Resolution Grid – MSK 15.01 and 15.13

Section	Commenter	Comment Received	Resolution (from authors/panel) - TBD
15.01	**Association of Academic Physiatry** **(Prakash Jayabalan, MD, PhD)**	The major issue with the edition is the lack of information for variability in pathophysiology leading to an impairment and diagnosis. For example the management of an individual with osteoarthritis or tendinopathy will vary by the mechanism of development to some extent. Treatment strategies should be individualized to the patient and there is very little in regards to a personalized approach.	
		The focus on illness behaviors may also be problematic as it is very subjective in terms of interpretation and may lead to practitioners to inappropriately designating psychosomatic presentations. This could lead to practitioners inappropriately discounting patients and their treatments.	
		It is pivotal that we as physicians avoid any bias towards patients that may discriminate against underserved populations. The paragraph that states that historical information is not reliable in compensation claims is too broad a statement and maybe perceived as biased against patients.	
	American Orthopaedic Foot & Ankle Society **(F. Scott Gray, MD)**	No comments or suggested changes per AFOS (organization submitting comments)	
	American Academy of Physical Therapy-Occupational Health SIG **(Rick Wickstrom,**	A notable gap in this section for upper extremity musculoskeletal impairment is that no data or references are cited for reliability and normative date for fine motor dexterity, grip strength, pinch strength or other more objective tests with hand-held manual muscle tests. There is too much emphasis on grading muscle strength methods from 0 to 5. References for further reading in reference to functional performance measures to substantiate consistency of performance include: • Wang YC, Bohannon RW, Li X, Sindhu B, Kapellusch J. Hand-Grip Strength: Normative Reference Values and Equations for Individuals 18 to 85 Years of Age Residing in the United States. J Orthop Sports Phys Ther. 2018;48(9):685-93. • Shechtman O. Use of coefficient of variation in detecting sincerity of effort: a meta-analysis. Work. 2006; 26(4): 335-41. • Mathiowetz V, Weber K, Vollard G and Kashman N: Reliability and validity of grip and pinch strength evaluations, J Hand Surg Am. 1984 Mar; 9(2): 222-6.	

	PT, DPT, CPE, CME)	• Mathiowetz V, Kashman N, Volland G, Weber K, Dowe M, Rogers S. Grip and Pinch Strength: Normative Data for Adults. Arch Phys Med Rehabil. 1985;66:69-74. • Shechtman O, Gutierrez Z, and Kokendofer E. Analysis of the Statistical Methods Used to Detect Submaximal Effort with the Five-Rung Grip Strength Test J Hand Ther. 2005 Jan-Mar;18(1): 10-8. • Bryden PJ, Roy EA (2005). A new method of administering the Grooved Pegboard Test: Performance as a function of handedness and sex; Brain and Cogn. 2005 Aug;58:258-68. • Ruff RM, Parker SB. Gender and age specific changes in motor speed and eye-hand coordination in adults: normative values for the Finger Tapping and Grooved Pegboard Tests. Percept Mot Skills. 1993;76(3 Pt 2): 1219-30. • MacMasters W, Allison S, Wickstrom R, McMenamin P. Functional Capacity Evaluation and Disability Determination. Edited by Simoneau G. *Independent Study Course 32.5 Advanced Therapy Programs in Occupational Health*. Academy of Orthopaedic Physical Therapy; 2022.	
		Page 6 – 15.01i The statement that "The functional loss is the same for either upper limb." does not appear to allow for comparison of grip strength, pinch strength, and dexterity differences that reflect better performance of the dominant hand compared to the non-dominant hand.	
		Page 14 – top paragraph, when possible please substitute "Rating Evaluator" or "Evaluator" for "rating physician" or "physician" to be more inclusive of other healthcare professionals who are qualified to use the AMA Guides to rate impairment within their scope of practice. Search for "physician" reveals edit opportunities on pages 15, 39, 43 (x2), 64 (x5), 65 ((x2), Consistent use of impairment evaluator or evaluator may be an issue in other sections	
		Page 14 – second to last paragraph. Include coordination in the parenthesis after motor. Include balance after range of motion.	
		Page 15 – (under 15.05e7) There should be guidance to encourage evaluators to report the location of pain, when pain is reported as limiting the function for a strength assessment.	
		Page 16 – (15.05c). Some further explanation should be provided for distinguishing inconsistencies due to atrophy versus enlargement form swelling when making comparisons to relative differences in grip strength.	

