

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition in California Workers' Compensation: Legal and Practical Analysis

(PART-A INJURED WORKERS ANALYSIS)

February 25, 2026

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THE AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, FIFTH EDITION, IN CALIFORNIA WORKERS' COMPENSATION

The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Fifth Edition is the required medical reference that doctors in California must use to measure how much a work injury has permanently affected your body. Since 2005, California law has required this book as the starting point for calculating your permanent disability (PD) benefits — the money you receive when a workplace injury leaves you with lasting physical limitations. This report explains how the system works, how your rating is calculated, what your rights are, and how you can challenge a rating you believe is too low.

Important: A difference of just five to ten percent in your permanent disability rating can mean tens of thousands of dollars more or less in compensation. Understanding this process helps you protect your financial future. Employees First Labor Law — Permanent Disability Ratings (<https://employeesfirstlaborlaw.com/permanent-disability-ratings-in-california-workers-comp-how-they-work-and-what-theyre-worth/>)

Part 1: What Are the AMA Guides and Why Do They Matter to You?

Understanding the AMA Guides

The AMA Guides is a medical textbook published by the American Medical Association. Doctors use it to assign a percentage number — called a Whole Person Impairment (WPI) rating — to your injury. This percentage measures how much your injury reduces your ability to perform everyday activities like walking, lifting, sleeping, and caring for yourself. Invictus Law PC — AMA Guides in Workers' Compensation (<https://www.invictuslawpc.com/resources/ama-guides-in-workers-compensation/>)

California law requires doctors to use the Fifth Edition of the AMA Guides, published in 2001. The state adopted this edition in 2005 as part of a major workers' compensation reform. Cal. Code Regs. tit. 8, § 9805 (<https://www.dir.ca.gov/t8/9805.html>)

How the Guides Measure Your Impairment

The Guides focus on Activities of Daily Living (ADLs) — the basic tasks you do every day. Your doctor must document how your injury affects these activities:

- Self-care: Bathing, dressing, eating, using the restroom
- Physical activity: Sitting, standing, walking, climbing stairs
- Hand activities: Grasping, lifting, carrying objects
- Communication: Writing, typing, speaking
- Sensory function: Seeing, hearing, feeling
- Sleep: Ability to get restful sleep
- Travel: Driving, using public transportation
- Sexual function: Ability to engage in intimate activity

Your doctor examines you, reviews your medical records and test results, and then uses tables in the AMA Guides to assign a WPI percentage. Employees First Labor Law — Whole Person Impairment (<https://employeesfirstlaborlaw.com/whole-person-impairment-wpi-california-workers-comp-2025/>)

Impairment vs. Disability: An Important Difference

The AMA Guides measure impairment — how your injury affects your body's function. Disability is a broader concept that also considers your age, your job, and how the injury affects your ability to earn a living. California's system converts your impairment rating into a disability rating using additional adjustments. The same impairment percentage can produce different disability ratings depending on whether you are a young construction worker or an older office worker. Employees First Labor Law — PDRS (<https://employeesfirstlaborlaw.com/permanent-disability-rating-schedule-pdrs-workers-comp/>)

Part 2: California's Legal Framework for Permanent Disability Ratings

The Law That Requires the AMA Guides

California Labor Code § 4660 is the main law governing permanent disability ratings. It requires that your rating account for the nature of your injury, your occupation, and your age at the time of injury. Cal. Lab. Code § 4660

(https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.&lawCode=LAB)

Specifically, Cal. Lab. Code § 4660(b)(1)

(https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.&lawCode=LAB)

requires that permanent disability ratings be based on the Permanent Disability Rating Schedule (PDRS), which must use "consensus-based, objective criteria." The regulation at Cal. Code Regs. tit. 8, § 9805 (<https://www.dir.ca.gov/t8/9805.html>) formally adopts the AMA Guides Fifth Edition into that schedule.

Three Rating Schedules Based on Your Injury Date

California uses different rating rules depending on when your injury occurred:

- Before January 1, 2005: The 1997 PDRS (<https://www.dir.ca.gov/dwc/pdr1997.pdf>) applies. This older schedule allowed doctors and judges more flexibility in rating disabilities.
- January 1, 2005, through December 31, 2012: The 2005 PDRS (<https://www.dir.ca.gov/dwc/pdr.pdf>) applies. This schedule introduced the AMA Guides Fifth Edition and included a Diminished Future Earning Capacity (DFEC) adjustment — an extra factor measuring how much your injury would reduce your future income.
- January 1, 2013, and later: The current PDRS applies. It still uses the AMA Guides Fifth Edition but removes the DFEC adjustment and uses a simpler formula with a 1.4 multiplication factor.

Important: You must know the date of your injury because it determines which set of rules applies to your case. Using the wrong schedule can result in an incorrect rating.

Automatic 100% Disability for Certain Injuries

California Labor Code § 4662 creates a rule that certain devastating injuries automatically qualify as 100 percent Permanent Total Disability (PTD). You do not need the AMA Guides to prove total disability if you have:

- Total blindness in both eyes
- Loss of both hands or both feet
- Paralysis of both legs
- Loss of both arms
- Loss of one arm and one leg

This law acts as a safety net so that the AMA Guides cannot produce an unfairly low rating for workers with catastrophic injuries. Invictus Law PC — AMA Guides in Workers' Compensation (<https://www.invictuslawpc.com/resources/ama-guides-in-workers-compensation/>)

Part 3: How Your Whole Person Impairment (WPI) Rating Is Calculated

Step 1: Reaching Maximum Medical Improvement

Before you can receive a permanent disability rating, your doctor must determine that you have reached Maximum Medical Improvement (MMI), also called Permanent and Stationary (P&S) in California. This means your condition has stabilized and is not expected to improve significantly with further treatment. Employees First Labor Law — P&S vs. MMI (<https://employeesfirstlaborlaw.com/permanent-and-stationary-ps-vs-maximum-medical-improvement-mmi/>)

Once you reach MMI, your doctor (or a medical evaluator) performs a detailed examination and writes a report that includes your medical history, current symptoms, test results, functional limitations, and a WPI percentage.

Critical: The quality of this medical report directly affects your lifelong benefits. Make sure your doctor documents all of your limitations in detail.

Step 2: The Doctor Assigns a WPI Percentage

Your doctor uses the AMA Guides to rate each injured body part. The method depends on the type of injury:

- Spine injuries: The Guides offer two methods. The Diagnosis-Related Estimates (DRE) method rates you based on your diagnosis and nerve damage. The Range of Motion (ROM) method measures how much spinal movement you have lost. If both methods apply, the doctor should use whichever produces a more accurate result.
- Upper extremity injuries (shoulder, arm, hand): The doctor measures your range of motion, grip strength (using a device called a Jamar dynamometer), pinch strength, and sensory loss. The Guides provide tables to convert these measurements into percentages.
- Lower extremity injuries (hip, knee, ankle, foot): Similar measurements assess range of motion, strength, sensory loss, and walking ability.
- Psychiatric injuries: California law under Cal. Lab. Code § 4660.1(c)(1) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4660.1.&lawCode=LAB) restricts when you can receive a disability rating for psychological conditions caused by a physical injury. Exceptions exist if your physical injury is catastrophic or if you were a victim of or witness to a violent crime at work. When psychiatric injury is ratable, doctors use the Global Assessment of Functioning (GAF) scale to assign a score that converts to a WPI percentage. Work Injury Help — GAF Score Guide (<https://www.workinjuryhelp.com/gaf-score-meaning-what-you-need-to-know/>)

Step 3: Combining Multiple Injuries

If you injured more than one body part, each injury is rated separately and then combined using the Combined Values Chart (CVC). The CVC is a mathematical table that prevents "double-counting" when two injuries affect the same daily activities. Employees First Labor Law — Whole Person Impairment (<https://employeesfirstlaborlaw.com/whole-person-impairment-wpi-california-workers-comp-2025/>)

The 2005 PDRS (<https://www.dir.ca.gov/dwc/pdr.pdf>) also specifies conversion factors for certain body parts. For example, lumbar spine impairments are multiplied by 90%, thoracic spine by 40%, and cervical spine by 80% to convert to the whole person scale.

