When an injured worker finishes active medical treatment and the healing plateaus, the case pivots from getting better to measuring what was lost. That measurement is the impairment rating. It sits at the crossroads of medicine and law, and it often decides the size of a permanent benefits award or the value of a settlement. I have seen people accept a low number because a form looked official, only to learn months later that a small change to the math could have meant thousands of dollars more and better access to care. I have also seen honest mistakes snowball when no one explained the rules of the road. If the rating process feels opaque, you are not alone.

Why impairment ratings carry so much weight

An impairment rating tries to nail down a permanent loss of bodily function, not pain in the abstract and not whether you can do your old job. Most states use it to calculate permanent partial disability benefits after you reach maximum medical improvement, usually shortened to MMI. The point is stability. You do not need to be pain free, you just need to be medically stable enough that further healing is not expected in the near term.

A small change in the rating can compound. If your state pays two-thirds of your average weekly wage for permanent partial disability, and it applies that percentage to a statutory number of weeks based on the rating, moving from a 5 percent whole person impairment to an 8 percent rating may add dozens of weeks of pay. The rating also influences settlement ranges. Carriers run their spreadsheets using this number. So do vocational experts and defense lawyers. When a workers compensation lawyer challenges or defends an impairment rating, we are contesting the foundation.

The moment you reach MMI

Doctors call MMI when treatment has done what it can. It does not mean you have no options, just that your condition has plateaued. The treating physician then either issues a rating or refers you for an evaluation. That evaluation can be quick or can involve a longer functional capacity exam, a nerve conduction study, updated imaging, or a gait assessment, depending on the injury.

The MMI conversation often feels abrupt. One week you are discussing a second round of physical therapy. The next, your doctor is describing permanent restrictions and a percentage impairment. Ask for a copy of the MMI note and the rating worksheet the same day. Those documents hold clues to how the number was built.

How doctors calculate impairment

Ratings usually come from a published guide. The most common reference is the American Medical Association’s Guides to the Evaluation of Permanent Impairment. Different editions exist, and states adopt them differently. Some require the Fifth Edition, others use the Sixth, a few still cite the Fourth. That matters because the same shoulder tear can rate higher in one edition than another due to methodology.

Two basic approaches show up often. Range of motion based ratings measure how far a joint moves in degrees and tie that to a percentage. Diagnosis based ratings assign a percentage based on the specific condition. The Sixth Edition leans diagnosis based with modifiers for objective findings. The Fifth Edition allows more room for measured deficits, such as grip strength or limited flexion.

Objective findings drive ratings. A reduced reflex on exam, an MRI showing a herniated disc, a nerve study confirming carpal tunnel syndrome, or a surgical report that documents a partial meniscectomy, these details

anchor the rating. Pain alone has little weight. If a doctor rates you based on your report of pain without tying it to clinical findings, expect a challenge from the insurer.

Apportionment can enter the picture. If part of the impairment existed before the work injury, some states allow the doctor to subtract that portion. The math should be transparent. For example, if a worker had a 10 percent impairment to the knee from a prior injury and the new surgery and residual symptoms rate at 20 percent, the net may be 10 percent. Not every state permits apportionment, and the burden to prove it is not on you. The report should specify the evidence for any subtraction.

State by state differences you feel in your wallet

Even when two states use the same AMA edition, their statutes and case law control how ratings convert to money. A 10 percent rating in Florida does not produce the same outcome as a 10 percent rating in California.

Some systems are schedule based. Loss of use for particular body parts pays a set number of weeks, then the rating scales that number. Hands, feet, hearing, and vision often sit on these schedules. Other systems treat injuries as whole person impairments with a total cap on weeks that gets multiplied by the percentage. A number of states blend the two approaches depending on the body part.

Vocational factors, like age, education, and job history, play a larger role in some jurisdictions than others. In states that consider loss of earning capacity, a modest medical impairment can still lead to a higher disability award if the worker cannot return to comparable employment. I have represented warehouse employees in their fifties whose back ratings were single digits, yet their permanent disability awards were significant because they could not safely resume heavy labor and had limited transferable skills.