		Page 20 – It is not clear what version of the PROMIS-PF is being recommended. Physical Function 10b is referenced in reference 73. Disagree with presentating the visual analog pain scale (VAS) as a credible example of a functional assessment tool. This is not substantiated by credible evidence.	
		Page 22 - Disagree with presenting the visual analog pain scale (VAS) as a credible example of a functional assessment tool. This is not substantiated by credible evidence.	
		Page 28, 30, 31: (Table 15-07i, j1, j2,j3) Disagree with presenting the visual analog pain scale (VAS) as a credible example of a functional assessment tool. This is not substantiated by credible evidence.	
		Page 28 – Table 15-07i interpretations for outcomes seems confusing for Moderate and Severe Problem using VAS, QuickDASH, and PROMIS-PF. With VAS, it is not clear whether the evaluator is expected to use an average or maximum pain rating? **The concerns raised about PROMIS physical function tool interpretation as a functional tool may be a problems in other sections.**	
		Page 54 – Consider revising the definition of Evaluator to "…and may be a physician or other qualified health care professional (QHP) who is qualified by education, training, licensure/regulation to examine, evaluate, and independently report the results of impairment ratings within their scope of practice."	
		Page 63 (VAS) Disagree with presenting the visual analog pain scale (VAS) as a functional assessment tool. Also, a line break is needed before WPI to separate this abbreviation from VAS.	
	Dan Bruns, PsyD, FAPA	**…uses ICF terminology.** There is no discussion of how these measures align with ICF activity, participation, or other concepts. We previously recommended two PROMIS measures aligned with ICF: Physical Function (ICF activity) and Social Function (ICF participation), and this was approved by the editors.	
		…best available evidence There is no mention of the vastly different levels of evidence for these measures. There is no evidence for the "atypical" use of the pain VAS: pain = function. If adopted, that would be the axiom of the pain chapter. PROMIS measures have best available evidence, but this is not mentioned. Furthermore, users	

		can choose tests not in Table 15-07i. This giant loophole would allow any measure to be used with no scientific requirements. Note: There are approximately 2000-3000 fPROMs to chose from.	
		…ensure physician interrater reliability. This approach ensures poor reliability. This Pain VAS does not assess function, but the Faces Pain Scale is valid for pain and depression [See commentary]. The PROMIS and SST only measure function, while the WORC assesses pain, social participation, psychological distress, not basic ADLs. The Constant-Murley Score is 65% physician ratings, and only 35% patient report. To assess shoulder function, 8 listed measures could be used, but these are markedly different. The user also free to choose any measure and cutoff score not listed. Differing official assessment methods ensures differing findings, and poor reliability.	
		Table 15-07i lists 12 measures as "examples", as Guides users can utilize other measures not in this table. This is an extremely concerning precedent. If 12 measures are listed for this chapter, and the Lower Extremity, Spine, and Pain chapters follow this precedent, there would be 48 listed measures in these chapters alone. This would be impossibly complex. Some of the listed measures have only one weak validity study. Some of the literature cited to support this approach are actually very critical of it (e.g., Kersten).	
		The NIH "Roadmap for the Future" scrutinized outcome measures and recommended best science. The Roadmap warned against the use of numerous similar measures and recommended "reducing the cacophony of disparate measures currently being used" (Cella 2010). Chapter 15 breaks this rule, using multiple poorly researched, nonequivalent measures of function. This leads to contradictory findings and chaos. PROMIS is based on >4000 published studies and is becoming the world standard for fPROMs. The science behind PROMIS is orders of magnitude above the other scales. Adopting PROMIS as the default method would align the Guides with ICF & NIH research standards.	
		Pain Language Concerns:	

