near the flexor tendon of the A1 pulley. (Data provided by *AMA Guides* Sixth 2008 example 15-3).

2008 for 15v03 Trigger

- **CH:** He has reported difficulty with handwriting, zipping clothing, and turning a key with his dominant (right) hand. The VAS score was 7; *Quick*DASH, 62. In-office observation of his handwriting and dressing abilities confirms this, as noted in the medical record by the treating physician.
- **PE:** Pain with minimal trigger phenomenon on active range of motion; full range of motion.
- **CS:** None.

2008 for 15v03 Trigger

- **DX:** Trigger finger (stenosing tenosynovitis) of the right index finger.
- **MMI:** Following the evaluation, the impairment value is expected to remain notably stable, with any potential change not anticipated to exceed 3% in the foreseeable future.

2008 for 15v03 Trigger

2008 Impairment Rating Explanation:

- Regional Impairments: Diagnosis "digital stenosing tenosynovitis (trigger digit)" and per criteria of "Symptomatic trigger finger +/- surgery. "Persistent triggering with normal motion" assigned to class 1 with midrange default value of 6% digit.

2008 for 15v03 Trigger

TABLE 15-2 (CONTINUED) Digit Regional Grid: Digit Impairments

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES	0	1%–13% Digit	14%–25% Digit	26%–49% Digit	50%–100% Digit
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
MUSCLE/TENDON					
Sprain/strain* includes initial diagnoses of first-, second-, and third-degree sprain, now at MMI*	0 No residual findings: No pain and no residuals	4 5 6 7 8 Residual pain and/or functional loss with normal motion			
Digital stenosing tenosynovitis* (trigger digit)	0 No residual findings: +/– surgical treatment	4 5 6 8 Symptomatic trigger finger +/– surgery. Persistent triggering with normal motion			

Default 6%

2008 for 15v03 Trigger

Adjustment Grids per 2008

1. Functional History: Grade modifier 2
2. Physical examination: Grade modifier 2
3. Clinical tests: Grade modifier not applicable (n/a). But the rule is to establish the CLASS, but how does Clinical tests establish the CLASS?

2008 for 15v03 Trigger

TABLE 15-7

Functional History Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; +/− medication to control symptoms	Pain/ symptoms with normal activity; +/− medications to control symptoms	Pain/symptoms with less than normal activity (minimal); +/− medications to control symptoms	Pain/symptoms at rest; +/− medications to control symptoms
		AND able to perform self-care activities independently	AND able to perform self-care activities with modification but unassisted	AND requires assistance to perform self-care activities	AND unable to perform self-care activities
*Quick*DASH Score	0–20	21–40	41–60	61–80	81–100

But wait, QuickDASH was 62 = GM 3

2008 for 15v03 Trigger

TABLE 15-7

Functional History Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
	Asymptomatic	Pain/symptoms with strenuous/vigorous activity; +/− medication to control symptoms	Pain/ symptoms with normal activity; +/− medications to control symptoms	Pain/symptoms with less than normal activity (minimal); +/− medications to control symptoms	Pain/symptoms at rest; +/− medications to control symptoms
		AND able to perform self-care activities independently	AND able to perform self-care activities with modification but unassisted	AND requires assistance to perform self-care activities	AND unable to perform self-care activities
*Quick*DASH Score	0–20	21–40	41–60	61–80	81–100

Added 2008 complexity, reduced intrarater & interrater reliability

2008 for 15v03 Trigger

Physical Examination

moderate palpatory findings

But mild, moderate severe not defined

TABLE 15-8

Physical Examination Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Observed and Palpatory Findings (tenderness, swelling, mass, or crepitance)	No consistent findings	Minimal palpatory findings, consistently documented, without observed abnormalities	Moderate palpatory findings, consistently documented, and supported by observed abnormalities	Severe palpatory findings, consistently documented, and supported by observed moderate or greater abnormalities	Very severe palpatory findings, consistently documented, and supported by observed severe abnormalities
Stability	Stable	Grade 1 (slight) instability	Grade 2 (moderate) instability	Grade 3 (serious) instability	Gross instability
Hand/finger/ thumb		Pain with stressing of ligament, but no opening of joint with stress	Pain and slight opening	Pain and >5 mm of joint opening with stress	Severe instability
Wrist		Clicking or clunking by history, but not reproducible	Clicking or clunking by history, and reproducible on physical examination		
Wrist excessive passive/active mediolateral joint deviation degrees compared to normal		<10° passive <20° active	10°–20° passive 20°–30° active	>20° passive >30° active	
Shoulder		Grade 1 (slight) instability; subluxable	Grade 2 (moderate) instability; easily subluxable	Grade 3 (serious) instability; dislocatable with anesthesia or sedation	
Alignment/ Deformity	Normal for individual with symmetry to opposite side	Mild	Moderate	Severe	Very severe
Range of Motion (reference Section 15.7)	None	Mild decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment <20% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of <12% upper extremity impairment.	Moderate decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 20% to 39% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 12% to 23% upper extremity impairment.	Severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment of 40% to 70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment of 24% to 42% upper extremity impairment.	Very severe decrease from normal or uninjured opposite side For digit impairments only, this reflects a total digit impairment >70% digit impairment. For wrist, elbow, and shoulder this reflects a total joint impairment >42% upper extremity impairment.
Muscle Atrophy (asymmetry compared to opposite normal)	<1 cm	1.0–1.9 cm	2.0–2.9 cm	3.0 cm–3.9 cm	4.0 cm +

Note: ROM indicates range of motion; GH indicates Glenohumeral.

2008 for 15v03 Trigger

Clinical Studies

Not applicable and does not establish DX

TABLE 15-9

Clinical Studies Adjustment: Upper Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Class Definitions	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Imaging Studies	No available clinical studies or relevant findings	Clinical studies confirm diagnosis, mild pathology	Clinical studies confirm diagnosis, moderate pathology	Clinical studies confirm diagnosis, severe pathology	Clinical studies confirm diagnosis, very severe pathology
Shoulder			Clinical studies confirm one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology		Clinical studies confirm more than one of the following symptomatic diagnoses: rotator cuff tear, SLAP or other labral lesion, biceps tendon pathology. The most significant diagnosis is the only one rated.
X rays					
Arthritis		Cartilage interval normal or mild joint space narrowing and/or osteophytes	Cartilage interval: moderate joint space narrowing with cystic changes on 1 or both sides of joint and/or osteophytes; radiographic evidence of mild posttraumatic arthrosis; avascular necrosis without collapse	Cartilage interval: severe joint space narrowing with cystic changes on both sides of joint and/or osteophytes; or avascular necrosis with bony collapse/ fragmentation	No cartilage interval; radiographic evidence of severe posttraumatic arthrosis
Stability					
Joint laxity (based on stress testing)		<10° instability	10°–20° instability	20°–30° instability	>30° instability
Wrist (see text for explanation)		Radiolunate angle 11°–20° Scapholunate angle 61°–70° Scapholunate gap 2–5 mm Triquetrolunate stepoff >1 mm Ulnar translation mild	Radiolunate angle 21°–30° Scapholunate angle 71°–80° Scapholunate gap 6–8 mm Triquetrolunate stepoff >2 mm Ulnar translation moderate	Radiolunate angle >30° Scapholunate angle >80° Scapholunate gap >8 mm Triquetrolunate stepoff >3 mm Ulnar translation severe	
Nerve Conduction Testing	Normal	Conduction delay (sensory and/or motor)	Motor conduction block	Partial axonal loss	Total axonal loss/denervation
Electrodiagnostic Testing Note: If the EMG test results meet some of, but not all of, the criteria for a specific class, the next lower class is the class to be used in rating the impairment.	Normal	Needle EMG done at least 3 wk but less than 9 mo after injury shows at least 1+ fibrillation potentials and positive waves in at least 2 muscles innervated by the injured nerve. If the EMG study is first done more than 9 mo post injury, the exam shows high-amplitude polyphasic muscle potentials in at least 1 muscle and recruitment in that muscle is at least mildly reduced.	Needle EMG done at least 3 wk but less than 9 mo after injury shows at least 2+ fibrillation potentials and positive waves in at least 2 muscles innervated by the injured nerve. If the EMG study is first done more than 9 mo post injury, the exam shows high-amplitude polyphasic muscle potentials in at least 2 muscles and recruitment in those muscles is at least moderately decreased.	Needle EMG done at least 3 wk but less than 9 mo after injury shows at least 3+ fibrillation potentials and positive waves in at least 2 muscles innervated by the injured nerve. If the EMG study is first done more than 9 mo post injury, the exam shows high-amplitude polyphasic muscle potentials in at least 2 muscles and recruitment in those muscles is severely decreased.	Needle EMG done at least 3 wk but less than 9 mo after injury shows at least 4+ fibrillation potentials and positive waves in at least 2 muscles innervated by the injured nerve. If the EMG study is first done more than 9 mo post injury, the exam shows no motor units (fibrofatty replacement of muscle) in at least 2 muscles.