Note: The CVC typically produces a combined number that is lower than simply adding your individual ratings together. However, as explained in Part 6, you may be able to challenge this reduction in certain situations.

Part 4: From WPI to Your Final Permanent Disability Rating

Occupational Adjustment

After your WPI is calculated, it is adjusted based on how physically demanding your job was at the time of injury. The PDRS divides occupations into groups labeled A through J. Group A represents sedentary desk jobs. Group J represents heavy physical labor such as construction or warehouse work. Employees First Labor Law — PDRS (<https://employeesfirstlaborlaw.com/permanent-disability-rating-schedule-pdrs-workers-comp/>)

If you performed heavy labor, your rating is adjusted upward because the same injury makes it harder for you to return to physically demanding work. If you had a desk job, the adjustment may be lower. 1997 PDRS — Occupational Variant Tables (<https://www.dir.ca.gov/dwc/pdr1997.pdf>)

Age Adjustment

Your rating is also adjusted for your age at the time of injury. The PDRS uses age 39 as the baseline. If you were younger than 39, your rating is adjusted upward because you have more working years ahead that the injury will affect. If you were older than 39, your rating may be adjusted slightly downward. Employees First Labor Law — Permanent Disability Ratings (<https://employeesfirstlaborlaw.com/permanent-disability-ratings-in-california-workers-comp-how-they-work-and-what-theyre-worth/>)

The 1.4 Adjustment Factor

For injuries on or after January 1, 2013, your adjusted rating is multiplied by 1.4 to produce your final permanent disability percentage. This factor was introduced to maintain adequate compensation levels after the DFEC adjustment was removed. Employees First Labor Law — PDRS (<https://employeesfirstlaborlaw.com/permanent-disability-rating-schedule-pdrs-workers-comp/>)

A Real-World Example

Here is how the full calculation works for a 45-year-old maintenance worker injured on January 15, 2018, with a lumbar spine injury:

1. WPI Rating: The doctor uses the ROM method and assigns 12% WPI
2. Occupational Adjustment: As a maintenance worker (category I — heavy labor), the rating adjusts to 14%
3. Age Adjustment: At age 45 (above the baseline of 39), the rating adjusts to approximately 13%
4. Apportionment: The insurance company proves 10% of the disability is from pre-existing degeneration. The industrial portion is 90% of 13% = approximately 12%
5. Final Adjustment Factor: $12\% \times 1.4 =$ approximately 17% final permanent disability
6. Compensation: At an average weekly wage of \$800, a 17% rating typically produces benefits in the range of \$20,000 to \$35,000

Part 5: Medical Evaluators — QMEs and AMEs

What Is a QME?

A Qualified Medical Evaluator (QME) is a doctor certified by the California Division of Workers' Compensation (DWC) to resolve medical disputes in workers' compensation cases. If you and the insurance company disagree about your impairment rating, either side can request a QME evaluation. Employees First Labor Law — QME vs. AME (<https://employeesfirstlaborlaw.com/qme-vs-ame-in-california-workers-comp-whats-the-difference/>)

The DWC provides a panel of three QMEs, and you (or your attorney) select one from the panel. The QME performs a full examination and writes a detailed report that becomes key evidence in your case.

What Is an AME?

An Agreed Medical Evaluator (AME) is a doctor that both you and the insurance company agree to use. AMEs are only available when both sides have attorneys. Because both parties chose the AME, judges typically give the AME's opinion strong weight. Employees First Labor Law — QME vs. AME (<https://employeesfirstlaborlaw.com/qme-vs-ame-in-california-workers-comp-whats-the-difference/>)

What Makes a Valid Medical Report?

Under Cal. Code Regs. tit. 8, § 10606 (<https://www.dir.ca.gov/t8/10606.html>), a medical report used for permanent disability must include:

- Your full medical history
- All diagnostic test results (X-rays, MRIs, lab work)
- Physical examination findings
- Specific functional limitations with measurements
- A clear diagnosis
- Discussion of what caused your condition
- Apportionment analysis (explained in Part 7)
- The WPI rating with a full explanation of how it was calculated

Important: If a medical report is missing any of these elements, you can challenge it as incomplete. A judge may order a new report or accept different medical evidence.

Part 6: Challenging an Unfair Rating — The Almaraz-Guzman Framework

Why the AMA Guides Sometimes Produce Unfair Ratings

The AMA Guides were designed to measure medical impairment, not to determine workers' compensation benefits. Several problems can occur with strict application of the Guides: Invictus Law PC — AMA Guides in Workers' Compensation (<https://www.invictuslawpc.com/resources/ama-guides-in-workers-compensation/>)

- Chronic pain is often undervalued because the Guides require objective findings (like nerve damage visible on an MRI), but many real and disabling pain conditions do not show up on tests
- Psychological injuries such as depression, anxiety, and PTSD are restricted by statute from being rated in most cases
- Rare conditions may not be specifically listed in the Guides
- Individual differences may not be captured by the Guides' standardized tables

Your Right to Challenge: The Almaraz and Guzman Decisions

The California Workers' Compensation Appeals Board (WCAB) issued landmark decisions in *Almaraz v. WCAB* and *Guzman v. WCAB* (WCAB En Banc, Sept. 2009) (https://www.dir.ca.gov/wcab/EnBancdecisions2009/WCABEnBancAlmarazMGuzmanJ_Sep2009.pdf) that protect injured workers from unfair ratings. These decisions established that:

- The AMA Guides ratings are prima facie evidence (meaning they are presumed correct but can be challenged)
- You can rebut (challenge and overcome) an AMA Guides rating by showing it does not fairly or accurately measure your actual permanent disability
- A doctor may use alternative methods within the AMA Guides to produce a more accurate rating
- The rebuttal must stay within the "four corners" of the Guides — meaning the doctor must use a different method from the same book, not invent a rating from outside the Guides

How Rebuttal Works in Practice

If your doctor rates your lumbar spine at 10% WPI using the DRE method, but another doctor demonstrates that the ROM method (also in the AMA Guides) would produce a 15% WPI that more accurately reflects your lost range of motion, you can present the 15% rating as a rebuttal. The workers' compensation judge then decides which method is more accurate for your specific condition.

This framework is especially important for chronic pain cases. A doctor can argue that a pain-specific rating table within the Guides better captures your impairment than a standard diagnosis-based rating.

Challenging the Combined Values Chart

You can also challenge how multiple injuries are combined. In the WCAB en banc decision in *Vigil v. County of Kern* and earlier appellate cases including *Athens v. WCAB* (Kite), the Board recognized two ways to rebut the CVC: *Bradford & Barthel* — En Banc Decision Clarifies Kite Rebuttals (<https://bradfordbarthel.com/2024/06/13/en-banc-decision-clarifies-kite-rebuttals/>)

- No overlap: Your injuries affect completely different daily activities with no interaction, so reducing the combined rating is unfair
- Synergistic effect: Your injuries together create greater functional loss than either one alone, so the CVC reduction underestimates your actual disability

Important: These challenges require detailed medical evidence. Your doctor must explain specifically which daily activities each injury affects and why the standard combination formula does not work for your situation.

Part 7: Apportionment — When Pre-Existing Conditions Affect Your Rating

What Is Apportionment?

Apportionment is the process of dividing your permanent disability between the work injury and other causes such as aging, prior injuries, or pre-existing medical conditions. Under Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB), your doctor must determine what percentage of your disability was caused by the work injury versus other factors.

The insurance company has the burden of proof — meaning it must present medical evidence to justify any apportionment. You are not required to prove that your entire disability is work-related; the insurer must prove what portion is not.

Rules That Protect You

- A doctor cannot apportion your disability simply because an MRI shows age-related wear and tear. The doctor must explain specifically how that pre-existing condition contributes to your current functional limitations.
- If you had no symptoms, no treatment, and no work restrictions before the injury, apportionment to pre-existing degeneration is much harder for the insurance company to prove.
- The Hikida Doctrine: If you had surgery or other medical treatment for your work injury and the treatment failed or caused complications, the resulting disability cannot be apportioned away. The treatment was necessary because of the work injury, so any complications remain the responsibility of the workers' compensation system.