		In addition to fPROM concerns, this chapter uses outdated pain language, using terms like "psychogenic", and referencing the DSM4 somatoform chapter, which was replaced by DSM5 in 2013. This DSM4 chapter was so flawed that both DSM5 and ICD11 erased this chapter in its entirety. WHO and IASP collaborated on ICD11, with multiple articles published in *Pain*. This is the best science. This editorial change quotes the IASP definition of pain, "… A person's report of an experience as pain should be respected…", but this chapter later lists multiple occasions when the patients pain level should be disregarded. This chapter claims to follow the biopsychosocial model but separates "psychogenic" pain from "real" conditions, with psychogenic pain being due to psychopathology. The differentiation of pain as being "real" vs. "in your head" is a cultural construct that blames patients and is unsupported by science. Current pain science demonstrates that both the limbic system and cognition are involved in all pain processing, with the difference being a matter of degree. Pain not explained by obvious pathophysiology is now thought to be explained by a nociplastic disease state: altered nociceptive synaptic chemistry, spinal gliopathy, and rewired brain connections on fMRI. This commonly co-occurs with depression, anxiety, and sleep disorder, but this is a biological condition that fits with evolutionary biological concepts. We recommend the Guides update its pain language.	
		The upper extremity chapter is the first to be developed based on our discussions about fPROMS. It sets an extremely concerning precedent that other chapters would be likely to follow. Listing 12 methods for assessing outcome in one chapter is by itself contraindicated. What is more concerning is that by allowing the user to pick a different measure and different cutoffs if desired, all standards are out the window. This will lead to frequent disagreements about ratings that cannot be resolved, because there are multiple nonequivalent official methods. If Guides ratings perpetually lead to chaos and unresolvable disputes, it would probably decrease utilization of the Guides, and decrease making performing functional assessments.	

		This method also creates a substantial burden on the users to learn how to administer, score and interpret a multitude of measures. Beyond the 12 measures mentioned for this chapter, professionals may select any measure that they desire. This is alarming. If all chapters follow this precedent, note that there are an estimated 2000 to 3000 fPROMs in existence, all of which could probably be used by some condition in the Guides. Allowing the user to pick from these would create a system with overwhelming complexity, disagreement, and controversy. Learning to use and interpret these measures would create a great burden to the user, and this unnecessary complexity could discourage users from wanting to perform Guides training and become involved with this controversy.	
		Full Commentary (Bruns) – See Executive Summary pg 7 Bruns_MSK 15.01 2023.pdf	
	Kathryn L Mueller, MD, MPH, FACOEM	I have a number of serious concerns regarding this chapter and its consistency with the basic premises of this 6th edition. One of the important new concepts of the 6th edition, and the ICF model, is that function should be evaluated separately as an important outcome for every patient. Function is not assessed purely through physical therapy testing or other "objective testing" but must reflect the patient's ability to function in their everyday life. This chapter, in its current form, references instrumental activities of daily living, which are the important outcomes for most patients. These functions cannot be accurately reflected from the patient's point of view without using tools which have been scientifically proven. The tools allow the patient to reflect not only their physical function, but also their ability to perform important activities of daily living in their life.	
		Scientific support for functional tools as been well presented by the APA with their in depth analysis of patient reported outcome measures. In addition NIH specifically supports use of PROMIS. (https://www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2016-2020-508.pdf - page 26). As we are all aware, no current randomized control studies on medical treatment are accepted for publication unless they include patient reported outcomes. The patient reported outcomes are frequently among the primary outcomes evaluated for the success of a particular treatment. We no longer merely use X-rays, for example, to demonstrate a successful spinal fusion, instead we also	

