

Resolution Grid – Sept 2022

Commenter	Public Comment(s)	Panel Comments / Actions
Panel	Ratings will be higher. Fee schedule changes are subject to approval processes and cost impact (will add cost to WC). More difficult to get approvals of the AMA Guides updates in the jurisdictions ...	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p> <p>Rationale: A patient can be Class 0 with 0 impairment OR could be in class 1-4. For example—if class 1 the 3 grades default as 1, next step up would be 2 or 3, next step up would be 4 to 5. This would result in no increase in the range of impairments considered when compared to the 6th edition 2008.</p>
	Conversion factors are from legacy, but there was a change in % to convert regional to WPI ratings. Need a good reason as to why we made those changes and need to know how the formula was derived. Need an overriding reason why that is the overwhelming choice of changing the numbers.	<p>Action: Refer to Spine applicants for acknowledgement and/or to clarify the concept.</p>
American Academy of Physical Medicine and Rehabilitation	1. The submitted literature does adequately support the proposed changes. However, consider adding the sacroiliac joint examination (the 5 tests needed) to diagnose sacroiliac joint dysfunction.	<p>Action: None</p> <p>Rationale: Limited relevance to rating an injured workers' impairment. Limited to physical examination and this is addressed in the pelvic section.</p>
	2. The panel may also want to incorporate chronic pain contract as a comment, if indicated.	<p>Action: None</p>
	3. Waddell's Signs on physical examination is not mentioned, which is important when evaluating all patients when an injury has taken place and some form of litigation or disability is being sought.	<p>Rationale: Limited to physical examination</p>

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	<p>4. There is no mention of facet degeneration or hypertrophy as a form of limitation to Cervical or Lumbar ROM. While this impairment may not rise to the severity as a radiculopathy or other neurological injury, the facet joints are critical in ROM which then provides a patient with greater ability to perform ADLs.</p>	<p>Action: None</p> <p>Rationale: Limited relevance to rating an injured workers’ impairment. Rationale: Spinal stenosis, age-related findings that are non predictive of clinical presentation and were not considered.</p>
	<p>5. It is not clear how the “Whole Spine” column (Table 17-1 Revised Version) makes anatomic or mathematical sense. The listed increase in Whole Person Impairment values is not explained in detail as to why the values are higher.</p>	<p>Action: Refer to Spine applicants for acknowledgement and/or to clarify the concept.</p>
	<p>6. Revised Tables 17-2, 17-3 and 17-4 show increased values across all categories, without any specific explanation as to the reason for the increase.</p>	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p> <p>Rationale: A patient can be Class 0 with 0 impairment OR could be in class 1-4. For example—if class 1 the 3 grades default as 1, next step up would be 2 or 3, next step up would be 4 to 5. This would result in no increase in the range of impairments considered when compared to the 6th edition 2008.</p>
	<p>7. It is unclear why it is recommended to use the PDQ. PROMIS is likely superior to all and widely applicable. The ODI and Roland Morris are well studied in the lumbar spine. The NDI is well validated in the cervical spine (page 7).</p>	<p>Action: None</p> <p>Rationale: This issue is currently being addressed by applicants from the APA and ACOEM.</p>
	<p>8. The statement that, “reliability and precision of the diagnosis is essential” is difficult in spine. It is not always clear when a disc herniation on imaging is a problem or causally related to an injury. There is no accepted definition of “instability” on flexion extension xrays and readings, angles of the beam, pain inhibition, and other factors all play a role. This complicates the idea</p>	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p>