Note: SLAP indicates superior labrum from anterior to posterior; EMG, electromyogram.

2008 for 15v03 Trigger

Example of

Standard Net Adjustment Formula

Net Adjustment Formula: Mathematical Explanation

Net adjustment may be obtained by a mathematical formula and then use of the resultant value to define the grade. The following abbreviations are used:

CDX = Class of Diagnosis (Regional Grid)
GMFH = Grade Modifier for Functional History
GMPE = Grade Modifier for Physical Examination
GMCS = Grade Modifier for Clinical Studies

Net Adjustment = (GMFH − CDX) + (GMPE − CDX) + (GMCS − CDX)

Grade Assignments

Net Adjustment (from default C)	Grade
−2	A
−1	B
0	C
1	D
2	E

For example, if the diagnosis is in impairment class 2, then CDX = 2. If net adjustment value is −2, then the Grade is A.

2008 for 15v03 Trigger

15v03 Trigger

Net Adjustment

Must return to

DBI Table

Class 1 Example Calculation: Default for Diagnosis = 6% Digit[a]

CDX	GMFH	GMPE	GMCS
1	2	2	n/a

Net adjustment

(GMFH − CDX) (2 − 1) = 1

+ (GMPE − CDX) + (2 − 1) = 1

+ (GMCS − CDX) n/a

Net adjustment = 2

Result is class 1 adjustment +2, which equals class 1 grade E = 8% digit

[a] CDX indicates class of diagnosis; GMFH, grade modifier for functional history; GMPE, grade modifier for physical examination; GMCS, grade modifier for clinical studies; and n/a, not applicable.

2008 for 15v03 Trigger

15v03 Trigger

Net Adjustment

Must return to DBI Table

Another error net adjust =+3

Class 1 Example Calculation: Default for Diagnosis = 6% Digit[a]

CDX	GMFH	GMPE	GMCS
1	2	2	n/a

Net adjustment GMFH 3 not 2

(GMFH − CDX) (2 − 1) = 1

+ (GMPE − CDX) + (2 − 1) = 1

+ (GMCS − CDX) n/a

Net adjustment = 2

Result is class 1 adjustment +2, which equals class 1 grade E = 8% digit

[a] CDX indicates class of diagnosis; GMFH, grade modifier for functional history; GMPE, grade modifier for physical examination; GMCS, grade modifier for clinical studies; and n/a, not applicable.

2008 for 15v03 Trigger

TABLE 15-2 (CONTINUED) Digit Regional Grid: Digit Impairments

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RANGES	0	1%–13% Digit	14%–25% Digit	26%–49% Digit	50%–100% Digit
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
MUSCLE/TENDON					
Sprain/strain* includes initial diagnoses of first-, second-, and third-degree sprain, now at MMI*	0 No residual findings: No pain and no residuals	4 5 6 7 8 Residual pain and/or functional loss with normal motion			
Digital stenosing tenosynovitis* (trigger digit)	0 No residual findings: +/− surgical treatment	4 5 6 7 8 Symptomatic trigger finger +/− surgery. Persistent triggering with normal motion			

Net Adjustment +2 for grade E for 8% no option for +3

2025 for 15v03 Trigger

15v03 Stenosing Tenosynovitis, Symptomatic, Impairment Rating, Chart Review

- Same Clinical Information as 2008
- 2025 Confirm Dx at MMI, appropriate DBI Table
- Apply specific individual elements (SIEs) to the Diagnostic Row, identify impairment value
- Report using diagnostic row number.

2025 for 15v03 Trigger

Required Steps for 2025

Step 1. DX

Step 2. MMI

Step 3. DBI Table

Step 4. Diagnostic Row

Step 5. Report: The report should include a statement similar to the following, incorporating details from Step 1 through 4

2025 for 15v03 Trigger

Required Steps for 2025

Step 1. DX = confirm clinically relevant DX

Step 2. MMI = confirm MMI

Step 3. DBI Table = Find Dx in table

Step 4. Diagnostic Row

Step 5. Report: The report should include a statement similar to the following, incorporating details from Step 1 through 4

2025 for 15v03 Trigger

Required Steps for 2025

Step 1. DX = confirm clinically relevant DX

Step 2. MMI = confirm MMI

Step 3. DBI Table = Find Dx in table

Step 4. Diagnostic Row

Step 5. Report: The report should include a statement similar to the following, incorporating details from Step 1 through 4

2025 for 15v03 Trigger

Required Steps for 2025

Step 1. DX = confirm clinically relevant DX

Step 2. MMI = confirm MMI

Step 3. DBI Table = Find Dx in table

Step 4. Diagnostic Row

Step 5. Report: The report should include a statement similar to the following, incorporating details from Step 1 through 4

2025 for 15v03 Trigger

Required Steps for 2025

Step 1. DX = confirm clinically relevant DX

Step 2. MMI = confirm MMI

Step 3. DBI Table = Find Dx in table

Step 4. Diagnostic Row = SIEs

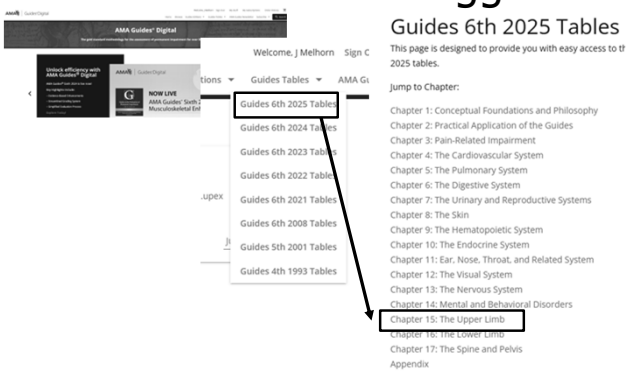
- Clinical History (CH) and MOI
- Physical Examination (PE)
- Relevant Clinical Studies (CS)