		assess how the results affect the patient's overall life and functional abilities. We are all also aware that assessment chronic pain treatment, which affects 20 to 30% of the US population, uses primarily patient function to reflect treatment success. In its current structure, this chapter completely diminishes the importance of patient reported function by merely inserting it into the clinical history and not allowing it to be an entirely separate category for the evaluators to consider as part of the rating.	
		I doubt many of us need reminders regarding this, but the 6th edition and other editions of the Guides have been strongly admonished for not reflecting the patient's point of view. Reliable patient reported functional tools such as the PROMIS would appear to be the most scientifically valid option for assuring that a patient's response to the treatment is reflected. As has been discussed ad infinitum, the evaluator need not accept the result if it is in conflict with other information they have assessed, however function must continue to be a separate category of assessment.	
		In addition, a myriad of tools, many of which are not highly respected in terms of their scientific rigor, are listed here as possible tools for an evaluator to use. This would merely add to the confusion and lack of standardization in impairment rating. I am completely against this laundry list. It is true that, as we understood it, the agreement was that a provider could use another tool if they explain why they used it and how they used it. This was to allow for some progression in time among evaluators who have previously used a specific tool on a regular basis. This chapter lists only the two PROMIS measures, but recommends 11 other lower quality measures, and allows the user to choose any measure they wish.	
		I do not find any literature that supports placing function into the clinical history, as opposed to providing function as a separate status, supporting patient reports of the effect of a condition on their actual daily life. Obviously the results of the PROMIS tools are only accepted if other measures and history support the relationship.	
		Having taught thousands of physicians to use the 6th edition, the original methodology was fairly easy to teach because it is generally uniform among the chapters, and the categories easily follow the usual outline for medical reports. The current proposal appears to mix categories, although without examples and the DBI tables it is a bit hard to understand how it would be used in practice. I believe the authors were trying to follow the initial plan but it is hard to know if their plan would work without	

		the accompanying tables. The chapter should follow the original plan of clinical history, clinical findings, physical exam findings, and functional outcome. My major concern is that it is very likely the current plan will end up with more disagreements among raters. This will certainly occur if all of the functional tools were somehow allowed and then imbedded in the clinical history. I anticipate less uniform ratings with the suggested system. At this point in time, most physicians are somewhat familiar with patient reported outcome measures and if the measures proposed by the APA were adopted they would likely have little difficulty adopting them and incorporating them into the rating.	
		Another major concern is that the tone of this chapter appears to be very confrontational and appears anti-patient. I have attached a number of direct quotes from the chapter below. The comments are aimed at reminding the evaluator of the many ways in which a patient can exaggerate, from some providers' points of view, or how conflicts in the record can be used to discount the patient's report during the evaluation exam. Many of us teach how to perform ratings and use some of the principles that are mentioned in the chapter to assure that the report is accurate, however putting it in the main part of the AMA upper extremity chapter would lead many people to conclude that the Guides are focused on trying to make the patient appear inconsistent or exaggerating their findings, thus resulting in lower ratings for patients in most cases. I do not believe that is the position of the AMA Guides authors, however this sort of information, particularly repetitively inserted as it is here, clearly gives an anti-patient biased impression. I can assure you that in Colorado this would never pass because the political side representing both patients' well-being, as well as the defense attorneys, would label this piece as being dramatically anti-patient. Therefore it would not be acceptable and our legislature would not agree to it. Here are some examples from the chapter, however I have many more if needed. Many of the points presented are valid but some could be included in the first chapters and many others would be best placed in an article focused on complex impairment evaluations. Prodromal: The first time a person notices pain or stiffness associated with osteoarthritis or tendinopathy, it may be misperceived as a new pathology or incorrectly attributed to a minor "injury" event.10,14-16 15.05b Selected Biases in Judgment or Reasoning on Physical Examination -- this entire section would be a problem for many jurisdictions.	