How to Fight Unfair Apportionment

- Gather evidence of your pre-injury health: work attendance records, performance reviews, and any medical records showing you were healthy before the injury
- Ask your doctor to explain specifically how the pre-existing condition does or does not contribute to your current limitations
- Challenge vague or unsupported apportionment opinions that fail to explain the "how and why"

Part 8: Functional Capacity Evaluations (FCEs)

What Is an FCE?

A Functional Capacity Evaluation (FCE) is a series of physical tests conducted by a physical therapist or occupational therapist to measure what you can and cannot do physically. These tests typically include lifting, carrying, pushing, pulling, bending, and job-specific tasks. Visionary Law Group — Functional Capacity Evaluation (<https://visionarylawgroup.com/functional-capacity-evaluation-workers-comp/>)

FCEs are usually performed near the time you reach MMI. The results give your doctor objective data to support your impairment rating.

How FCE Results Affect Your Rating

If an FCE shows you can only lift 15 pounds when you could lift 50 pounds before your injury, your doctor may use this 70% loss of lifting capacity to support a higher WPI rating. However, the FCE does not automatically determine your rating — your doctor must interpret the results within the AMA Guides framework.

Validity Concerns

FCEs include tests for whether you gave your full effort. If the evaluator notes inconsistencies — such as grip strength measurements that vary widely between attempts — the insurance company may argue you did not try your hardest. This can reduce the credibility of the entire evaluation.

Note: Be honest during your FCE. Do your best on each task, but do not push through severe pain in a way that could injure you further. Consistent, honest effort produces the most credible results.

Part 9: Your Benefits, Settlements, and Compensation

Types of Permanent Disability Benefits

Permanent Partial Disability (PPD) applies if your rating is between 1% and 99%. You receive biweekly payments for a set number of weeks determined by your disability percentage and weekly wages. DWC — Permanent Disability Benefits (<https://www.dir.ca.gov/dwc/permanentdisability.htm>)

Permanent Total Disability (PTD) applies if your rating is 100%. You receive lifetime wage replacement payments and ongoing medical care. Invictus Law PC — AMA Guides in Workers' Compensation (<https://www.invictuslawpc.com/resources/ama-guides-in-workers-compensation/>)

Settlement Options

You have two main settlement options:

- **Compromise and Release (C&R):** A lump-sum payment that closes your case, including future medical care. You receive one large payment but give up the right to future workers' compensation medical treatment for that injury.
- **Stipulated Award:** You agree on a disability rating and receive periodic payments, but you keep the right to future medical care through workers' compensation.

Supplemental Job Displacement Benefits (SJDB)

If you cannot return to your old job because of your injury and your employer cannot offer you modified or alternative work paying at least 85% of your pre-injury wages, you may qualify for a \$6,000 voucher to pay for job retraining, vocational counseling, licensing fees, or job search services. Personal Injury Law San Diego — SJDB (<https://www.personalinjurylawsandiego.com/workers-compensation/supplemental-job-displacement-benefits-sjdb/>)

Typical Settlement Ranges

Settlement amounts vary based on your specific rating, wages, and injury, but general averages include: Scheran & Bassett — Workers' Comp Body Part Values (<https://scherandbassett.com/workers-comp-body-part-values-in-california-breakdown/>)

- Spine and central nervous system: \$50,000 to \$150,000 for moderate ratings
- Knee injuries: approximately \$25,000
- Neck, arm, and lower back: \$35,000 to \$60,000
- Multiple body parts: approximately \$63,000 or more
- Hip, thigh, and pelvis: approximately \$60,000

Important: These are general averages only. Your actual settlement depends on your specific disability rating, wages, future medical needs, and the strength of your evidence.

Part 10: Practical Steps to Protect Your Rights

Getting an Accurate Initial Rating

- **Choose a knowledgeable doctor:** Find a treating physician who understands the AMA Guides Fifth Edition and documents your limitations thoroughly
- **Describe your limitations clearly:** Tell your doctor exactly how your injury affects your daily life — trouble sleeping, difficulty lifting your children, inability to sit for long periods, problems with concentration
- **Complete all recommended tests:** Make sure all imaging (MRIs, X-rays), lab work, and specialist referrals are finished before your P&S evaluation
- **Prepare for QME or AME evaluations:** Bring all medical records, be honest about your symptoms, and avoid both exaggerating and minimizing your limitations

Challenging an Inadequate Rating

1. Request a complete written explanation of how the doctor calculated your WPI, which AMA Guides method was used, and the reasoning for any apportionment
2. Get a second medical opinion from a doctor who can evaluate whether an alternative AMA Guides method would produce a more accurate rating
3. Request a QME panel evaluation (if unrepresented) or negotiate for an AME (if you have an attorney)
4. Preserve your Almaraz-Guzman rebuttal arguments with detailed medical evidence for potential appeal

Fighting Apportionment

- Challenge any apportionment opinion that does not specifically explain how a pre-existing condition contributes to your current functional limitations
- Present evidence of your ability to work without restrictions before the injury
- Remind doctors and judges that the presence of degeneration on imaging does not automatically mean it caused your disability

Part 11: Current Legal Developments

The AMA Guides Sixth Edition

The AMA has been releasing updated chapters for the Sixth Edition of the Guides, covering areas such as the spine, upper and lower limbs, and the nervous system. However, California law still requires the Fifth Edition. A change to the Sixth Edition would require a formal regulatory update. *AMA — Guides Overview* (<https://www.ama-assn.org/practice-management/ama-guides/ama-guides-evaluation-permanent-impairment-overview>)

Evolving Case Law

Courts continue to refine the rules established by Almaraz-Guzman and Vigil. Recent decisions have clarified when and how you can rebut AMA Guides ratings, what level of medical detail is required, and how much weight judges should give to clinical judgment versus strict Guides methodology.

Note: Workers' compensation law changes over time. Stay informed about new WCAB decisions and legislative proposals that may affect your rating or benefits. An experienced attorney can help you understand how recent changes apply to your case.

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The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition in California Workers' Compensation: Legal and Practical Analysis

(PART-B LEGAL ANALYSIS)

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The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition in California Workers' Compensation: Comprehensive Legal and Practical Analysis

Executive Summary

The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Fifth Edition, serves as the mandatory medical-legal foundation for determining permanent disability compensation in California workers' compensation claims.[6] Since California's adoption of this standardized impairment rating system in 2005, the Guides have fundamentally transformed how injured workers receive benefits—converting complex medical conditions into percentage ratings that directly determine compensation amounts, benefits duration, and vocational retraining eligibility.[1][6] However, this system has also become the subject of significant legal controversy, with California courts recognizing that rigid application of the AMA Guides can produce ratings that do not fairly or accurately reflect an injured worker's true functional limitations.

For injured workers in California, the practical implications are substantial: a five to ten percent difference in a permanent disability rating can translate into tens of thousands of dollars in lost compensation.[1] The calculation process requires precise understanding of multiple components—whole person impairment (WPI) determination, age and occupational adjustments, apportionment of pre-existing conditions, and the application of the Combined Values Chart for multiple injuries.[7][8] Medical evaluators (qualified medical evaluators, or QMEs, and agreed medical evaluators, or AMEs) bear significant responsibility for applying these guidelines accurately, yet many practitioners and injured workers report that the Guides undervalue subjective pain, psychological trauma, and chronic functional limitations that profoundly affect quality of life and earning capacity.[6]

Key Takeaways:

Risk Assessment: High risk that injured workers will receive undervalued ratings if their claims are not carefully managed through medical evidence development, appropriate medical evaluator selection, and—when necessary—legal challenges to AMA Guides applications under established California precedent allowing rebuttal of scheduled ratings.

Primary Strategic Options: Workers may pursue either initial medical evaluation with careful documentation of functional limitations to maximize the WPI rating on the front end, or alternatively, reserve arguments challenging the adequacy of AMA Guides ratings for appeal or judicial review if initial ratings prove inadequate to the actual injury's impact.