2025 for 15v03 Trigger

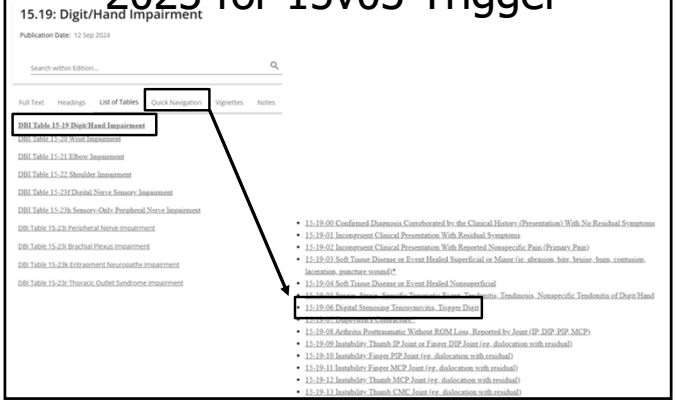
Specific Individual Elements (SIEs)

- CH: He has reported difficulty with handwriting, zipping clothing, and turning a key with his dominant (right) hand. The VAS score was 7; QuickDASH, 62. In-office observation of his handwriting and dressing abilities confirms this, as noted in the medical record by the treating physician.
- PE: Pain with minimal trigger phenomenon on active range of motion, palpable nodule over A1 pulley, full range of motion.
- CS: none
- DX: Trigger finger (stenosing tenosynovitis) of the right index finger

2025 for 15v03 Trigger



2025 for 15v03 Trigger



2025 for 15v03 Trigger

SIEs Check List That Matches
CH
PE
CS

15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit

15-19-06 class 1A (4% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX

15-19-06 class 1B (5% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

15-19-06 class 1C (7% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (two of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

2025 for 15v03 Trigger

SIEs Check List That Matches
CH
PE
CS

15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit

15-19-06 class 1A (4% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX

15-19-06 class 1B (5% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

15-19-06 class 1C (7% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (two of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

2025 for 15v03 Trigger

SIEs Check List That Matches
CH
PE
CS

15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit

15-19-06 class 1A (4% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** consistent with DX

15-19-06 class 1B (5% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (one of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

15-19-06 class 1C (7% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (two of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

2025 for 15v03 Trigger

15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit

15-19-06 class 1C (7% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (two of the following)
  - palpable nodule over A1 pully
  - persistent digit triggering

Excerpt from DBI Table 15-19 Digit/Hand Impairment.

Final impairment 7% vs 8% 2008, with both 1% HI, 1% ULI, or 1% WP.

2025 for 15v03 Trigger

Evaluator, Stakeholder, Adjudicator, Etc

Key to Report = diagnostic row 15-19-06 class 1C

15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit

15-19-06 class 1C (7% digit) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- **and PE** (two of the following)
  - palpable nodule over A1 pulley
  - persistent digit triggering

Excerpt from DBI Table 15-19 Digit/Hand Impairment.

2025 for 15v03 Trigger

Step 5 Example Report:

This 24-year-old man who sustained an injury to his right index finger while operating a nail gun at work. At 6 months after surgical treatment, he has moderately severe persisting pain with residual triggering without locking and swelling ("nodule") near the flexor tendon of the A1 pulley and reported difficulty with handwriting, zipping clothing, and turning a key with his dominant (right) hand. The VAS score was 7/10 and *Quick*DASH was 62 and were determined to be clinically consistent with the in-office observation of his handwriting and dressing abilities noted in his medical record.

2025 for 15v03 Trigger


15-19-06 Digital Stenosing Tenosynovitis, Trigger Digit¶
15-19-06 class 1C (7% digit) CH (residual symptoms) with mechanism of injury consistent with DX,¶
• and PE (two of the following:¶
• – palpable nodule over A1 pully¶
• – persistent digit triggering>
Excerpt from DBI Table 15-19 Digit/Hand Impairment,¶

At maximum medical improvement (MMI) and in accordance with the *AMA Guides* Sixth Edition 2025, the specific individual elements (SIEs) were matched to DBI Table 15-19 Digit/Hand Impairment, diagnostic row 15-19-06 for digit stenosing tenosynovitis (trigger digit), was selected, with "persisting pain with trigger and swelling (nodule)" indicating class 1C. In my professional opinion, although the medical record review did not provide insight into the requirement of "palpable nodule over A1 pully," the reported clinical presentation in the medical record and the natural history of the condition would suggest that grade 1C better reflects this individual's impairment of the right index finger at 7% digit.

2025 for 15v03 Trigger

In accordance with the jurisdiction's specific mandates this impairment can be converted to 1% hand, 1% upper limb, or 1% whole person.

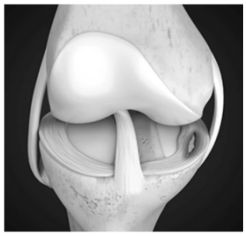
The same impairment values in 2008 or 2025 for hand, upper, limb and whole person.

Review of the JOEM articles for details.

2025 Summary

AMA Guides 2008	AMA Guides 2025
Identify DBI Table	Identify DBI Table
Obtain data for functional history (FH), physical examination (PE), and clinical studies (CS)	Obtain data (specific individual elements) for clinical history (CH), physical examination (PE), and relevant clinical studies (CS)
Apply the data to grade modifier tables for FH, PE, CS	
Determine grade modifier value for FH, PE, CS	
Apply grade modifier value to the net adjustment formula	
Obtain the Net adjustment value	
Return to the original DBI Table, locate default impairment value for grade C	
Apply the net adjustment value to the final grade with the class	Apply the specific individual elements (SIEs) to the diagnostic row
Identify the impairment value based on the final grade	Identify the impairment value based on the correct diagnostic row

2008 for 16v08 Meniscal



2008 for 16v08 Meniscal

16v08 Meniscal "Tear" Injury

- **HPD:** 45-year-old man who sustained a twisting injury to left knee resulting in pain and swelling. An MRI at 1 month post injury confirmed a medial meniscal tear. He declined surgery and was treated conservatively. (Data provided by AMA Guides Sixth Edition 2008 example 16-8.)
- *Does mechanism of injury (MOI) match DX (SIE in diagnostic row 2025)?*

2008 for 16v08 Meniscal

- **CH:** Six months later he denied any symptoms or functional limitations. *(CH Residual Symptoms 2025)*
- **PE:** Normal *(SIEs in diagnostic row 2025)*
- **CS:** MRI showed medial meniscal tear, and mild patellofemoral chondromalacia. *(SIEs in diagnostic row 2025)*
- **DX**: Medial meniscal tear, treated conservatively, asymptomatic. *(Step 1. 2025)*
- **MMI**: Established. *(Step 2. 2025)*

2008 for 16v08 Meniscal

2008 Impairment Rating Explanation:

- Regional impairment: Diagnosis: "meniscal injury" and per criteria of "partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair" assigned to class 1 with mid-range default value of 2% LEI.

2008 for 16v08 Meniscal

2008 Impairment Rating Explanation:

- Adjustment grids: Functional history: Grade modifier 0;
- Physical examination: Grade modifier 0;
- Clinical studies: Grade 1 (chondromalacia).
- With 2 grade modifier 0, adjustments moved 2 to the left of midrange default resulting in grade A and final rating of 1% LEI and converts to 1% WPI.