		If information provided by the individual or contained in the previous medical records are inconsistent with the CH, PE and/or CS, the evaluator should reference these inconsistencies in their report. It is important to reconcile inconsistencies, if any, between the individual's medical chart review, (CH) and their CCP with the PE and/or (CS). The evaluator may consider using Section 15.07c Findings Inconsistent With the Natural History of the Diagnosis to provide an impairment rating value	
		Psychosocial factors are known to have a substantial effect on self-reported CH (pain) and FL.[44] Such factors include low job satisfaction, low social support at work, and smoking.[45-51] These factors should be noted in sections related to inconsistences required by Chapter 2, as they may play a role in pain expression, self- reported FL, and treatment recovery. My Note: These are not inconsistencies but rather accompanying risk factors. Many state WC guidelines include payment for smoking session. Also counseling for work issues is promoted.	
	Mitchell Silverman, MD	Assigning the Correct Diagnosis (DX) appears straight forward with appropriate clinical data. That is the Physical Exam (PE) and Clinical Studies (CS) will allow for appropriate DBI and Class.	
		My concern is if the Clinical History (CH) is inconsistent, how does that affect inter-examiner reliability? Is there any other method to determine this or should the examiner best describe the inconsistencies to document their opinion.?	
15.13	**Association of Academic Physiatrists** **(Prakash Jayabalan, MD, PhD)**	Although we do think the editorial changes could be important there is minimal information or content provided to support the need for these changes or the evidence they are based on (see below).	
		The process for determining impairment following these steps is relatively clear in the text, if a bit arcane in application. However, the process is founded on the idea that providers can accurately and consistently diagnose musculoskeletal injuries or disease as isolated problems impairing a single limb. In practice, this is often not true.	

		Imaging of individuals is rarely normal for any joint after age 50, and asymptomatic “abnormalities” are routinely noted in imaging studies of asymptomatic individuals of all ages. The determination that something is “age related” or related to a specific event is often unclear, as is the potential for any “age-related” change to become symptomatic after a particular injury or event. ‘ Physical exam, though helpful, has also been shown to be inconsistent between providers and most “confirmatory” provocative tests have limited sensitivity and specificity. Clinicians are rarely 100% certain that a given issue identified on imaging is actually causing a problem nor is the degree of impairment from an injury or disease equal across all affected individuals. The effects of various injuries or comorbidities are also not necessarily “additive,” with some comorbid conditions causing a relatively greater impact from further injury. Consider the effect of a left shoulder injury in an individual with a spinal cord injury and paraplegia with prior limitations of the right arm. What seems a potentially minor injury may be devastating, and the potential solution, such as a surgical procedure requiring immobilization of the limb, may threaten the ability to live independently. Assigning a grade is extremely subjective and as outlined above, certain individuals such as the individual described above will have a worse global function as a result of the impairment compared to an individual with a single limb impairment due to a musculoskeletal pathology.	
		We also suggest that these evaluations may want to account for the potential duration of an impairment and it’s severity i.e. temporary (i.e. potential for improvement) versus a permanent impairment. This certainly could be accounted for in ‘establish maximal medical improvement’ but this needs to be very clearly delineated. In addition to concurrent medical conditions and age-related factors, the variability of symptoms that may fluctuate over time and the absence of objective tests, particularly in cases involving pain-related musculoskeletal disorders, can add complexity to the diagnostic process. For example certain conditions such as osteoarthritis causing a leg impairment may vary based on when the examination is performed and there is not always a strong correlation between imaging findings and patient functional impairment. This in turn could lead to an inappropriate designation of NHD. Establishing an accurate diagnosis during the initial evaluation, in accordance with the natural progression of the condition, can often pose significant challenges. For example , certain neurological conditions such as multiple sclerosis will vary in terms of impairment rating based on timing of the evaluation, When to re-evaluate should also be clearly defined or at least accounted for in categorizing impairments.	