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	<p>of “altered motion segment integrity”- It may be difficult to make a reliable or precise absent a surgical or post infection fusion or fracture. If those are the conditions to which this refers, they should not use AOMSI but the actual diagnoses or surgical fusion, as it could be too subjective otherwise. “Sprain” means a ligamentous injury and “strain” means a musculotendinous junction injury. These terms are generally used without any true anatomic context in back pain which is problematic and also not reliable or precise (page 11).</p>	
	<p>9. Thoracic radiculopathy is difficult as there are rarely physical exam findings other than numbness, which is somewhat subjective, and electrodiagnosis is neither reliable or feasible (page 23).</p>	<p>Action: None Rationale: Addressed in the change proposal.</p>
	<p>10. Measuring atrophy may not be as objective as it seems. Questions that arise include: Where and how to measure people? How reflective is that of a given radiculopathy? Does baseline body habitus matter? The same measurements may not apply to particularly large or thin legs. Some people are asymmetric and some have persisting atrophy from prior immobilization. In general, this is unreliable and should not be weighted equally with loss of reflexes or electrodiagnostically confirmed radiculopathy (page 38).</p>	<p>Action: None Rationale: Physical exam findings addresses this. Electrodiagnostics should not be mandated to stay or jump classes. Clinicians should not be mandated to obtain this test.</p>
	<p>11. Spondylolysis is not present in 7-11% of adults – the number is closer to 5-7% depending upon the method of evaluation (See Sakai T et al, Spine 2009;34:2346-2350, and Roche MA, Rowe GG. The incidence of separate neural arch and coincident bone variations: A survey of 4,200 skeletons. Anat Rec 1951; 109: 233-252). Degenerative spondylolisthesis is seen far more commonly in older adults- closer to 20-40%- incidence increases with age (See Wang YXJ, Zolta’n K, Deng M, et al. Lumbar degenerative spondylolisthesis epidemiology: a systematic review with a focus on gender-specific and age-specific prevalence. J Orthop Translat 2017; 11:39–52) (Page 40).</p>	<p>Action: Refer to spine proposal team for acknowledgement, consider adjusting to say 5-11%</p>
	<p>12. There is no mention of nuclear medicine or CT myelography as imaging options (page 41).</p>	<p>Action: None Rationale: These imaging options should not be mandated</p>
	<p>13. “Physical medicine specialists” should be “specialists in physical medicine and rehabilitation” (page 41).</p>	<p>Action: Refer for Revision</p>

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	<p>14. Regarding mental health conditions - this determination fundamentally undercuts the significance of mental health disorders in ongoing pain. Individuals can have depression, anxiety, or PTSD as a result of trauma, injury, or ongoing pain and these need to be diagnosed and treated appropriately, and considered independently of the spine pathology in many cases, hence the need for multidisciplinary treatment for many patients with spinal injuries (page 44).</p>	<p>Action: Refer to the spine proposal team for acknowledgement and/or to clarify the concept as needed.</p>
<p>American Psychological Association</p>	<p>1. Guides chapter 1 should have a more detailed discussion of standards for measures of functioning to be used in the Guides. These criteria would be used to select measures for Guides use.</p>	<p>Action: None Rationale: Table for a Chapter 1 proposal</p>
	<p>2. Overall, the APA/IHC review concluded that the PDQ, while useful in some contexts, was not a good fit for the intended purpose of the Guides. A) It seems to be more a measure of distress and pain interference as opposed to following the ICF model, B) within the context of Guides assessment, some PDQ items are problematic, and C) the PDQ community norm group is strongly biased towards white females, is not a representative sample on which to establish what constitutes “normal,” and thus is not valid for making determinations about what constitutes an unusually high or low score.</p> <p>3. Previously the Guides panel voted to approve the PROMIS 29 for functional assessment, and we would recommend its use in this chapter.</p>	<p>Action: None Rationale: This issue is currently being addressed by applicants from the APA and ACOEM</p>
<p>International Academy of Independent Medical Evaluators (James Williams)</p>	<p>IAIME has reviewed the proposed changes to the AMA Guides Chapter 17, Spine and has multiple concerns regarding the proposed changes. We had access to the comments submitted by James B Talmage on behalf of the Tennessee Bureau of Workers’ Compensation and our concerns align closely with these concerns. Rather than duplicate this commentary, we have chosen to formally endorse those comments and are available to field questions or provide additional commentary, if necessary.</p>	<p>Action: None Rationale: See responses to TWBC</p>
	<p>In addition, as the comments by Dr. Talmage touch on, IAIME reviewers are particularly concerned about the lack of widespread availability/use of spine imaging addressing “sagittal balance” in clinical practice involving injured workers/claimants. This specifically creates an expectation of something being done (i.e. it is described in the AMA Guides) while practitioners will not typically have it available when evaluating injured workers/claimants.</p>	<p>Action: None Rationale: Acknowledged this concept during the revision. Looked at the predictive ability of positive sagittal balance for the likelihood of a future surgery. As SB goes beyond 5 and increases, this</p>