2008 for 16v08 Meniscal

Knee Regional Grid (LEI)

DIAGNOSTIC CRITERIA (KEY FACTOR)	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
IMPAIRMENT RANGES	0% LE	1%–13% LE	14%–25% LE	26%–49% LE	50%–100% LE
GRADE LIGAMENT / BONE / JOINT		A B C D E Do not use with PE stability	A B C D E Do not use with PE stability	A B C D E	A B C D E
Meniscal injury		1 2 3 4 2 3 Partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair 5 6 7 8 9 Total meniscectomy (medial or lateral) or meniscal transplant (allograft) 7 8 10 12 13 Partial (medial and lateral)	19 20 22 24 25 Total (medial and lateral)		

Default 2%

2008 for 16v08 Meniscal

- Please define "Do not used with PE stability".
- Now to the modifier tables

2008 for 16v08 Meniscal

TABLE 16-6
Functional History Adjustment – Lower Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
GAIT DERANGEMENT	None	Antalgic limp with asymmetric shortened stance, corrects with footwear modifications and/or orthotics	Antalgic limp (in the presence of objectively defined significant pathology) with asymmetric shortened stance; stable with use of external orthotic device (eg, ankle-foot orthosis), routine use of single gait aid (cane or crutch), or positive Trendelenburg test	Antalgic/unstable transfers and ambulation requires routine use of gait aids (2 canes or crutches) or KAFO brace*	Nonambulatory
AAOS LOWER LIMB INSTRUMENT (OR OTHER INVENTORY)	Normal	Mild deficit	Moderate deficit	Severe deficit	Near-total to total deficit

* KAFO indicates knee, ankle, foot orthosis; AAOS, American Academy of Orthopaedic Surgeons.

2008 for 16v08 Meniscal

Physical Examination

TABLE 16-7
Physical Examination Adjustment – Lower Extremities

	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
OBSERVED AND PALPATORY FINDINGS (tenderness, swelling, mass, or crepitance)	No consistent findings	Minimal palpatory findings, consistently documented, without observed abnormalities	Moderate palpatory findings, consistently documented, and supported by observed abnormalities	Severe palpatory findings, consistently documented, and supported by observed moderate or greater abnormalities	Very severe palpatory findings, consistently documented, and supported by observed severe abnormalities
STABILITY	Stable	Grade 1 (slight) instability	Grade 2 (moderate) instability	Grade 3 (serious) instability	Gross instability
KNEE		Grade 1 Lachman's test; slight laxity patellar mechanism	Grade 2 Lachman's test; moderate laxity patellar mechanism	Grade 3 Lachman's test; severe laxity patellar mechanism	Multidirectional instability
ALIGNMENT/ DEFORMITY	Normal for individual with symmetry to opposite side	Mild	Moderate	Severe	Very severe
RANGE OF MOTION (reference Section 16.7)	None	Mild or arthrodesis in position of function	Moderate	Severe	Very severe
MUSCLE ATROPHY (asymmetry compared to opposite normal)	<1 cm	1.0–1.9 cm	2.0–2.9 cm	3.0–3.9cm+	4.0 cm+
LIMB LENGTH DISCREPANCY	<1.9 cm	2.0–2.9 cm	3–4.9 cm	5.0–5.9 cm+	6.0 cm+

2008 for 16v08 Meniscal

Clinical Studies

Lots of details to review with high risk of missing items.

Used to establish the DX? – but was included in the Net Adjustment?

2008 for 16v08 Meniscal

16v08 Meniscal

Net Adjustment

Must return to

DBI Table

Class 1 Example Calculation			
CDX	GMFH	GMPE	GMCS
1	0	0	1

$$\begin{array}{r} (0-1)\ \ -1 \\ +(0-1)\ \ -1 \\ +(1-1)\ \ 0 \\ \hline \text{Net adjustment} = \ -2 \end{array}$$

Adjustment of −2 equals 2 positions to the left of default grade C resulting in grade A

Class 1, grade A = 1%

2008 for 16v08 Meniscal

Knee Regional Grid (LEI)

DIAGNOSTIC CRITERIA (KEY FACTOR)	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
CLASS DEFINITIONS	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
IMPAIRMENT RANGES	0% LE	1%–13% LE	14%–25% LE	26%–49% LE	50%–100% LE
GRADE LIGAMENT / BONE / JOINT		A B C D E Do not use with PE stability	A B C D E Do not use with PE stability	A B C D E	A B C D E
Meniscal injury		1 2 2 2 3 Partial (medial or lateral) meniscectomy, meniscal tear, or meniscal repair 5 6 7 8 9 Total meniscectomy (medial or lateral) or meniscal transplant (allograft) 7 8 10 12 13 Partial (medial and lateral)	19 20 22 24 25 Total (medial and lateral)		

Net Adjustment -2 for grade A for 1%

2025 for 16v08 Meniscal

- 16v09 Meniscal "Tear" Injury

- Same Clinical Information as 2008
- 2025 Confirm Dx at MMI, appropriate DBI Table
- Apply specific individual elements (SIEs) to the Diagnostic Row, identify impairment value
- Report using diagnostic row number.
- 2025 current terms for defining meniscal "tears"

2025 for 16v08 Meniscal

- 16-20-09 Meniscal Injury
  16-20-09 class 1A (1% LLI) **CH** (residual symptoms) with mechanism of injury consistent with DX;
  - → **and PE** (all of the following)
    - → consistent with CS
    - → flexion >110°;
  - → **and CS** (one of the following) imaging or findings at surgery demonstrates
    - → partial (central or inner two-thirds or white zone) medial meniscal tear, meniscectomy, or repair
    - → partial (peripheral or outer third or red zone) lateral meniscal tear, meniscectomy, or repair

Clear objectively verifiable anatomical specific individual elements (SIEs)

2025 for 16v08 Meniscal

- 2008 for 1% LLI or 1% WPI

- 2025 for 1% LLI or 1% WPI based on SIEs that can be easily identified and confirmed instead of 2008 poorly defined adjustment grade modifiers

2025 for 16v08 Meniscal

Step 5 Example Report:

This 45-year-old man sustained twisting injury to left knee resulting in pain and swelling. The MRI at 1 month post injury confirmed a partial medial meniscal tear. He declined surgery and was treated conservatively. Six months later he denied any symptoms or functional limitations. His current physical examination is normal. The clinical studies (MRI) showed medial meniscal tear, and mild patellofemoral chondromalacia. His current diagnosis is medial meniscal tear, treated conservatively, asymptomatic.

2025 for 16v08 Meniscal

A functional loss is established for this individual based on the information available for the specific individual elements of CH, PE, and relevant CS using diagnostic row 16-20-09. The individual would be considered an under reporter for the CH as he currently reports no symptoms. Based on the anatomical verifiable SIEs of the MRI there has been some functional loss of the meniscus due to the "tear." The Guides 2025 allows for the evaluator to provide an impairment if the PE and CS are consistent with the NHD.

2025 for 16v08 Meniscal

At maximum medical improvement (MMI) and in accordance with the AMA Guides Sixth Edition 2025, the specific individual elements (SIEs) were matched to DBI Table 16-20 Knee Impairment, diagnostic row 16-20-09 class 1A for 1% LLI. If requested, in accordance with the jurisdiction's specific mandates this impairment can be converted from 1% lower limb using Table 16-16b Impairment Values Conversion for Lower Limb to Whole Person to 1% whole person. An evaluator, using their professional judgement, may elect to provide a 0% impairment since he is reporting no current symptoms.