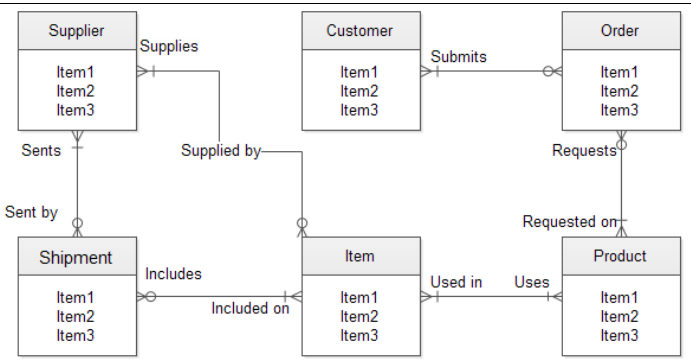
		Given the numerous assumptions and subjective nature of the process described in the text, it is also hard to imagine that ratings are consistent across individuals, physician specialty types or between providers within pertinent specialties. There needs to be additional guidance provided to the physician evaluator to minimize this subjectivity, otherwise this guide will be ineffective in practice.	
		Moreover, accurately assessing an individual's functional limitations can prove to be a formidable task. This evaluation encompasses both physical and psychological aspects, and these limitations are not static. Introducing validated outcome measures into the impairment rating process may offer substantial benefits. While the inclusion of functional history as an adjustment factor may be subject to debate, it has the potential to enhance the objectivity of assessments, as well as promote consistency and transparency.	
		Providing further guidance on the utilization of validated outcome measures within the impairment rating process could contribute to ensuring the precision, patient equity and accuracy of impairment ratings.	
	American Chiropractic Association (ACA)	The American Chiropractic Association (ACA) in conjunction with the ACA Council on Forensic Sciences reviewed the proposed changes and are without disagreement with the presented changes. Overall, the proposed changes or edits promote consistency across the AMA Guides, they seem reasonable, and they are consistent with the current evidence. While these updates may impact other sections within the musculoskeletal chapters, it seems that this has been considered. It seems that comment periods #2 and #3 will adequately address other portions of the musculoskeletal sections that are impacted.	
	International Academy of Independent Medical Evaluators **(James Williams, MD)**	The emphasis on the effects of the injury or disease on function follows the ICF model and is consistent with the principles of the Guides. The emphasis on obtaining a correct diagnosis as the initial step in Impairment Rating is consistent with the Guides Principle of Diagnosis Based Impairment The emphasis on considering the natural history of the disease along with the diagnosis takes advantage of this specialized knowledge that all physicians should possess.	

		The methodology is relatively simple and similar to methods in previous editions of the *Guides*. The proposed system allows the evaluator to weigh alternative diagnoses and contributing factors, including natural aging, comorbidities, prior injuries, over and under reporting, and the consistency of the presentation of the disease/individual when making a diagnosis and proceeding through the steps to an impairment rating. The option for delineating Consistent and Inconsistent presentations is well reasoned.	
		The assignment of a once-in-a-lifetime 1% impairment when the evaluator believes there is a reasonable explanation for inconsistencies between the diagnosis and the NHD allows for individual clinical judgment (potentially helpful) as well as conscious and unconscious bias (potentially unhelpful) to be introduced into the impairment rating process. In addition, the "lifetime" assignment may be jurisdictional, and may be subject to interpretation. There is also the possibility that, in states where adding, rather than combining, impairments is allowed, this could lead to inconsistencies.	
		Additional comments on/modified wording are as follows [see italics]: [paragraph #1, 15.13] …Determination of the correct diagnosis requires an understanding of and a requirement for consistency and relevance of the clinical history (CH), physical examination findings (PE), and/or results of clinical studies (CS); the natural history of the diagnosis *must be considered,* including any *confounders such as:* preexisting impairment, diseases, conditions, illnesses, comorbidities, and/or psychosocial factors (*i.e. the* differential diagnosis). If the wrong diagnosis is selected in the DBI tables, the impairment value may not appropriately reflect the individual's functional loss. *If the natural history and potential confounding factors are not considered, the impairment value may not appropriately reflect the individual's functional loss attributable to the diagnosis of concern…* [paragraph #2, 15.13] …This is why only factors consistent with the natural history of the injury or disease are considered relevant to determine the effects thereof on upper limb function, after taking into consideration age-related changes; the impact of no treatment, appropriate treatment, or inappropriate treatment; and any *confounders such as:* preexisting impairment, diseases, conditions, illnesses, comorbidities, and/or psychosocial factors (*i.e. the* differential diagnosis)…	