Timeline Considerations: The permanent disability rating process typically begins once a worker reaches Maximum Medical Improvement (MMI) or becomes "Permanent and Stationary" (P&S)—a critical juncture where the quality of medical reporting directly impacts lifelong benefits. Claims arising before January 1, 2005, are governed by the 1997 PDRS; claims from 2005 through December 31, 2012, apply the 2005 PDRS with the now-removed Diminished Future Earning Capacity (DFEC) adjustment; and claims from January 1, 2013, onward, apply the current streamlined version without DFEC but subject to strict AMA Guides application.[8]

Likelihood of Success in Securing Fair Compensation: Moderate confidence that workers with strong objective medical findings will receive appropriate initial ratings, but low to moderate confidence that subjective complaints (pain, fatigue, cognitive difficulties) will be adequately captured in standard AMA Guides methodology. Moderate to high confidence that competent legal representation identifying genuine flaws in impairment analysis can successfully challenge undervalued ratings through the appeals process or force settlement at higher values by highlighting record defects.

Legal Framework and Statutory Authority

California's Mandatory Adoption of the AMA Guides

California Labor Code Section 4660 establishes the legal foundation for permanent disability ratings and explicitly mandates the use of the AMA Guides for impairment assessment.[9] The statute provides that in determining the percentage of permanent disability, "account shall be taken of the nature of the physical injury or disfigurement, the occupation of the injured employee, and his age at the time of such injury." [3] Critically, Labor Code Section 4660(b)(1) requires that permanent disability determinations "shall incorporate by reference the permanent disability rating schedule, which shall be based on the recommendations of the

Administrative Director, adopted in accordance with the Administrative Procedure Act, utilizing consensus-based, objective criteria." [8]

The regulatory framework is codified in California Code of Regulations Title 8, Section 9805, which states that "the schedule adopts and incorporates the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment 5th Edition." [9] This regulatory incorporation means that physicians performing disability evaluations in California must use the methodology, tables, ratings, and diagnostic-related estimates contained within the Fifth Edition published by the AMA. [6]

The adoption of the Fifth Edition in 2005 represented a significant departure from California's prior system, which allowed greater medical and judicial discretion in rating permanent disabilities. [6] The 2004 Workers' Compensation Reform Act (SB 899) implemented this change, which legislative history shows was intended to create consistency and reduce compensation costs statewide. However, the tension between consistency and accuracy has generated substantial case law, particularly through the landmark decisions in *Almaraz v. WCAB* and *Guzman v. WCAB*, discussed below.

Regulatory Schedule Structure

The Permanent Disability Rating Schedule (PDRS) operates as a three-tiered system depending on the injury date. [8] For claims with dates of injury before January 1, 2005, the 1997 PDRS applies when a physician declared the worker permanent and stationary or when the employer provided the required notice. This older schedule contained less detailed AMA Guides integration and allowed broader medical judgment. [3][5]

For dates of injury between January 1, 2005, and December 31, 2012, the 2005 PDRS applies, which integrated the AMA Guides Fifth Edition and included a diminished future earning capacity (DFEC) adjustment factor. [8] This means that the physician would rate the impairment using AMA Guides tables, and that rating would then be adjusted by an occupational and age factor based on the worker's remaining earning capacity. [5][8]

For dates of injury on or after January 1, 2013, the current PDRS applies, which continues the AMA Guides Fifth Edition methodology but eliminates the DFEC adjustment. Under post-2013 ratings, the formula is more streamlined: (1) WPI is determined using AMA Guides; (2) the WPI is adjusted for occupation using occupational variant tables; (3) the result is adjusted for the worker's age using age adjustment tables; and (4) the final figure is multiplied by an adjustment factor of 1.4 for dates of injury on or after January 1, 2013. [8]

Labor Code Section 4662: Conclusive Presumptions for Total Disability

An important statutory exception exists under Labor Code Section 4662, which provides conclusive presumptions that certain catastrophic injuries result in 100 percent permanent total disability (PTD). [1] These include total blindness in both eyes, loss of both hands, loss of both feet, paralysis of both legs, loss of both arms, or loss of one arm and one leg. [1][6] This statute functions as a safety valve preventing the AMA Guides from producing absurdly low ratings for workers with devastating injuries. [6]

Key Definitions: Impairment vs. Disability

The California system maintains a critical distinction between impairment and disability. [7] Impairment, measured by the AMA Guides, refers to "a reduction in whole-person function" and reflects the medical severity of a condition and how it affects a person's ability to perform activities of daily living (ADLs)-excluding work. The AMA Guides explicitly state that their ratings measure impairment based on functional limitations in self-care, communication, physical activity, sensory function, hand activities, travel, sexual function, and sleep.

Disability, by contrast, refers to "an alteration of an individual's capacity to meet personal, social, or occupational demands because of an impairment." In California's workers' compensation system, the permanent disability rating translates the medical impairment into a compensation amount based on statutory formulas that also consider the worker's age, occupation, and future earning capacity (for pre-2013 claims). [1][7][8] Therefore, the same WPI percentage may result in different final PD ratings depending on whether the injured worker is a 25-year-old laborer versus a 58-year-old office worker.

The AMA Guides Fifth Edition: Philosophy, Purpose, and Application

Historical Context: Why California Adopted the AMA Guides

Before 2005, California used a 1997 Permanent Disability Rating Schedule that, while referencing AMA Guides concepts, allowed physicians and judges substantial discretion in applying impairment percentages and permitted consideration of subjective pain, functional limitations, and earning capacity loss in ways the current system restricts.[6] The 2004 Workers' Compensation Reform Act fundamentally altered this approach, mandating the use of AMA Guides Fifth Edition impairment percentages as the foundation for permanent disability ratings.[6]

This shift was driven by a legislative intent to reduce workers' compensation costs and increase predictability and uniformity.[6] However, critics argue-and California courts have increasingly acknowledged-that the AMA Guides were designed by medical specialists to measure functional impairment in activities of daily living, not to determine appropriate workers' compensation disability benefits or future earning capacity loss.[6] The Guides themselves explicitly state that impairment ratings "do not directly correspond to disability, work capacity, or the need for rehabilitation services."

Structure of the Fifth Edition

The Fifth Edition, published in 2001, provides detailed methodology for assessing permanent impairment across multiple body systems and organ functions. The Guides organize impairment ratings around several key principles:

Activities of Daily Living (ADLs) as the Benchmark: The Guides measure how an impairment reduces a person's ability to perform normal ADLs, including self-care and personal hygiene (urinating, defecating, brushing teeth, eating, bathing, dressing); communication (writing, typing, seeing, hearing, speaking); physical activity (sitting, standing, reclining, walking, climbing stairs); sensory function (hearing, seeing, taste, smell, touch); hand activities (grasping, lifting, tactile discrimination); travel and transportation; sexual function; and sleep. The evaluating physician must document how the injury affects each relevant ADL domain.

Clinical Judgment Within the Guides Framework: The Guides explicitly state that physicians should "select the clinically most appropriate (i.e., most specific) method(s)" for rating an impairment and that in some cases, "more than one method needs to be used to accurately assess all features of the impairment." This language has become critical in California appellate decisions recognizing that physicians may rebut inappropriate AMA Guides ratings by using alternative methods within the Guides' own framework.

Rating by Analogy for Conditions Not Specifically Listed: The Guides provide a framework for evaluating conditions not explicitly rated by comparing measurable impairment from unlisted conditions to similar conditions with similar ADL impact. This mechanism allows flexibility in rating novel or rare conditions while remaining theoretically grounded in the Guides' methodology.

Distinction Between Subjective and Objective Findings: The Guides acknowledge the existence and importance of subjective complaints (pain, fatigue, emotional distress) to the individual and their functional impact, but they historically have provided limited mechanisms for rating subjective conditions in the absence of objective clinical findings. This has generated substantial criticism and is discussed further below.

Whole Person Impairment (WPI) Calculation Process

Step 1: Medical Evaluation and MMI Determination

The permanent disability rating process begins when an injured worker reaches Maximum Medical Improvement (MMI), also called "Permanent and Stationary" (P&S) in California terminology. MMI is defined as the point at which the medical condition has stabilized, is unlikely to improve further with additional treatment, and has reached a state of maximum functional recovery. For many workers, MMI is reached when treating physicians declare the condition permanent and stationary in a medical report, typically a P&S report or PR-4 form.

The MMI determination is critical because it triggers the shift from temporary disability benefits to permanent disability compensation and initiates the impairment rating process. At this juncture, either the treating physician or a medical-legal evaluator (typically a QME or AME) must complete a comprehensive evaluation

that documents the nature of the injury, medical history, treatment course, current clinical status, diagnostic test results, functional limitations, and a WPI rating.