Table 17-01g Spine and Pelvis Impairment Evaluation Record Template

1 of 7 pages

nerve root for
cervical
thoracic
lumbar

pelvis

Table 17-01g Spine and Pelvis Impairment Evaluation Record Template AMA *Guides*® Sixth 2024 1/7

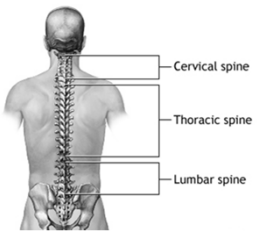
Section 17.1 Spine or Pelvis Impairment Rating Steps Summary, details the five-step process for completing an impairment rating. The third step involves using the relevant diagnosis-based impairment (DBI) table to determine the diagnostic row, class, grade, and impairment value for a confirmed diagnosis based on the specific individual elements (SIEs) obtained from the clinical history, physical examination, and relevant clinical studies. Table 17-01g is provided as a structured resource to ensure a thorough and accurate assessment. The spine-specific individual elements (SIEs) include sensation in a neuroanatomically plausible dermatomal distribution [1]. confirms residual radicular symptoms of pain or subjectively altered sensory perception (paresthesia-like often described as numbness) without objectively verifiable sensory loss for dullness to pinprick or loss of sharp vs dull perception, 2. sensory deficit dullness to pinprick, or 3. sensory deficit loss of sharp vs dull perception (decreased protective sensibility)], the presence of tension signs specific to the nerve root, muscle strength evaluated on a 5/5 scale to indicate normalcy, atrophy measured in centimeters, the clinical relevance of diminished or absent reflexes for the specific nerve root, and fracture identification, described in terms of percentage of height loss. It is essential to identify and match all SIEs listed in the diagnostic row. Additionally, secondary diagnoses that are not redundant and meet all necessary SIE criteria may be considered for combination if they are appropriate and non-duplicative. For further details, refer to all sections within Chapter 17.

Name:							Exam Date:	
ID Number:	Sex: ☐F ☐ M	Side: ☐R ☐ L					Birth Date:	
Diagnosis 1:							Injury Date:	
Diagnosis 2:								
Diagnosis 3:								
Cervical								
Diagnostic Row	Root	Clinical studies confirm	Sensory Loss	Neural Tension	Muscle Strength	Atrophy	DTR	Vertebral Body Fracture (Height Loss, %)
17-19-03	C1	yes / no	N/A	N/A	N/A	N/A	N/A	yes / no
17-19-04	C2	yes / no	N/A	N/A	N/A	N/A	N/A	yes / no
17-19-05	C3	yes / no	Pin prick or sharp/dull	N/A	N/A	N/A	N/A	No, <25, 125 to <50, ≥ 50%

AMA | Guides Digital

2025 Spine

Introduction to 2025 spine



2025 Spine

- Specific individual elements (SIEs) of physical examination (PE) and relevant clinical studies (CS) are required for determining the appropriate spine diagnostic row for spine-related radiculopathy as follows:

2025 Spine

Physical Examination =
Specific Individual Elements (SIEs) =
neuroanatomically plausible dermatomal

- Sensory (sharp/dull)
- Neural tension sign (if appropriate)
- Motor
- Atrophy
- Deep tendon reflex (if appropriate)

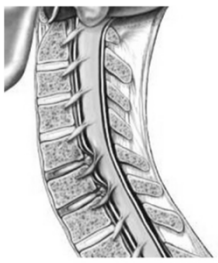
2025 Spine

Relevant Clinical Studies =
Specific Individual Elements (SIEs) =
neuroanatomically plausible dermatomal

One of the following:

- MRI or CT image demonstrating
- Electrodiagnostic findings confirming
- Surgeon's clear objective verification

2008 for 17v03 Cervical



2008 for 17v03 Cervical

17v03 Intervertebral Disk Herniation or AOMSI at a Single Level (Cervical)

- **HPD:** A 35-year-old woman had an onset of neck pain and left arm pain after repetitive lifting of boxes while stocking shelves at work which has been accepted as work compensable injury. She was treated with epidural injections and physical therapy. Ultimately, she underwent an anterior cervical fusion. (Clinical information provided by AMA Guides Sixth Edition 2008 example 17-3.

2008 for 17v03 Cervical

17v03 Intervertebral Disk Herniation or AOMSI at a Single Level (Cervical)

HPD continued:

- However, it is important to note that the clinical information it contains may not fully align with the more detailed and specific individual elements required for clinical history [CH], physical examination [PE], and clinical studies [CS] as outlined in the updated AMA Guides 2025.) *Does mechanism of injury (MOI) match DX (SIE in diagnostic row 2025)?*

2008 for 17v03 Cervical

- **CH:** Resolution of neck pain and persistent pain in the left arm. Symptoms occur only with strenuous activity. The PDQ is 50 consistent with mild disability. *(CH Residual Symptoms 2025)*
- **PE:** Slightly decreased range of motion of the cervical spine and slight weakness of wrist extensors on the left, diminished light touch in C6 distribution. Note: The 2008 example does not include specific individual elements (SIEs) for a neural tension test and atrophy, which are required for the Sixth Edition 2025.

2008 for 17v03 Cervical

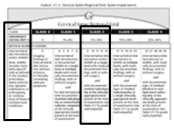
- **PE continued:** Sensory deficit loss of sharp vs dull perception is present, reflex intact, neural tension is considered as negative, *(SIEs in diagnostic row 2025)*

2008 for 17v03 Cervical

- **CS:** Preoperative MRI showed a disk herniation at C5-6, left. Postoperative films show a healed anterior interbody fusion at C5-6. *(SIEs in diagnostic row 2025)*
- **DX:** Status post herniated nucleus pulposus and anterior cervical diskectomy and fusion at C5-6 with persistent left arm pain. *(Step 1. 2025)*
- **MMI:** Following the evaluation, the impairment value is expected to remain notably stable, with any potential change not anticipated to exceed 3% in the foreseeable future. *(Step 2. 2025)*

2008 for 17v03 Cervical

2008 Impairment Rating Explanation:



- Diagnosis is consistent with "Intervertebral disk herniation or documented AOMSI at a single or multiple levels with medically documented findings; with or without surgery, AND with documented resolved radiculopathy or non-verifiable radicular complaints at the clinically appropriate level present at the time of examination," and therefore, assigned to class 2.

2008 for 17v03 Cervical

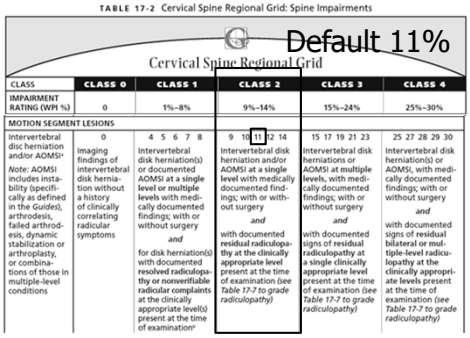


TABLE 17-2 Cervical Spine Regional Grid: Spine Impairments

Cervical Spine Regional Grid

Default 11%

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (WPI %)	0	1%–8%	9%–14%	15%–24%	25%–30%
MOTION SEGMENT LESIONS					
Intervertebral disc herniation and/or AOMSI[a] *Note:* AOMSI includes instability (specifically as defined in the Guides), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	4 5 6 7 8 Intervertebral disk herniation(s) or documented AOMSI at a single level or multiple levels with medically documented findings; with or without surgery *and* for disk herniation(s) with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate level(s) present at the time of examination[a]	9 10 11 12 14 Intervertebral disk herniation and/or AOMSI at a single level with medically documented findings; with or without surgery *and* with documented residual radiculopathy at the clinically appropriate level present at the time of examination (*see Table 17-7 to grade radiculopathy*)	15 17 19 21 23 Intervertebral disk herniations or AOMSI at multiple levels, with medically documented findings; with or without surgery *and* with documented signs of residual radiculopathy at a single clinically appropriate level present at the time of examination (*see Table 17-7 to grade radiculopathy*)	25 27 28 29 30 Intervertebral disk herniation(s) or AOMSI, with medically documented findings; with or without surgery *and* with documented signs of residual bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination (*see Table 17-7 to grade radiculopathy*)