		THIS WORDING CLARIFIES THE DIRECTIVE/METHOD AND HELPS EXPLAIN THE RATIONALE FOR CONSIDERING THE NATURAL HISTORY AND CONFOUNDING FACTORS	
		Additional comments on/modified wording are as follows [see italics]: [paragraph #1, 15.13.b1] … At the time of the current evaluation, the DX is established using the traditional three components listed below that are *primarily* based on objectively verified anatomic and/or physiological findings and are determined to be consistent with the natural history of the diagnosis (NHD)… *NOT ALL DIAGNOSES ARE ENTIRELY BASED ON OBJECTIVE MEASURES AND SOME ELEMENTS OF A DIAGNOSIS AND/OR CLINICAL PRESENTATION RELY ON SUBJECTIVE REPORTS, ALBEIT CONSISTENT WITH PHYSIOLOGY/PATHOPHYSIOLOGY/NATURAL HISTORY/ETC.*	
		Additional comments on/modified wording are as follows [see italics]: [paragraph #3, 15.13.b1] … Determination of the DX requires an understanding and a requirement of consistency and relevance of the CH, PE, and/or CS; the natural history of the diagnosis including any natural aging-related changes; the impact of no treatment, appropriate treatment, or inappropriate treatment; and any *confounders such as:* preexisting impairment, diseases, conditions, illnesses, comorbidities, and/or psychosocial factors (differential diagnosis). The evaluator should rule out and comment on other potential explanations for the current clinical presentation (CCP) such as preexisting injury, preexisting impairment, diseases, conditions, illnesses, comorbidities, and/or psychosocial *factors when appropriate*… *THE WORD 'ALL' BEFORE POTENTIAL CREATES AN ONEROUS STANDARD FOR EVALUATORS – THEREFORE, WE RECOMMEND DELETING IT AS ABOVE; 'WHEN APPROPRIATE' MAKES IT CLEAR THAT AN EVALUATOR MAY INCLUDE THIS OR NOT BASED ON THE CIRCUMSTANCES OF THE INDIVIDUAL CASE.*	
		Additional comments on/modified wording are as follows [see italics]:	

		[paragraph #4, 15.13.b1] … Conversely, when an inconsistent diagnosis is made based on the CH, PE, and/or CS (three components) and the three components of the diagnosis are inconsistent with the NHD, no class is assigned. *THE WORD 'ALL' BEFORE THREE COMPONENTS IS TOO RIGID AND DOES NOT ALLOW FOR 1 OR 2 OUT OF 3 INCONSISTENT COMPONENTS TO ESTABLISH AN INCONSISTENT DIAGNOSIS/PRESENTATION (FOR EXAMPLE, WHEN THE CLINICAL STUDIES ARE 'CONSISTENT' WITH A DIAGNOSIS BUT THE HISTORY AND PHYSCIAL EXAMS ARE NOT – I.E. INCIDENTAL IMAGING FINDINGS). THE KEY TO INCONSISTENCIES BEING SIGNIFICANT (OR A CONSISTENT PRESENTATION BEING VALID) IS THE ENTIRE CLINICAL PICTURE AS A WHOLE. SOMETIMES THIS WILL NOT HAVE 'ALL' ELEMENTS BEING CONSISTENT OR INCONSISTENT.*	
		Additional comments on/modified wording are as follows [see italics]: [paragraph #1, 15.13.b3] … After establishing the correct diagnosis and MMI, find the diagnosis in the appropriate DBI table based on the anatomical region (digits/hand, wrist, elbow, and shoulder), peripheral nerve, amputation, vascular, *complex* regional pain syndrome, and major trauma… *TERM CONSISTENT WITH THE LITERATURE AND PREVIOUS EDITIONS OF THE GUIDES*	
		Additional comments on/modified wording are as follows [see italics]: [paragraph #2, 15.13.b4b] …When an inconsistent diagnosis is made based on the CH, PE, and/or CS (three components) and the three components of the diagnosis are inconsistent with the NHD, no class can be established… *SEE DISCUSSION RE: 'ALL' THREE COMPONENTS ABOVE*	
	William H Brady, MD	As someone who performs IMEs and rating 2-3 times weekly, the proposed changes assist the physician in performing the rating. It does not change the actual ratings, but will assist the physician in better understanding the rating process.	