Step 2: WPI Rating Using AMA Guides Methodology

Once MMI is established, a licensed physician applies the AMA Guides Fifth Edition to assign a WPI percentage to each affected body part or system.[1][6][7] The physician conducts a detailed physical examination, reviews diagnostic imaging and laboratory results, assesses range of motion (ROM) and strength, evaluates neurological findings, and documents the extent to which the injury impairs the specific ADLs relevant to the affected body system.

For spinal impairments, the AMA Guides provide two primary rating methodologies: the Diagnosis-Related Estimates (DRE) approach and the Range of Motion (ROM) approach. The DRE method assigns ratings based on diagnostic findings and the presence of neurological deficits, categorizing conditions into Categories I through V with increasing severity. The ROM method measures loss of spinal motion and uses measurements to determine impairment. Under the AMA Guides, a physician may use either methodology or both, and if both methods produce different results, the higher rating should be selected if clinically justified.

For upper extremity impairments, the Guides provide detailed protocols for measuring range of motion losses, grip and pinch strength deficits, sensory loss, and functional limitations. Grip strength is measured using a Jamar dynamometer with three repetitions; measurements are considered valid if they do not vary more than 20 percent between trials. Pinch strength is similarly measured. The Guides provide tables correlating strength deficits to impairment percentages.

For lower extremity impairments, similar protocols assess range of motion, strength, sensory loss, and gait or station disorders. The Guides acknowledge that lower extremity impairments often affect the ability to ambulate, climb stairs, balance, and perform physical labor-ADLs with clear functional significance.

For psychiatric and psychological injuries, California law restricts PD ratings for such conditions. Under Labor Code Section 4660.1(c)(1), there is no increase in impairment rating for sleep dysfunction, sexual dysfunction, or compensable psychiatric disorder arising from a compensable physical injury. However, exceptions exist: psychiatric injuries are ratable if the physical injury is "catastrophic" (defined as resulting in permanent total disability, loss of use of two or more extremities, severe burn, severe head injury, or serious burn) or if the injured worker was the victim of or witness to a violent crime in the course of employment. When psychiatric injury is ratable, the evaluator uses the Global Assessment of Functioning (GAF) scale, which provides a numeric rating from 1 to 100 based on symptom severity and functional impairment, which is then converted to a WPI percentage using a conversion table.

Step 3: Converting Body-Part Impairments to Whole Person Impairment

When a worker has multiple injured body parts, each body-part impairment must be converted to the whole person scale and then combined using a mathematical formula to avoid "pyramiding" (double-counting overlap in functional limitations).[5][7] For example, a worker with both a lumbar spine impairment and a left knee impairment would have each rated separately using the AMA Guides, then combined using the Combined Values Chart (CVC), a table that mathematically reduces the combined rating to account for overlapping functional effects.[5][7]

The conversion formulas specified in the PDRS ensure that all impairments are expressed on the whole person scale before combination.[5] For spine impairments, the PDRS specifies conversion percentages: lumbar spine impairments are multiplied by 90 percent, thoracic spine by 40 percent, and cervical spine by 80 percent to derive whole person impairment. For extremity impairments, similar conversion factors apply.[5]

The Combined Values Chart reflects the principle that multiple impairments typically have overlapping effects on ADLs. A person with both a back impairment and a knee impairment, for example, will experience limitations on physical activity, travel, and other ADLs that are affected by both conditions; using simple addition would count this overlap twice. The CVC methodology acknowledges this through mathematical formulas that reduce the combined rating.[5] However, as discussed below, California law increasingly allows workers to rebut CVC applications by demonstrating non-overlapping effects or amplifying (synergistic) effects between multiple impairments.

Converting WPI Ratings to Final Permanent Disability Percentages

Step 4: Occupational Adjustment

Once the WPI is calculated, California law mandates adjustments based on the injured worker's occupation at the time of injury.[1][3][5][8] The PDRS specifies occupational variant groups-lettered A through J-reflecting the physical demands of different job categories.[3][5] Heavy labor occupations (variant J) receive higher occupational adjustments than sedentary work (variant A), reflecting the principle that the same functional impairment creates greater future earning capacity loss for a warehouse worker than for an office clerk.[1][3][5]

The occupational adjustment is applied through tables in the PDRS that show the adjusted rating for each standard WPI percentage across occupational variants.[5] For example, a 15 percent WPI for a worker in occupational category H (higher physical demands) might be adjusted upward to 17 percent, while the same 15 percent WPI for a category C worker (lower physical demands) might be adjusted to 14 percent.[5][8]

Step 5: Age Adjustment

After occupational adjustment, the rating is further adjusted based on the injured worker's age at the time of injury.[1][3][5][8] The PDRS provides age adjustment tables that reflect the principle that permanent impairments have greater impact on future earning capacity for younger workers with longer remaining work lives than for workers approaching retirement.[1][3][5][8]

Unlike occupational adjustments that may increase or decrease ratings depending on job demands, age adjustments consistently increase ratings for workers under age 39 (the theoretical "average" worker used as the baseline) and decrease ratings for workers age 40 and older.[5][8] For example, a 20-year-old worker with a 20 percent WPI rating adjusted for occupational category might receive a final age adjustment increasing the rating to 23 percent, while a 65-year-old worker with the same occupational-adjusted rating might see it reduced to 18 percent.[5]

Step 6: Apportionment of Pre-Existing Conditions

One of the most contentious aspects of California PD rating is apportionment-the process of allocating a portion of the worker's permanent disability to non-industrial (pre-existing) causes. Under Labor Code Section 4663, physicians must determine what percentage of the worker's permanent impairment was caused by the industrial injury versus other factors such as aging, prior injuries, degenerative conditions, or systemic diseases.

The burden of proving apportionment rests on the insurance carrier (defendant). To successfully establish apportionment, medical evidence must show: (1) a prior factor (documented medical history); (2) that the current permanent impairment is greater than it would have been from the prior factor alone; and (3) evidence indicating the prior factor caused or contributed to the impairment based on reasonable medical probability. A physician cannot simply apportion disability because degenerative changes appear on imaging; the physician must explain the functional "how and why" of how the pre-existing condition contributes to the current functional limitations.

For example, in a warehouse worker with both an acute herniated disc from a lifting injury and pre-existing degenerative disc disease visible on MRI, a qualified medical evaluator might apportion 70 percent of the permanent disability to the industrial injury and 30 percent to degenerative changes-but only if the QME provides a detailed explanation of how the underlying degenerative pathology contributed to functional limitations alongside the acute injury. This apportionment analysis affects only the permanent disability rating; it does not reduce the worker's right to medical treatment or temporary disability benefits, which remain fully payable regardless of apportionment.

One important limitation on apportionment exists under the Hikida principle: disability resulting from industrial medical treatment (including failed surgeries or their complications) generally cannot be apportioned away to non-industrial factors, as the treatment itself was necessitated by the industrial injury.

Step 7: Final Calculation and Adjustment Factor

For dates of injury before January 1, 2013, the final permanent disability rating is calculated by applying the adjustments for occupation, age, and (for 2005-2012 injuries) the diminished future earning capacity adjustment, then applying the statutory adjustment factor of 1.4.[5][8] For dates of injury on or after January

1, 2013, the calculation applies occupational and age adjustments, then multiplies by the 1.4 adjustment factor.[8]

The adjustment factor of 1.4 was introduced to ensure adequate compensation levels after the elimination of DFEC and other factors in the 2013 rule changes.[8] This multiplication factor is applied to the final adjusted rating to produce the ultimate permanent disability percentage.[8]

Practical Example of the Complete Calculation

To illustrate, consider a 45-year-old maintenance worker injured on January 15, 2018 (post-2013 date of injury) who suffered a lumbar spine strain with documented disc bulge:

WPI Rating: A qualified medical evaluator, using the AMA Guides ROM method, determines the lumbar spine impairment as 12 percent whole person impairment (based on reduced ROM and mild neurological findings consistent with nerve irritation).

Occupational Adjustment: The worker is classified in occupational category I (heavier physical labor). The PDRS table for 12 percent WPI and occupational category I shows an adjusted rating of 14 percent.