Deadlines differ too. Some states require challenges to an impairment rating within 30 to 90 days. Others set hearing deadlines for disputes. Miss the window and you may be stuck with a low figure. Calling a workers compensation lawyer early in this phase is less about gearing up for a fight and more about not tripping over a procedural wire.

Scheduled loss, whole person impairment, and the math that follows

Think of two tracks. On the schedule track, a state might say a hand is worth 244 weeks. If the doctor assigns a 20 percent loss of use, the pay is 20 percent of 244 weeks at the applicable rate. On the whole person track, a statute might set a 500 week maximum for permanent partial disability. A 10 percent whole person impairment yields 50 weeks of pay. Some states use a grid or multiplier that is more complex, but the principle holds.

Fine print matters. Caps on weekly rates change every year. Offsets for prior awards can reduce the new award. Cost of living adjustments may or may not apply. In hearing loss claims, audiograms must meet specific technical standards before a rating counts. In vision claims, uncorrected vs corrected vision and whether the loss is monocular or binocular change the numbers.

If you received permanent restrictions, the rating does not automatically cover the cost of accommodations or the wage gap if you earn less in a new role. Separate provisions handle wage loss benefits, vocational rehabilitation, or job displacement vouchers. Do not assume the impairment check settles everything.

Common traps that lower ratings

I have seen ratings dip for reasons that have little to do with the true severity of the injury. Patients often try to be polite in exams. They downplay pain or overexert on strength tests. A few specific traps come up again and again.

Goniometer use dictates range of motion measurements. If the examiner eyeballs your shoulder arc instead of using an instrument, the number can swing by ten or fifteen degrees, which may shave points off the rating. Some doctors use quick grip tests even though the AMA Guides caution against isolated grip strength ratings in certain injuries due to variability. With spine injuries, motor and sensory deficits need thorough documentation. If your reflexes were diminished at three prior visits but normal on the rating day because you took a muscle relaxer, the narrative portion of the report should still reflect the consistent pattern over time.

Surgical reports carry power. If the operative note fails to capture a resection or tendon debridement that the surgeon actually performed, the diagnosis based method can undercount impairment. It is often worth asking the surgeon to clarify the note rather than accepting a lower diagnostic class.

Getting a fair rating takes preparation

Your body is not a test, but rating days feel like one. It helps to approach them with the same focus you would bring to an important meeting.

Keep a daily function journal in the weeks leading up to the appointment. Write down how far you can walk, how long you can sit, when numbness flares, and what household tasks you avoid. Do not dramatize, just record. Concrete examples help the physician tie your symptoms to objective findings. Bring surgical records, imaging reports, and prior exam notes. If you use a brace or TENS unit, bring it. If your employer provided modified duties, describe them with specifics, not generalities.

If an independent medical exam has Georgia Workers' Compensation been scheduled by the insurer, arrive early, be courteous, and give full effort without pushing through pain. Answer questions directly. If an examiner asks how you feel on a 10 point scale, pick a number and anchor it to an activity. For instance, a six on days when you sit through a two hour safety meeting without standing can make the report more useful than a loose description like pretty bad most days.

What to do if you disagree with the rating

Disagreement does not mean the doctor is unqualified or biased. It often means the right edition of the Guides was not used, or a measurement method did not match the injury. Sometimes it means apportionment was applied without a factual basis. Start with the written report. Look for the edition, the diagnostic class, and the specific tables cited. Most states allow rebuttal, reconsideration, or a second opinion, but the rules are technical.

A treating physician can amend a rating if given new objective information. That might be a functional capacity evaluation showing unsafe lifting tolerance, or a new EMG confirming neuropathy. If you have had a second surgery, the rating must be revisited. Some jurisdictions permit a panel qualified medical evaluator. Others schedule a hearing where each side presents expert testimony. A workers compensation lawyer can align the process with the rules so that ***local workers' comp lawyer*** the argument is about medicine, not procedure.