2008 for 17v03 Cervical

- **2008 Rules:**
- If any of these factors are determined by the examiner to be unreliable or inconsistent, they should be disregarded in the grading adjustment. Page 569
- If a grade modifier is found to be unreliable or inconsistent, it should be disregarded and eliminated from the calculation. Page 411, 521, 582
- As stated earlier, if a grade modifier has been used to determine the impairment class, it may not be used again in this calculation. Page 515, 569
- In the spine, radiographic findings will often be excluded from the Net Adjustment Formula calculation because they are frequently used to determine the impairment class in the regional grid (eg, single or multiple level conditions). Page 569

2008 for 17v03 Cervical

Functional History

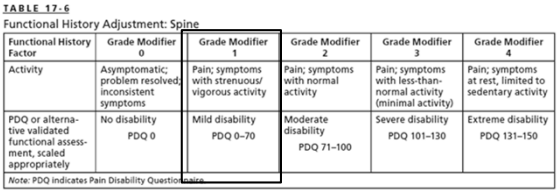


TABLE 17-6
Functional History Adjustment: Spine

Functional History Factor	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Activity	Asymptomatic; problem resolved; inconsistent symptoms	Pain; symptoms with strenuous/ vigorous activity	Pain; symptoms with normal activity	Pain; symptoms with less-than-normal activity (minimal activity)	Pain; symptoms at rest, limited to sedentary activity
PDQ or alternative validated functional assessment, scaled appropriately	No disability PDQ 0	Mild disability PDQ 0–70	Moderate disability PDQ 71–100	Severe disability PDQ 101–130	Extreme disability PDQ 131–150

Note: PDQ indicates Pain Disability Questionnaire.

Grade modifier 1 below default of 2

2008 for 17v03 Cervical

Physical Examination

no objective findings

TABLE 17-7
Physical Examination Adjustment: Spine

Physical Examination Factor	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Lumbar Neural Tension Signs	Negative straight leg raising test for radicular pain or invalid examination		Positive straight leg raising test, with reproducible radicular pain at 35°–70°		
Cervical Compression/ Foraminal Compression	Negative cervical compression/ foraminal compression		Positive cervical compression/foraminal compression (Spurling's test) with reproducible radicular pain		
Reflexes	Normal and symmetrical		New and asymmetrical abnormality consistent with other radicular findings (ie, differentiate between old and new changes)		
Atrophy UE LE	<1 cm <1 cm	1.0–1.9 cm 1.0–1.9 cm	2.0–2.9 cm 2.0–2.9 cm	3.0–3.5 cm 3.0–3.5 cm	>3.5 cm >3.5 cm
Sensory Deficit	No loss of sensibility, abnormal sensation, or pain	Diminished light touch (with or without minimal abnormal sensations or pain) in a clinically appropriate distribution, that is forgotten during activity	Diminished light touch (with some abnormal sensations or slight pain) in a clinically appropriate distribution, that interferes with some activities	Decreased protective sensibility (with abnormal sensations or moderate pain in a clinically appropriate distribution) that may prevent some activities	Absent superficial pain and tactile sensibility or absent protective sensibility (abnormal sensations, or severe pain) that prevents all activity
Motor Strength	Normal Active movement against gravity with full resistance (5/5)	Active movement against gravity and some resistance (4/5)	Active movement against gravity only, without resistance (3/5)	Active movement with gravity eliminated (2/5)	Slight contraction and no movement or no contraction (0–1/5)

2008 for 17v03 Cervical

Clinical Studies

TABLE 17-9
Clinical Studies Adjustment: Spine

Clinical Studies Factor	Grade Modifier 0	Grade Modifier 1	Grade Modifier 2	Grade Modifier 3	Grade Modifier 4
Imaging studies: Radiographs, bone scan, MRI	Imaging findings do not support symptoms or structural diagnosis within normal limits or normal age-related changes or clinically insignificant degenerative changes, or findings on the side opposite clinical presentation		CT/MRI/other imaging findings consistent with clinical presentation, including evidence of AOMSI with segmental instability, fusion, or motion preservation device defined by region (see row below)		Imaging evidence of major surgical complications, including infection or major deformity
Electrodiagnostic testing	Normal		EMG evidence consistent with single nerve root radiculopathy		EMG evidence consistent with multiple nerve root radiculopathy

Note: CT indicates computed tomography; MRI, magnetic resonance imaging; AOMSI, alteration of motion segment integrity; and EMG, electromyographic.

2008 for 17v03 Cervical

17v03 Cervical

Net Adjustment

Must return to

DBI Table but grade B is 10% not default of 11%

Class 2 Example Calculation			
CDX	GMFH	GMPE	GMCS
2	1	2	2

Net adjustment

(GMFH − CDX) (1 − 2) = −1
+ (GMPE − CDX) (2 − 2) = 0
+ (GMCS − CDX) (2 − 2) = 0
Net adjustment = −1

Result is class 2 with an adjustment −1; therefore this impairment is class 2, grade B, which equals 11% impairment

Note: CDX indicates class of diagnosis; GMFH, grade modifier for Functional History; GMPE, grade modifier for Physical Examination; and GMCS, grade modifier for Clinical Studies.

2008 for 17v03 Cervical

Net Adjustment of -1 for grade B for 10%

TABLE 17-2 Cervical Spine Regional Grid: Spine Impairments

Cervical Spine Regional Grid

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (WPI %)	0	1%–8%	9%–14%	15%–24%	25%–30%
MOTION SEGMENT LESIONS					
Intervertebral disc herniation and/or AOMSI[a] *Note:* AOMSI includes instability (specifically as defined in the *Guides*), arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those in multiple-level conditions	0 Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms	4 5 6 7 8 Intervertebral disk herniation(s) or documented AOMSI at a single level or multiple levels with medically documented findings; with or without surgery *and* for disk herniation(s) with documented resolved radiculopathy or nonverifiable radicular complaints at the clinically appropriate level(s) present at the time of examination[b]	9 10 11 12 14 Intervertebral disk herniation and/or AOMSI at a single level with medically documented findings; with or without surgery *and* with documented residual radiculopathy at the clinically appropriate level present at the time of examination (*see Table 17-7 to grade radiculopathy*)	15 17 19 21 23 Intervertebral disk herniations or AOMSI at multiple levels, with medically documented findings; with or without surgery *and* with documented signs of residual radiculopathy at a single clinically appropriate level present at the time of examination (*see Table 17-7 to grade radiculopathy*)	25 27 28 29 30 Intervertebral disk herniation(s) or AOMSI, with medically documented findings; with or without surgery *and* with documented signs of residual bilateral or multiple-level radiculopathy at the clinically appropriate levels present at the time of examination (*see Table 17-7 to grade radiculopathy*)

2025 for 17v03 Cervical

17v03 Intervertebral Disk Herniation or AOMSI at a Single Level (Cervical)

- Same Clinical Information as 2008
- 2025 Confirm Dx at MMI, appropriate DBI Table
- Apply specific individual elements (SIEs) to the Diagnostic Row, identify impairment value
- Spine based on radiculopathy plus
- Report using diagnostic row number.