Age Adjustment: At age 45, the worker falls above the baseline age of 39. The age adjustment table for age 45 reduces the rating by approximately 5 percent, bringing it to 13 percent (rounding).

Apportionment: The insurance company's medical evidence shows the worker has mild degenerative disc disease unrelated to the industrial injury. The QME apportions 10 percent of disability to non-industrial degeneration. The industrial portion is 90 percent of 13 percent = 11.7 percent, rounded to 12 percent.

Final Adjustment Factor: The 12 percent rating is multiplied by 1.4, yielding a final permanent disability rating of 16.8 percent, rounded to 17 percent.

Compensation Calculation: Under the California statutory schedule, a 17 percent PD rating at a worker's average weekly wage of \$800 translates into a specific number of weeks of benefits (determined by statutory formulas), with typical values in the \$20,000 to \$35,000 range depending on the exact wage and date of injury.

The Role of Medical Evaluators: QME, AME, and Physician Credibility

Qualified Medical Evaluators (QMEs)

When a dispute arises regarding a treating physician's impairment rating, either party may request evaluation by a Qualified Medical Evaluator (QME)-a physician certified by the California Division of Workers' Compensation to resolve medical disputes.[10] A QME is selected from a DWC-maintained panel organized by specialty and geographic location.[10] The selection process is designed to be neutral: if the parties cannot agree, the requesting party typically chooses one QME from a panel of three offered by the DWC.[10]

QMEs are instructed to perform comprehensive evaluations addressing all factors required by the PDRS and AMA Guides, including medical history, physical examination, diagnostic test review, functional limitations assessment, and causation/apportionment analysis.[10] The QME's report becomes central evidence in any subsequent workers' compensation judge proceedings or settlement negotiations.[10]

However, QME selections can be strategically important. Injured workers' counsel often requests QMEs known for thorough functional analysis and consideration of subjective complaints, while defense counsel may request QMEs favoring strict AMA Guides application. The credibility and reasoning quality of the QME's report substantially influence case outcomes.

Agreed Medical Evaluators (AMEs)

If both the worker and insurance company are represented by counsel, they may mutually agree on an Agreed Medical Evaluator (AME) instead of proceeding through the QME panel process.[10] An AME must be mutually agreed upon and, once selected, becomes the binding medical expert whose opinion is typically given substantial deference by judges.[10]

AMEs are generally considered more persuasive than QME opinions because they reflect consensus between both parties about the most appropriate evaluator for the case.[10] Complex or high-stakes cases often proceed to AME evaluation when counsel for both sides can identify a respected physician with relevant expertise.[10]

Qualifications and Mandatory Requirements

Physicians who provide WPI ratings in California workers' compensation cases must be licensed to practice medicine in California and must either have received specific training in the AMA Guides Fifth Edition or be able to demonstrate competence in applying the Guides' methodology. For a physician's WPI opinion to constitute "substantial medical evidence"-the legal threshold for admissibility in workers' compensation proceedings-the opinion must comport with the AMA Guides, including as those Guides have been applied and interpreted in published appellate opinions and en banc decisions.

This requirement means that physicians cannot simply render an impairment opinion based on general clinical judgment; they must document that their rating reflects proper application of the Guides' methodology, measurements, tables, and diagnostic-related estimates. Physician reports that fail to explain the AMA Guides basis for a rating, or that contradict the Guides without stated justification, are subject to challenge as lacking substantial medical evidence.

Limitations and Criticisms of Strict AMA Guides Application: The Almaraz-Guzman Framework

The Problem: AMA Guides Undervaluing Functional Limitations

Despite California's statutory mandate to use the AMA Guides, both injured workers and courts have increasingly recognized that mechanical or "strict" application of the Guides can produce impairment ratings that do not fairly or accurately reflect an injured worker's actual functional limitations and permanent disability.[6] The Guides were designed by medical specialists to measure functional impairment in activities of daily living; they were not designed to determine appropriate workers' compensation disability or to capture the full impact of chronic pain, psychological trauma, or synergistic effects of multiple injuries on earning capacity.[6]

Common criticisms of the AMA Guides Fifth Edition include:[6]

Undervaluation of Subjective Pain and Chronic Pain Syndromes: The Guides provide limited mechanisms for rating subjective pain in the absence of objective clinical findings such as neurological deficits or diagnostic imaging abnormalities. Yet chronic pain often profoundly impacts function and earning capacity. Workers with Complex Regional Pain Syndrome (CRPS), fibromyalgia, or chronic back pain with normal imaging may receive minimal WPI ratings that do not reflect their actual limitations.[6]

Limited Integration of Psychological and Psychiatric Injury: The statutory restriction on rating psychiatric injuries arising from physical injuries (except in catastrophic cases or violent crime contexts) means that workers who suffer genuine psychological trauma from their injuries-anxiety disorders, depression, post-traumatic stress-may receive no disability compensation for these real functional limitations.

Insufficient Guidance for Conditions Not Specifically Listed: While the Guides theoretically allow rating by analogy for unlisted conditions, the procedure is often unclear, leading to undervaluation of rare or novel conditions or conditions with primarily subjective presentations.

Fixed Scales That May Not Capture Individual Variation: The Guides' tables and percentages reflect population averages and may not account for significant individual variation in how the same objective findings translate into functional limitation.

The Legal Solution: Almaraz & Guzman En Banc Decisions

In response to growing evidence that strict AMA Guides application could produce unfair ratings, the California Workers' Compensation Appeals Board issued en banc decisions in *Almaraz v. WCAB* and *Guzman v. WCAB* that fundamentally changed the legal landscape.

The WCAB held that the Permanent Disability Rating Schedule-including the AMA Guides portion-is not conclusively binding but rather constitutes prima facie evidence that may be rebutted. This means that while the AMA Guides ratings are presumed correct, a party (typically the injured worker) may rebut them by presenting evidence demonstrating that application of a specific AMA Guides methodology would result in a

permanent disability award that is "inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability."

The key holding states that one method of successfully rebutting an AMA Guides impairment rating is to show that the methodology selected by the rating physician, while technically within the Guides' scope, does not produce the most accurate measure of the injured worker's actual impairment. The physician may select alternative methods or tables within the AMA Guides-remaining within the "four corners" of the Guides-that more accurately reflect the worker's functional limitations.

Importantly, the WCAB emphasized that a physician may not go outside the AMA Guides entirely to produce a desired result; rebuttal must still rely on Guides methodologies, but the physician must explain in detail why an alternative Guides method more accurately reflects the worker's impairment. As courts noted, this respects the Legislature's intent to adopt the Guides while acknowledging that the Guides contain flexibility and multiple methodologies designed precisely to address the variety and unpredictability of medical conditions.

Practical Application: How Almaraz-Guzman Rebuttal Works

Under Almaraz-Guzman, if a treating physician or QME rates a worker's lumbar spine impairment using the DRE method and assigns a 10 percent WPI, but an alternative physician argues that the ROM method, also authorized by the AMA Guides, would more accurately capture the worker's range of motion loss and would yield a 15 percent WPI, the second physician may present this opinion as a rebuttal rating. The workers' compensation judge would then evaluate which methodology was more clinically appropriate and accurate for that specific worker's condition.

This framework has proven particularly important in cases involving chronic pain, where strict DRE categorization may undervalue the functional impact of pain that limits ADLs even without significant neurological findings. A physician can argue that a pain-based rating methodology within the Guides (such as Table 13-22 for chronic pain in upper extremity conditions) more accurately reflects the injured worker's impairment than a standard DRE rating that might assign a lower percentage based purely on diagnostic categorization.

Combining Impairments: The Combined Values Chart and Kite Rebuttal

A related controversy involves the Combined Values Chart (CVC), which mathematically reduces the combination of multiple impairments to avoid pyramiding.[5] The statute and Schedule presume the CVC is appropriate for most cases; however, California appellate decisions (particularly *Athens v. WCAB (Kite)* and the recent *Vigil v. County of Kern en banc* decision) have recognized that the CVC can also be rebutted in specific circumstances.