The role of vocational evidence

Medical impairment is not the same thing as disability. Impairment is about function. Disability is about work and earning capacity in your labor market. Some states use the impairment percentage almost mechanically to set permanent partial benefits. Others open the door to vocational analysis, which can change outcomes.

A vocational expert studies your age, education, job history, and the local market, then measures how permanent restrictions affect the kind of jobs you can secure and what they pay. A truck driver with a 7 percent whole person impairment due to cervical radiculopathy might clear a relatively small scheduled award in a strict impairment

system. In a loss of earning capacity system, if the neck restrictions keep him from commercial driving and his alternatives drop his wage by 30 percent, his disability award can be much larger.

When the case has both medical and vocational parts, coordinate their timing. If a doctor updates restrictions based on a new MRI, the vocational report should reflect that change. I have watched cases falter because the vocational expert worked off a stale restriction that later got loosened, undercutting the theme of the case.

Case snapshots from the field

A warehouse selector in her early forties tore the labrum in her dominant shoulder while pulling a pallet. After surgery and therapy, her surgeon assigned a 6 percent whole person impairment based on the Sixth Edition, diagnosis based class for a distal clavicle resection with good range of motion. The first rating shorted the usual modifier for objective weakness documented over several visits. We provided handheld dynamometer measurements from therapy notes and photographs of surgical anchors visible on imaging. The revised rating came in at 10 percent. In her state, that change translated into about 20 additional weeks of permanent partial benefits and shifted the negotiation band by nearly 15,000 dollars.

A maintenance tech in his fifties developed bilateral carpal tunnel syndrome. The initial examiner used grip strength as a primary measure, which is not favored for the diagnosis in the Guides he was rated under. Nerve studies showed persistent median nerve delay despite surgery. Reframing the rating around the nerve conduction findings and documented thenar atrophy moved the schedule loss of use from 7.5 percent per hand to 15 percent per hand. On a 244 week schedule for hands capped at a state maximum rate, that change was tangible.

A roofer with a prior low back strain aggravated his spine in a fall. The carrier pressed for apportionment using an old urgent care note that described back pain five years earlier. Imaging from that time did not show herniation or stenosis. The new MRI did. The rating physician initially split the impairment 50-50. At deposition, we walked through the imaging history and the lack of work restrictions before the fall. The apportionment dropped to 10 percent. The difference funded additional pain management and paid down accumulated bills.

Time limits and the rhythm of appeals

Watch the calendar. Some states require you to object to a rating within 30 days. Others give 60 or 90. If you request a second evaluation, the clock may pause, but not always. After a hearing, decision letters come with appeal instructions and your window might be as short as three weeks. If your condition worsens after an award, petition to reopen rules range from six months to three years, with strict proof requirements. Make copies of everything and keep them in a simple folder, paper or digital. When things move fast, organization buys time.

Permanent total disability, threshold issues, and reality checks

A high impairment rating does not guarantee permanent total disability status. Conversely, a low rating does not preclude it in systems that look beyond the number. In some states, catastrophic injuries like loss of both hands, significant brain trauma, or paralysis create a presumption of permanent total disability. In others, the analysis leans on vocational evidence and whether any regular gainful employment is realistic given the restrictions.

I counsel clients to think in two tracks. Track one is the medical rating. Track two is the ability to perform competitive work at a sustained pace. Even if permanent total disability is not on the table, the restrictions linked to the rating can support job protections under disability laws or prompt an interactive process with your employer. These parallel paths can ease the transition long after the impairment award is paid.

Psychological injuries and the subtlety of measurement

Mental health injuries interact awkwardly with impairment guides that were built around anatomy and physiology. Some states rate psychiatric impairment using separate chapters of the AMA Guides or other standardized tools. Many limit or bar psychological impairment unless it stems from a physical injury. Where allowed, the rating must tie symptoms to functional categories, such as activities of daily living, social functioning, and concentration, with objective anchors like testing or consistent clinical notes.

From a practical standpoint, consistent therapy records matter more than a single evaluation. If your anxiety spikes in crowded spaces and prevents you from safe forklift operation, the notes need to reflect that pattern. If medication side effects impair concentration, that should appear in the medical narrative. Bring these issues into the light with your treating providers before the rating phase, not after.

