Resolution Grid – Comment Period #5 (Feb 2024)

Commenter	Comment Received
American Chiropractic Assn	On page 23, we suggest that the bold, underlined word in the "Notes Lumbar Spine" section should be "lumbar" instead of "cervical": "If the diagnostic criteria outlined in diagnostic row 17-20-02 Nonspecific Lumbar Spine, are employed to assign a one-time, once-in-a-lifetime 1% impairment rating, this rating must stand alone. It cannot be added or combined with any other cervical spine impairment ratings, nor can it be reapplied or reconsidered in future evaluations."
	Additionally, we suggest the bolded, underlined term "cervical" should be replaced with "lumbar" in the following sentence of section 17-21-02 on page 25: "Simply put, nonspecific lumbar spine (low back) pain with similar complaints on multiple occasions; with or without radicular spine and/or pelvis symptoms of pain, numbness and/or paresthesias that are not in a neuroanatomically plausible dermatomal distribution or compatible with a cervical root dermatome should be considered non-verifiable and therefore nonspecific.
John Hopkins, MD	If you talk to Dr. Mark and Dr. Martin, would you ask if they have any plan for Spine at the federal level/ Department of Labor since 1974, the DOL still does not accept spine? do we still continue with AMA Newsletter by Dr. Christopher Brigham July/August 2009 on rating spinal nerve extremity? is there any better way to calculate to make is more simple and accurate? instead of using AMA 5th? the challenge is if we have multiple fusion in cervical and lumbar spine etc..
	In case of multiple cervical fusion, 3-4 levels, if we have still 2-3 nerve involvement via EMG confirmation(chronic radiculopathy) is the first nerve C5 at 100% , second nerve 50%, and third nerve 25%?
	So we don't have class 4 anymore in the new 2024 edition? Just class: 0,1,2,3?
	In case of cervical injury, posterior element fracture (lamina etc..) and disc herniation at same level C5, under the new version, we combine these 2 elements or select the most severe DDX in order to avoid double grading?
	Can you elaborate on if patient has upper or lower motor neuron lesion as a result of an injury to the head and spine, can we still use spine chapter #17 or we have to limit only to chapter 13, central/peripheral nervous system?
	In recent years we see number of sacral fusion surgeries, what is our option beside table 17-11 page 593 of the 2009 AMA 6th edition? Will you address in AMA 6th 2024?

Geert Lammens	Are there examples of fe. Class1 a, b, c, d and e ? Not only of 1a, 1b and 1c because the jump from Class1 c to Class 2a is rather big. The thing is I cannot compare with the exact tables I see examples who would be rated differently Thoracic spine fractures are exemplary different rated but I don't see the full class with the 5 grades wich have changed for the better
Steven Mandel, MD	**Cervical Spine – Where is the C1 – odontoid and foramen magnum** **Please include the occipital cervical (occiput C1) and atlantoaxial articulation (C1/2)** **And subaxial, which includes from C2/2 to C7/T1** **In what chapter is the thoracis spine discusses as related to the sympathetic chain?** **Lumbar – T12 and L2 have specific pelvic nerves … iliohypogastric, ilioinguinal , ilio femeral** **The charts do don't address these issues….**
Jim Talmage, MD **TN BWC**	If the goal is to get the science "right", the definitions of grades for radiculopathy should correspond to the IASP definitions of possible neuropathic pain and probable neuropathic pain [Finnerup, et al. Pain 2016; 157 (8):1599-1606]. Ideally there would be guidance on determining reliability of the location of sensory loss from poorly documented medical treatment records e.g. "decreased sensation in L5 dermatome" means ????. The cervical radiculopathy definitions by nerve root do not reflect the normal human variation [see Riew, The Spine J 2019; 19: 1143-5 – McAnany, et al. The Spine J 2019; 19: 1137-1142 – Rainville, et al. Spine 2017; 42 (20): 1545-51 – Redebrandt, et al. Health Sci Reports 2022. https://doi.org/10.1002/hsr2.589]. Similar issues are present in the lumbar spine [Nezar, et.al. The Spine J 2013; 13: 657-674 – Taylor et al. Spine 2013; 38 (12): 995-8 – Hancock et al. Spine 2011; 36 (11): E712-E719 – Taylor et al. Spine 2013; 38 (12): 995-998 -- also Mathieu, et al J clinical medicine 2023; 12: 3851]
	The text does not describe how to differentiate nociceptive pain, neuropathic pain, and nociplastic pain. The text does not detail how to deal with medical records that say only "decreased sensation if the _ Dermatome", or how to deal with weakness on exam and a normal EMG of the involved muscles, or whether "4/5" strength includes "4 minus/5", "4/5", and especially "4+/5", or what to do with 3/5 strength yet normal gait. Sadly, text defining how to do a physical exam is needed.

	The proposed text deals only with classic anatomy teaching and does not deal with the poor documentation and anomalous innervation issues that obfuscate many of the claims for which the Guides is used. The judges may think any disc herniation is painful and explains the patient's pain, so there should be a discussion of the anatomic changes in asymptomatic people, and the conundrum of establishing whether an imaging finding really is "pain generating" or is an asymptomatic normal finding.
	Minor issue, but the proposed text reads as if loss of sharp versus dull discrimination and loss of protective sensation are the same severity. The 2008 text, Table 16-11, has the former as Grade 3, and the later as Grade 4 (not synonymous). There is no discussion on "objectifying" sensory testing, and disqualifying forced choice testing (sharp dull) when the answers are far from achievable by chance alone ("calling Sharp as 'Dull' and Calling Dull as 'Sharp' on 8 consecutive stimuli – also 2 point discrimination on fingers consistently "wrong" multiple consecutive times.
Patrick Luers, MD	Although I have no problem adding sagittal Balance/Imbalance as a ratable condition, this condition does not equate with or have anything to do with AOMSI, which is basically impending or actual spinal instability. It should be defined separately from AOMSI. I was a reviewer for the 6th edition, chapter 17 AOMSI section. I have communicated with the editors that the AOMSI section was not complete without a figure illustrating cervical spine angular motion measurement technique at the time it was published. I subsequently wrote an article in the AMA Guides Newsletter discussing the proper methodology for determining AOMSI in the spine using the 6th edition. I had previously written a similar AMA Newsletter article for determining AOMSI in the spine using the 5th edition. (attached) Why did the editors not update the spinal AOMSI section for the 2022 printing of the 6th edition, including fig13-c from 5th edition and include appropriate White and Panjabi references (same as 5th edition)? Plaintiff lawyers and chiropractors are trying to utilize angular motion methodology defined for the LS-spine in the 6th edition AMA guides and applying it to the cervical spine, which is not supported by the literature. Please correct this in future editions or reprints. I will be glad to serve as a reviewer/consultant if desired.