The *Vigil en banc* decision formalized two approved methods for rebutting CVC application: First, showing that there is no overlap between the effects on ADLs between the rated body parts-meaning that the impairments to two or more body systems affect completely different functional domains with no interaction. Second, showing that although there is overlap, the overlap "increases or amplifies" the impact on overlapping ADLs such that the combined effect is greater than expected from simple overlap reduction. This second approach recognizes the concept of "synergistic effect"-where two impairments together create greater functional loss than either alone.

However, the WCAB emphasized that these rebuttals require substantial medical evidence: detailed physician analysis of how each impairment affects specific ADLs, explanation of why overlap is absent or amplified, and reasoning supported by the clinical record. Generic conclusory statements that "impairments should be added" without detailed ADL analysis do not survive scrutiny.

Apportionment, Degeneration, and Common Disputes

Apportionment of Pre-Existing Degenerative Conditions

One of the most frequent sources of dispute involves the apportionment of permanent disability to pre-existing degenerative conditions, particularly in the spine. Defense counsel often argue that MRI findings of degenerative disc disease, facet arthropathy, or spondylosis should be apportioned away as non-industrial causes, reducing the worker's ultimate disability rating.

California law addresses this through reasoned medical opinion: a physician may apportion disability to pre-existing degeneration only if the physician explains the specific functional mechanism by which the degeneration contributes to the current disability. Courts have rejected apportionment based on the mere presence of imaging findings. A worker may have asymptomatic degenerative changes visible on MRI that never contributed to functional limitation before the injury and do not contribute to functional limitation after the injury; such findings cannot be apportioned.

By contrast, in cases where a worker has prior work restrictions, disability awards, or medical treatment for a specific condition (such as prior back surgery), the evidence of prior functional impact strengthens apportionment arguments.

Hikida Principle: Medical Treatment is Not Apportionable

An important limitation exists: under the Hikida doctrine, disability resulting from industrial medical treatment—including failed surgeries or complications thereof—cannot be apportioned to non-industrial causes. If a worker undergoes an industrial lumbar fusion that fails or causes complications resulting in additional disability, that treatment-related disability remains fully attributed to the industrial injury and cannot be reduced through apportionment.

This principle reflects the policy that workers should not be penalized through reduced benefits when medical treatment necessitated by their industrial injury produces suboptimal results.

California-Specific Implementation and San Francisco Context

San Francisco Immigration Court Reference (Correction)

The personalization section of this research template references San Francisco Immigration Court and immigration law procedures. However, the actual user query and all search results address workers' compensation law and the AMA Guides, not immigration matters. This section addresses California workers' compensation implementation specific to Northern California, where relevant.

PDRS Implementation by the Division of Workers' Compensation

The California Department of Industrial Relations, Division of Workers' Compensation (DWC), maintains official PDRS schedules, tables, and guidance documents. The DWC website (www.dir.ca.gov/dwc) provides the official rating schedule documents, frequently asked questions for practitioners, and information for injured workers.

When disputes arise regarding permanent disability calculations, injured workers or employers may request summary ratings (for unrepresented workers), consultative ratings (for workers who have filed applications for adjudication), or formal ratings issued by a workers' compensation judge after a hearing. The DWC maintains disability evaluators who perform these calculations based on medical evidence and rating schedules.

Medical-Legal Reporting Requirements

Medical reports establishing permanent disability must comply with California Regulation Title 8, Section 10606, which specifies the format and content requirements for comprehensive medical-legal reports.[10] A complete report must include detailed medical history, all relevant diagnostic test results, physical examination findings, functional limitations documented through range of motion and strength testing, clinical diagnosis, discussion of causation, apportionment analysis, and the WPI rating with complete explanation of how the rating was calculated.[10]

Reports failing to address these required elements are subject to challenge as incomplete or inadequate medical-legal reports, which may result in the judge ordering supplemental reporting or accepting alternative medical evidence.

Northern California Practitioner Considerations

In Northern California workers' compensation practice, several considerations affect the PD rating process:[1][6][10]

First, San Francisco and Bay Area insurance carriers and self-insured employers vary in their approaches to apportionment and medical evaluator selection, with some carriers taking aggressive apportionment positions and others being more collaborative. Knowledge of specific carrier and defense counsel practices can inform strategy.

Second, availability of skilled QMEs and AMEs in the Bay Area is relatively good, with access to physicians experienced in detailed functional assessment and familiar with Almaraz-Guzman rebuttal principles. Counsel routinely negotiate for AMEs with specific expertise in complex cases.

Third, many Northern California workers' compensation judges are experienced in applying AMA Guides principles and the Almaraz-Guzman rebuttal framework, meaning that arguments about inadequate AMA Guides application are taken seriously when supported by competent medical evidence.

Fourth, the interplay between California state criminal law and workers' compensation may affect disability benefits. For example, PC Section 1473.7 allows workers to challenge prior criminal convictions for immigration consequences; while this addresses immigration issues, some workers' comp cases involve injury-related criminal conduct (assault charges if a worker became violent due to traumatic brain injury, etc.), making this intersection occasionally relevant.

Functional Capacity Evaluations and Their Role in Impairment Rating

Purpose and Components of FCEs

A Functional Capacity Evaluation (FCE) is a standardized, objective series of physical and cognitive tests performed by a physical therapist, occupational therapist, or physician to measure an injured worker's current physical abilities, restrictions, and safe work capacity. FCEs typically include medical history review, standardized lifting, carrying, pushing, and pulling tasks with measured weights and repetitions, validity and effort checks, job-specific simulations, and a written report with functional restrictions and a functional level classification.

FCEs are often scheduled near Maximum Medical Improvement, before return-to-work decisions, when disputes exist about capacity, or when permanent impairment and restrictions are being considered. Results document objective performance on standardized tasks, providing data that physicians use when assigning permanent impairment percentages under the AMA Guides.

How FCE Results Influence Impairment Ratings

FCE data provides objective measurements of functional capacity that physicians may use when determining WPI ratings, particularly in contexts where the AMA Guides reference functional limitations or loss of strength. For example, if an FCE documents that a worker can lift only 15 pounds compared to the pre-injury capacity of 50 pounds, a physician may use this 70 percent loss of lifting capacity to support an impairment rating for lower extremity or spinal injury.

However, FCE results do not automatically determine impairment ratings; the evaluating physician must interpret how FCE findings translate into AMA Guides impairment percentages. Additionally, FCE findings must be considered alongside clinical examination findings, diagnostic imaging, and medical diagnosis. A worker may have limited lifting capacity on FCE due to pain inhibition or deconditioning, which the physician must reconcile with objective clinical findings before assigning a rating.

FCE Validity Concerns and Credibility Issues

A significant limitation of FCEs is the validity of the testing, particularly regarding whether the worker gave full effort or was influenced by pain, fear, or motivation factors. FCEs include validity indicators—inconsistencies in grip strength measurements, lack of consistency between test occasions, or failure to complete tasks despite evidence of adequate physical capacity.

Courts and insurers give weight to FCE findings demonstrating good effort and reliability, but findings suggesting submaximal effort or symptom exaggeration are challenged and may reduce the credibility of the entire FCE result and any impairment rating based upon it. Additionally, FCEs performed under poor conditions (fatigue from prior appointments, medication effects, weather-related symptom flares) may not reflect the worker's true capacity.

Permanent Disability Benefits, Settlements, and Compensation Calculation

Types of Permanent Disability Benefits

Workers with permanent partial disability (PPD)-ratings between 1 and 99 percent-receive benefits calculated as a function of their disability percentage, weekly wages, and statutory formulas.[1] Most injured workers receive PPD ratings between 5 and 30 percent (for workers injured before 2005) or slightly higher percentages under post-2013 formulas.

Permanent Total Disability (PTD) ratings of 100 percent are rare but entitle workers to lifetime wage replacement and ongoing medical care.[1][6] As noted earlier, Labor Code Section 4662 provides conclusive presumptions that certain catastrophic conditions (total blindness, loss of both hands or feet, paralysis of both legs, etc.) constitute 100 percent PTD.[1][6]

For PPD workers, benefits are typically paid in biweekly installments over a fixed period determined by statutory formulas based on the PD percentage and weekly wage.[1] However, workers may elect to settle their cases in one of two ways: Compromise and Release (C&R) agreements, which provide a lump-sum settlement covering all future PD benefits and future medical care; or Stipulated Awards with ongoing payment, which allow workers to receive periodic benefits while maintaining access to future medical care.[1][7]

Supplemental Job Displacement Benefits (SJDB)

Workers with permanent partial disability who cannot return to their pre-injury job due to medical restrictions may qualify for Supplemental Job Displacement Benefits, a \$6,000 voucher covering job retraining expenses, occupational licensing fees, vocational counseling, and job search services. SJDB eligibility requires that the employer cannot offer regular, modified, or alternative work paying at least 85 percent of the pre-injury wage.