Apportionment and preexisting conditions

Preexisting does not mean disqualifying. Many adults carry degenerative changes in their spines or joints that never caused a lost workday. The key questions are whether the prior condition was symptomatic and whether it impaired function before the work incident. When a rating physician assigns apportionment, they should cite objective evidence like prior imaging, documented restrictions, or earlier impairment awards. Vague references to wear and tear are not enough in most jurisdictions.

This is where your own memory helps. If you had no prior treatment for that knee, no time off, and you ran 5k races on weekends, say so. If you did have a prior strain but fully recovered without restrictions, make sure that truth gets into the record. Silence invites guesswork.

Settlements, Medicare set asides, and the downstream effects of the rating

In many cases, the impairment rating not only sets permanent partial benefits, it anchors settlement negotiations. Carriers often build a settlement model that starts with the rating, then layers in future medical, possible vocational exposure, and litigation risk. Your leverage grows when the medical basis for the rating is clear, and when your future care plan is concrete.

For older workers or those who expect to become Medicare eligible within 30 months, future medical in a settlement may trigger Medicare’s interest. A Medicare set aside allocates a portion of the settlement to pay for work related care that Medicare would otherwise cover. The impairment rating and MMI date help project future care. Sloppy projections can freeze money in an account that is either too big or too small. Coordinating with a workers compensation lawyer who has handled set asides saves headaches later, including preserving your access to Medicare without a coverage fight.

A short checklist for the day you receive your impairment rating

- Ask for the full written report, not just the percentage. Confirm the AMA Guides edition and tables cited.
- Compare the report to prior records. Look for missing surgeries, therapy measurements, or diagnostic findings that should affect the rating.
- Calendar your objection or appeal deadline. Some are as short as 30 days.
- Talk with your treating physician about whether the report accurately reflects your function and restrictions.

- Consult a workers compensation lawyer about whether a second opinion, functional capacity evaluation, or hearing makes sense under your state’s rules.

Preparing for an independent medical exam without sabotaging yourself

- Sleep the night before, take your regular prescribed medications, and bring any braces or assistive devices you use daily.
- Arrive early and assume you are being observed from the parking lot onward. Move naturally. Do not perform movements you would not do at home.
- Answer questions directly and briefly. Avoid minimizing or exaggerating. Anchor pain scores to specific activities.
- Give full, safe effort on tests. If a maneuver hurts, say so and stop. Consistency matters more than heroics.
- Before you leave, verify that all your imaging and surgical records were available to the examiner. If not, tell your lawyer or claims adjuster immediately.

When to involve a lawyer, and what good representation looks like

You do not need a lawyer for every rating. You do need clarity on whether the number accurately reflects your loss. If your rating seems low, if apportionment appears without evidence, if the wrong edition shows up in the report, or if the insurer rushes you toward settlement before you can review the math, call a lawyer who focuses on this terrain.

A good workers compensation lawyer will translate the medical logic, gather the right missing records, and set up second opinions that count. We read the rating the way auditors read financial statements, tracing footnotes and assumptions. We also keep an eye on the nonpublic rules that govern how adjusters set reserves and when a case can sensibly settle. The goal is not to fight for sport. It is to convert your real-world loss into the most accurate, supportable number the system allows, and pair that with a plan for work and health that respects your limits.

The human side of a percentage

A rating can feel like a label. Ten percent of your back or twenty percent of your hand is a strange way to talk about your body and your livelihood. I have sat with clients who felt that the number shrank their struggle to a line on a chart. That feeling is valid. The antidote is to keep the number in its place. It is a tool the system uses to deliver money and structure. It is not a judgment of your grit or your worth.

Use the process to gather what helps you move forward. That might be an accurate set of permanent restrictions to protect you from re-injury, a clear plan for maintenance care, a settlement that funds a career pivot, or a wage loss benefit to bridge a tight season. When the impairment rating reflects the medical truth, everything else gets easier. When it does not, the law gives you ways to ask for a better measure.