	John Hopkins, MD	For page one of the proposal section 15.13a upper extremity, step 1 should be establish MMI, then step 2, should be establish and confirm the correct diagnosis	
		• For page 1, step 3, do you recommend we do ROM evaluation first then determine DBI table ? • Page 2 of proposal, we need some clarification on ICD 10 code, any possibility we can add additional diagnosis in tables for new hand, wrist, elbow, shoulder conditions? One of the challane is we get patient that we can't locate the match in those upper extremity table 15-2 pages 391-404 what is the best solution? Example page 404, table 15-5 we have bicep tendon rupture, the surgeon couldnot locate the tendon to attached during rotator cuff tear, surgeon fixed the repair for RCT but not able to fix the tendon rupture, grid needs to be more apprehension. • We need solution for preexisting condition like discogenic spondylosis but we have large disc herniation at other levels! • Need solution for any of the modifier which is not apply to the condition of regional grid/ DDX • Page 3 of proposal, regarding to modifier, since we are facing range between A-E, in order to be accurate, any solution to narrow the option to get more accurate IR rating? Example in some state, 1% makes difference of $2,500 in comensation. • Page 4 of the draft, If one of the modifier is not valid, what would be the option in the new AMA 6th edition to eliminate in in the calculation protocol? • Table 15-23 page 449/ entrapement compression neuropathy, first nerve is 100% value, second nerve 50% value, we had case with 3 nerve entrapment (Median, ulnar, radial) is the 3rd nerve at 25% value like radial nerve?	
		Can we do like step by step chart like below to make it easier for Doctors to follow? Example: 1) step one, make the correct diagnosis/ regional Grid 2) step 2,functional history 3) step 3,physical exam 4) step 4, clinical studies	

			
	Steven Mandel, MD	• Sensory Impairment- does this include touch, temperature and position and vibratory sense • Brachial plexus- is this any division, upper or lower trunk- or measured by individual muscle groups • What is meant by vascular peripheral neuropathy? • CRPS- are the criteria the same for the upper and lower extremities- I recall that in an earlier edition, there were differences? • Is lumbosacral plexus included as a category of individuals muscles or nerves	
		MMI- as described- unlikely to change over the next year by less than 3%. If it does change is the individual locked in or can that person request a repeat evaluation? When it comes to neurological diseases, ie CIDP, MS- what is the impairment when at the time of exam it is normal?	
		Inconsistent- individuals may have abnormal EMGs and radiological findings- coincidental- or thought to be? What is the approach in these cases?	
	Mitchell Silverman, MD	I anticipate that the clinical history superseding the functional history will allow for a more accurate grade modification (if necessary).	
	James Stiehl, MD	In general, I really like what they have done. Importantly they discuss natural history of disease, which is the approach to stimulate an extensive body of knowledge that every physician possesses. The other important factor is to determine where the status of the case presents based on the NHD. For example, many patients get shoulder surgical procedures, when the surgeon assumes any abnormality can be and is caused by particular injury or event.	

		More importantly, I have seen spine fusions patients where they are truly normal. This new scheme allows you to rate them at 0. This is simple and intuitive, following the SOAP method that most of us practice by.	
		The most important contribution is a rather heavy consideration of inconsistent results. This is truly a big factor, and those of us who do sigficant examinations will tell you this is about the most significant problem that needs to be addressed. The paper guides gave you some simple conversions like if 2 grade modifiers are noted over the DBI class, they should not be considered. That is arbitrary, and gives another, not very intuitive example of adjustment. Examiners are now asked to state CH is inconsistent and the determination of that fact is made and documented in the medical report. Those who read the report, are likely to become confused by these little schemes in the paper guides that are not intuitive, and requires some knowledge of the manipulation. It goes to 'how did he come up that' which is not helpful. So in conclusion, the new rating method is intuitive to how doctors are trained to think, and does not minimize relevant issues, that we all have to make a basic judgement about, 'is the patient telling me a true story'.	