The SJDB voucher is valid for two years from receipt or five years from the date of injury, whichever is later, and represents an important transitional benefit for workers who cannot physically perform their original occupations.

Settlement Values and Case Valuation

Settlement values in California workers' compensation cases are driven primarily by the permanent disability rating, the worker's average weekly wage at the time of injury, the extent of future medical needs, and the worker's age and remaining work capacity.[1] Average settlement values vary by body part injured:

Spine/central nervous system injuries typically settle in the range of \$50,000 to \$150,000 for moderate ratings, with higher values for severe impairments.

Knee injuries average approximately \$25,000, reflecting that knee impairments, while functionally significant, often result in moderate PD percentages.

Neck, arm, and lower back injuries typically range from \$35,000 to \$60,000.

Multiple body part injuries may average around \$63,000 or higher.

Hip, thigh, and pelvis injuries often settle around \$60,000.

These are general averages; actual settlement values depend on the specific PD rating, weekly wages, the quality of future medical evidence, and the extent to which the case involves complex apportionment or Almaraz-Guzman rebuttal issues.[1]

Practical Guidance for Injured Workers and Strategic Considerations

Getting an Accurate Initial Rating

The most important step in securing fair permanent disability compensation is ensuring that the initial WPI rating accurately captures the injured worker's functional limitations. To achieve this:

Choose the Right Treating Physician: A treating physician who understands the AMA Guides Fifth Edition and takes time to document detailed functional limitations-range of motion measurements, strength testing,

sensory examination findings, and specific ADL limitations-will provide the foundation for a defensible rating.

Detailed Functional History: Workers should communicate clearly with their physicians about how their injuries affect daily activities: difficulty sleeping, limitations in lifting or carrying, balance problems, difficulty concentrating, pain with prolonged sitting or standing, and restrictions on hobbies or family activities. These functional details should appear in medical records.

Complete Diagnostic Workup: Ensuring that all appropriate imaging, laboratory tests, and specialist consultations have been completed before the P&S declaration prevents subsequent disputes about whether adequate medical evaluation was performed.

Prepare for QME or AME Evaluation: If a medical dispute arises, workers should prepare thoroughly for QME or AME evaluations by bringing all prior medical records, being honest about symptoms and limitations, and avoiding both exaggeration and minimization of complaints. Consistency between what the worker reports to the physician and what appears in treatment records is critical to credibility.

Challenging Inadequate Ratings

If a permanent disability rating appears inadequate, workers have several options:

Request Detailed Explanation: Ask for a complete written explanation of how the physician calculated the WPI, what AMA Guides methodology was used, how each adjustment factor was applied, and the reasoning for any apportionment determination. Vague or conclusory reports often contain errors or inadequately justified decisions.

Obtain a Second Medical Opinion: Before pursuing formal dispute through QME panel request or litigation, obtain a comprehensive evaluation by an independent physician who can identify whether an alternative AMA Guides methodology might produce a more accurate rating.

Pursue QME or AME Evaluation: If a formal dispute exists, request evaluation by a QME panel (for unrepresented workers) or negotiate for an AME (if represented by counsel). A second medical opinion addressing specific deficiencies in the initial rating often results in increased ratings.

Preserve Almaraz-Guzman Arguments: Even if initial efforts to secure higher ratings fail, preserve arguments that the selected AMA Guides methodology does not accurately reflect the worker's impairment, with detailed medical evidence supporting why an alternative methodology within the Guides would produce more accurate results. These arguments are powerful on appeal if initial claims are denied.

Addressing Apportionment Disputes

When insurance carriers argue for apportionment of disability to non-industrial causes:

Challenge Unsupported Apportionment: If the QME or medical report does not explain specifically how pre-existing conditions contributed to the current functional limitations, challenge the apportionment as lacking a reasoned basis. Insurance carriers often fail to meet their burden of proof on this issue.

Highlight Pre-Injury Function: Present evidence of the worker's pre-injury functional capacity: prior work attendance and performance, absence of prior medical treatment or restrictions, statements that the worker was able to perform their job duties without limitation. This evidence undermines apportionment arguments.

Address Causation Separately from Apportionment: Remind physicians and judges that the diagnosis of pre-existing degeneration does not automatically establish that it contributes to functional limitation. The physician must explain the specific functional mechanism.

Current Legal Developments and Future Considerations

AMA Guides Sixth Edition and Transition

The AMA is currently transitioning the Guides to a digital platform and publishing updates to the Sixth Edition of the AMA Guides, with chapters addressing the pulmonary system, ear/nose/throat, upper limb, lower limb, spine and pelvis, and the nervous system released or forthcoming as of early 2025. However,

California's statutory mandate continues to reference the Fifth Edition, and regulatory changes would be required to adopt a newer edition.[9]

This creates a potential future issue: if the Sixth Edition is eventually adopted in California, impairment ratings may change for conditions previously evaluated under the Fifth Edition. Workers and practitioners should monitor for proposed regulatory changes mandating a shift to newer editions.

Ongoing Appellate Development

The Almaraz-Guzman and subsequent precedents continue to evolve through appellate decisions. Recent cases have further clarified the boundaries of permissible rebuttal, the adequacy of ADL analysis in supporting alternative ratings, and the weight given to clinical judgment versus strict AMA Guides methodology. Practitioners should monitor WCAB en banc decisions and published appellate opinions for emerging principles affecting rating disputes.

Legislative Proposals

Periodically, legislative proposals emerge addressing PD rating issues, such as proposals to increase adjustment factors, expand psychiatric injury coverage, or modify apportionment rules. As of February 2026, no major pending legislation addresses AMA Guides methodology, but the field remains subject to legislative change.

Conclusion

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, represents the foundation of California's system for determining permanent disability benefits for injured workers.[1][6][8][9] Since mandatory adoption in 2005, the Guides have provided consistency and objectivity to impairment rating while simultaneously generating significant criticism for undervaluing subjective pain, psychological trauma, and functional limitations that do not translate neatly into the Guides' structured methodology.[6]

For injured workers navigating the California workers' compensation system, understanding the AMA Guides framework is essential. The process begins with accurate WPI rating based on comprehensive medical evaluation and detailed documentation of functional limitations across all relevant activities of daily living.[1][7] The WPI is then converted to a final permanent disability percentage through adjustments for occupation, age, apportionment, and statutory multiplication factors.[1][5][8]

However, injured workers should also understand that the Permanent Disability Rating Schedule-including the AMA Guides portion-is not conclusively binding. Under Almaraz and Guzman, ratings can be rebutted by demonstrating that an alternative AMA Guides methodology would more accurately reflect the worker's actual impairment, or that application of a particular methodology produces results that are inequitable, disproportionate, or inaccurate. This framework provides an important safeguard against the harshest effects of mechanical application of medical guidelines designed to measure functional impairment, not workers' compensation disability.[6]

Successful navigation of the permanent disability rating process requires detailed medical documentation, careful selection of medical evaluators, strategic use of QME or AME evaluations when disputes arise, and willingness to challenge inadequate ratings through appellate processes when necessary.[1][6][10] For workers with injuries affecting multiple body systems, apportionment disputes, or primarily subjective functional limitations, legal representation by counsel experienced in workers' compensation law and familiar with current precedent is invaluable to ensuring that disability ratings accurately capture the full scope of the injury's impact and result in fair compensation.[1][6]

The permanent disability rating determination is not a routine administrative calculation but rather a complex medical and legal process with profound implications for injured workers' financial security and ability to retrain or adjust to permanent work restrictions. Understanding how the AMA Guides are applied, what constitutes adequate impairment analysis, and how to identify and challenge flawed ratings empowers workers to advocate effectively for themselves or work with counsel to secure the compensation they deserve.[1][6][10]

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