2008 for 17v03 Cervical

Specific Individual Elements (SIEs)

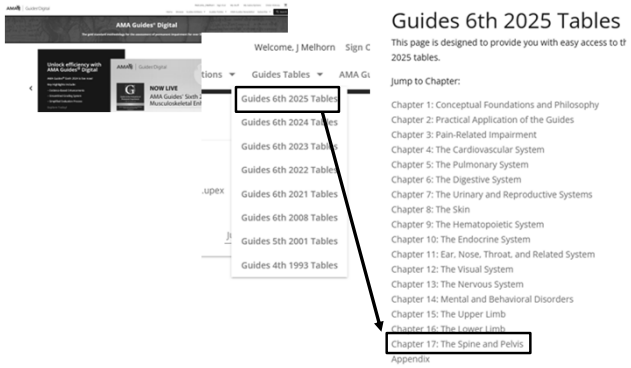
- CH: Resolution of neck pain and persistent pain in the left arm. Symptoms occur only with strenuous activity. The PDQ is 50 consistent with mild disability.
- PE:
- Sensory = Slightly decreased range of motion of the cervical spine and slight weakness of wrist extensors on the left, diminished light touch in C6 distribution = sensory deficit loss of sharp vs dull perception
- Neural tension sign = negative
- Motor = 5/5
- Atrophy = none
- DTR = reflex intact

2008 for 17v03 Cervical

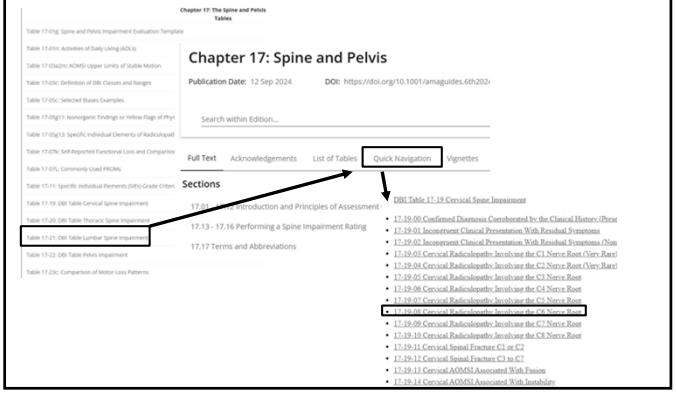
Specific Individual Elements (SIEs)

- CS: Preoperative MRI showed a disk herniation at C5-6, left. Postoperative films show a healed anterior interbody fusion at C5-6.
- DX: Status post herniated nucleus pulposus and anterior cervical diskectomy and fusion at C5-6 with persistent left arm pain.
- 2025 DX: 17-19-08 Cervical Radiculopathy Involving the C6 Nerve Root and one level fusion 17-19-13 Cervical AOMSI Associated With Fusion

2025 for 17v03 Cervical



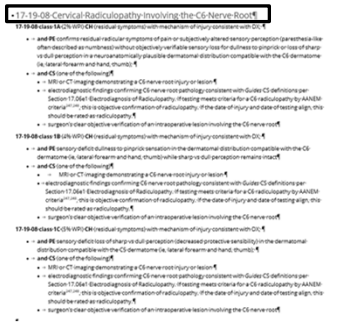
2025 for 17v03 Cervical



2025 for 17v03 Cervical

Match SIEs for CH, PE, CS

You are in the correct table



2025 for 17v03 Cervical

17-19-08 Cervical Radiculopathy Involving the C6 Nerve Root

17-19-08 class 1C (5%-WPI) **CH** (residual symptoms) with mechanism of injury consistent with DX;

- → **and PE** sensory deficit loss of sharp vs dull perception (decreased protective sensibility) in the dermatomal distribution compatible with the C5 dermatome (ie, lateral forearm and hand, thumb);
- → **and CS** (one of the following)
  - → MRI or CT imaging demonstrating a C6 nerve root injury or lesion
  - → electrodiagnostic findings confirming C6 nerve root pathology consistent with *Guides* CS definitions per Section 17.06e1 Electrodiagnosis of Radiculopathy
  - → surgeon's clear objective verification of an intraoperative lesion involving the C6 nerve root

Excerpt from DBI Table 17-19 Cervical Spine Impairment.

2025 for 17v03 Cervical

Summary of Possible Impairment Combinations for Cervical Spine Based on the SIEs in DBI Table 17-19 Cervical Spine Impairment

17-19b01. Cervical Radiculopathy is only rated in Chapter 17.

17-19b02. Cervical spinal fracture is only rated in Chapter 17.

17-19b03. Cervical AOMSI is only rated in Chapter 17.

17-19b04. Cervical myelopathy is only rated in Chapter 13.

17-19b05. Cervical radiculopathy, when combined with either spinal fractures or AOMSI (but not both), is rated in Chapter 17.

17-19b06. Cervical radiculopathy (Chapter 17) may be combined with myelopathy (Chapter 13).

17-19b07. Cervical myelopathy (Chapter 13), when combined with either a spinal fracture or AOMSI (but not both), is rated in Chapter 17.

17-19b08. Cervical radiculopathy, when combined with either spinal fractures or AOMSI (but not both) (Chapter 17), may also be combined with myelopathy (Chapter 13).

17-19b09. Brachial plexus injuries are rated in DBI Table 15-23j Brachial Plexus Impairment upper limb. They may be combined with either spinal fracture or cervical AOMSI (but not both) (Chapter 17), if not duplicative.

17-19b10. Additional Instructions

17-19b11. FECA Converting a Spine Impairment Rating to an Extremity Impairment That Includes T1

2025 for 17v03 Cervical

- SIEs provide for two diagnoses which are combined

DBI Table 17-19 Cervical Spine Impairment

- 17-19-00 Confirmed Diagnosis Corroborated by the Clinical History (Prese
- 17-19-01 Incongruent Clinical Presentation With Residual Symptoms
- 17-19-02 Incongruent Clinical Presentation With Residual Symptoms (Non
- 17-19-03 Cervical Radiculopathy Involving the C1 Nerve Root (Very Rare)
- 17-19-04 Cervical Radiculopathy Involving the C2 Nerve Root (Very Rare)
- 17-19-05 Cervical Radiculopathy Involving the C3 Nerve Root
- 17-19-06 Cervical Radiculopathy Involving the C4 Nerve Root
- 17-19-07 Cervical Radiculopathy Involving the C5 Nerve Root
- 17-19-08 Cervical Radiculopathy Involving the C6 Nerve Root
- 17-19-09 Cervical Radiculopathy Involving the C7 Nerve Root
- 17-19-10 Cervical Radiculopathy Involving the C8 Nerve Root
- 17-19-11 Cervical Spinal Fracture C1 or C2
- 17-19-12 Cervical Spinal Fracture C3 to C7
- 17-19-13 Cervical AOMSI Associated With Fusion
- 17-19-14 Cervical AOMSI Associated With Instability

DBI Table 17-19 Cervical Spine Impairment

- 17-19-00 Confirmed Diagnosis Corroborated by the Clinical History (Prese
- 17-19-01 Incongruent Clinical Presentation With Residual Symptoms
- 17-19-02 Incongruent Clinical Presentation With Residual Symptoms (Non
- 17-19-03 Cervical Radiculopathy Involving the C1 Nerve Root (Very Rare
- 17-19-04 Cervical Radiculopathy Involving the C2 Nerve Root (Very Rare
- 17-19-05 Cervical Radiculopathy Involving the C3 Nerve Root
- 17-19-06 Cervical Radiculopathy Involving the C4 Nerve Root
- 17-19-07 Cervical Radiculopathy Involving the C5 Nerve Root
- 17-19-08 Cervical Radiculopathy Involving the C6 Nerve Root
- 17-19-09 Cervical Radiculopathy Involving the C7 Nerve Root
- 17-19-10 Cervical Radiculopathy Involving the C8 Nerve Root
- 17-19-11 Cervical Spinal Fracture C1 or C2
- 17-19-12 Cervical Spinal Fracture C3 to C7
- 17-19-13 Cervical AOMSI Associated With Fusion
- 17-19-14 Cervical AOMSI Associated With Instability

2025 for 17v03 Cervical

Match SIEs for CH, PE, CS

You are in the correct table

- 17-19-13·Cervical·AOMSI·Associated·With·Fusion¶

17-19-13·class·1A·(5%·WPI)·**CH**·(residual·symptoms)·with·mechanism·of·injury·and·physical·examination·consistent·with·DX;¶

- → **and·PE**·consistent·with·DX;¶
- → **and·CS**·imaging·or·findings·at·surgery·consistent·with·DX·of·single·level·cervical·fusion¶

2025 for 17v03 Cervical

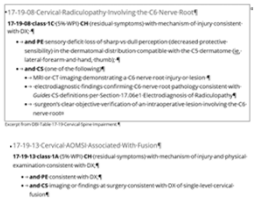
- 17-19-13·Cervical·AOMSI·Associated·With·Fusion¶

17-19-13·class·1A·(5%·WPI)·**CH**·(residual·symptoms)·with·mechanism·of·injury·and·physical·examination·consistent·with·DX;¶

- → **and·PE**·consistent·with·DX;¶
- → **and·CS**·imaging·or·findings·at·surgery·consistent·with·DX·of·single·level·cervical·fusion¶

2025 for 17v03 Cervical

Radiculopathy is the Key to understand functional loss in the spine



- 17-19-08·Cervical·Radiculopathy·Involving·the·C6·Nerve·Root¶

17-19-08·class·1C·(5%·WPI)·**CH**·(residual·symptoms)·with·mechanism·of·injury·consistent·with·DX;¶

- → **and·PE**·sensory·deficit·loss·of·sharp·vs·dull·perception·(decreased·protective·sensibility)·in·the·dermatomal·distribution·compatible·with·the·C5·dermatome·(ie,·lateral·forearm·and·hand,·thumb);¶
- → **and·CS**·(one·of·the·following:¶
  - → MRI·or·CT·imaging·demonstrating·a·C6·nerve·root·injury·or·lesion·¶
  - → electrodiagnostic·findings·confirming·C6·nerve·root·pathology·consistent·with·Guides·CS·definitions·per·Section·17.06e1·Electrodiagnosis·of·Radiculopathy;¶
  - → surgeon's·clear·objective·verification·of·an·intraoperative·lesion·involving·the·C6·nerve·root¶

Excerpt from DBI Table 17-19 Cervical Spine Impairment ¶

- 17-19-13·Cervical·AOMSI·Associated·With·Fusion¶

17-19-13·class·1A·(5%·WPI)·**CH**·(residual·symptoms)·with·mechanism·of·injury·and·physical·examination·consistent·with·DX;¶

- → **and·PE**·consistent·with·DX;¶
- → **and·CS**·imaging·or·findings·at·surgery·consistent·with·DX·of·single·level·cervical·fusion¶

Radiculopathy can be combined with other SIEs to reflect the total functional loss

2025 for 17v03 Cervical

- 2008 for 10% WPI
- 2025 for 10% WPI based on SIEs that can be easily
- Although individual vignettes may be higher or lower for 2025 a study found that the composite total average was unchanged for the spine chapter.

2025 for 17v03 Cervical

Step 5 Example Report:

A 35-year-old woman had an onset of neck pain and left arm pain after repetitive lifting of boxes while stocking shelves at work which has been accepted as a work compensable injury. She was treated with epidural injections and physical therapy. Ultimately, she underwent an anterior cervical fusion with resolution of neck pain and persistent pain in the left arm with strenuous activity.

2025 for 17v03 Cervical

The physical examination has slightly decreased range of motion of the cervical spine and slight weakness of wrist extensors on the left with diminished light touch (loss of sharp vs dull) in C6 distribution.

2025 for 17v03 Cervical

Preoperative MRI showed a disk herniation at C5-6, left. Postoperative films show a healed anterior interbody fusion at C5-6. The diagnosis is status post herniated nucleus pulposus and anterior cervical diskectomy and fusion at C5-6 with persistent left arm pain (C6 radiculopathy). At maximum medical improvement (MMI) and in accordance with the AMA Guides Sixth Edition 2025, the specific individual elements (SIEs) were matched to DBI Table 17-19 Cervical Spine Impairment, diagnostic row 17-19-06 class 1C for 5% WPI.

2025 for 17v03 Cervical

In addition, her single level cervical fusion is assessed using diagnostic row 17-19-13 class 1A for 5% WPI. As instructed the impairments are combined using the Table 17-16d Combined Values Chart, starting with the largest value first.

Combining the residual radiculopathy with the single level fusion (AOMSI).

The final impairment is 10% WPI.

Impairment without SIEs

- 2008 impairment requires MMI, DX, SIEs
- 2025 impairment requires DX, MMI, SIEs

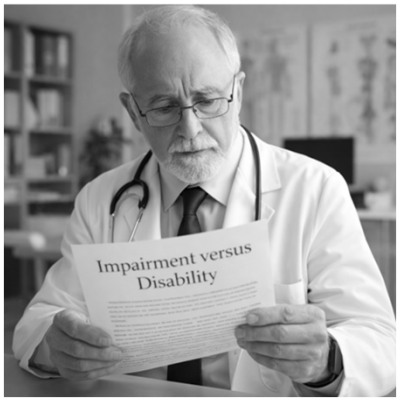
- Just like in 2008 the impairment is based on the PE and clinical studies
- In a chart review you may not have any or all the SIEs, the impairment is based on what you do have.

2025 Summary

- Confirm a clinically relevant diagnosis at MMI
- DBI Table = Diagnostic row based on Specific Individual Elements (SIEs) of the Clinical History, Physical Examination, and Relevant Clinical Studies
- Accuracy, consistency, reliability, and reproducibility
- Fair and Equitable Impairment Values

2025 Summary

AMA Guides 2008	AMA Guides 2025
Identify DBI Table	Identify DBI Table
Obtain data for functional history (FH), physical examination (PE), and clinical studies (CS)	Obtain data (specific individual elements) for clinical history (CH), physical examination (PE), and relevant clinical studies (CS)
Apply the data to grade modifier tables for FH, PE, CS	
Determine grade modifier value for FH, PE, CS	
Apply grade modifier value to the net adjustment formula	
Obtain the Net adjustment value	
Return to the original DBI Table, locate default impairment value for grade C	
Apply the net adjustment value to the final grade with the class	Apply the specific individual elements (SIEs) to the diagnostic row
Identify the impairment value based on the final grade	Identify the impairment value based on the correct diagnostic row



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Thank You

Feedback is encouraged

Additional presentations featuring more clinical impairment vignettes are available.

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