		<p>likelihood further increases the side effects that come along with surgery.</p> <p>Carrying AOMSI forward because it’s historic and a placeholder for a larger generalized concept that may require surgical intervention.</p> <p>Needed a category and placeholder and Class entry criteria.</p>
	<p>With regards to the proposed Box 17-1 Definition of Commonly Used Terms, we have alternative language for parts of this section</p> <p>Muscle Spasm: Muscle spasm is a term that should be reserved for muscles involuntarily contracting due to an upper motor neuron pathology, i.e. “spasticity.” The term “muscle spasm” as often used in general clinical practice is a misnomer and has not been found to be a reliable or useful clinical finding. Muscle guarding (see below), voluntary muscle contraction, differences in tissue density/resting tone, and misidentification of palpated anatomy are some of the findings erroneously labeled as “muscle spasm” in general clinical practice.</p> <p>Muscle Guarding: Guarding is a contraction of muscle that minimizes motion or agitation of the injured tissue. It may be difficult during an examination to differentiate muscle guarding from other findings. Loss of normal cervical or lumbar lordosis may be present on examination or lateral standing radio-graph. Persistent loss of segmental motion is often associated with chronic, painful spinal pathology <i>[what is the/is there a scientific basis for this last sentence?]</i>.</p> <p>Electrodiagnostic Verification of Radiculopathy: Electromyographic evidence of nerve root pathology includes the presence of multiple positive sharp waves and/or fibrillation potentials in muscles that share a similar nerve root innervation (i.e. at least two muscles innervated by different peripheral nerves as well as corresponding paraspinal muscles, depending on the timing of the test). The skill and methods of the individual performing and interpreting the electrodiagnostic study are crucial. Only licensed physicians with adequate education, training, experience, and specialty certification may prepare a report deemed valid for the purposes described herein. Electromyographic evidence is useful in detecting radicular findings, even independent of imaging studies. The presence or intensity of pain is never evaluated by electrodiagnostic studies.</p>	<p>Spasm- Action: Refer for Spine applicants for acknowledgement. Rationale: Spasm cannot be easily clinically confirmed. Help the evaluating physician understand that concept or consider removal from the revision.</p> <p>Guarding –Action: None. Rationale: Applicants wanted to clarify things like upper/motor neuron. Wanted to give something in clinical practice to rely on with an extra emphasis on science.</p> <p>Electrodiagnostic Verification of Radiculopathy – Action: Refer to Spine applicant group to consider suggested clarification</p>

<p>Gallagher</p>	<p>1. Remove “no residual signs or symptoms” from Class 0 in the spine tables (17-2, 3, and 4) and replace with “asymptomatic with no objective finding”</p> <p>Class 0 as indicated by the five classes in the DBI grid below with “no objective problem”, technically would be a condition with no objective radicular findings. In the tables for chapter 17 for Class 0 includes “no residual signs or symptoms.” By including residual findings there is an assumption of findings at the onset. This is inconsistent with the DBI grid for other spinal conditions.</p> <p>The challenge I have come to with this is that most compression fractures, especially those that would be considered minimal are asymptomatic and are typically incidental findings in a radiographic study. This is such a common occurrence that radiologist rarely even mentioned a minimal compression fracture that can be measured. For that matter in my experience radiologist typically overlook compression fractures at, above, or just below 25% unless the radiology request includes a clinical finding relative to that involved vertebral body.</p> <p>I believe Class 0 in the tables for chapter 17 should be posted as “asymptomatic with no objective finding” and rated at 0%. With the ICF system functionality is a major concern in rating impairments. For a minimal compression fracture that is asymptomatic with no documentation of any functional deficiency this should be rated at 0% and considered a coincidental finding. In the same tables addressing intervertebral disc herniation and/or AOMSI Class 0 with a 0% rating includes, “Imaging findings of intervertebral disk herniation without a history of clinically correlating radicular symptoms” here the table provides for an asymptomatic condition without including an impairment rating for such a radiographic finding.</p>	<p>Action: None.</p> <p>Rationale: This has been addressed in the revision.</p>
	<p>2. Class 1-4 in tables 17-2, 17-3, and 17-4 should require radicular findings at least at the beginning of care thus allowing for the possibility of those symptoms to resolve.</p> <p>Classes 1 – 4 cervical, thoracic, lumbar spines for each class includes, “may have documented radiculopathy at the clinically appropriate level present at the time of examination.” With the option of “may have” the door is open to exclude any radiculopathy in rating Classes 1 – 4. This leaves the possibility of rating compression fractures based solely on the extent of the compression.</p>	<p>Action: Refer. Spine applicants to acknowledge and review.</p>

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	<p>In these same charts under intervertebral disc herniation and/or AOMSI each class includes a requirement of radiographic findings and at least radicular findings at the onset of care with the possibility of resolution of those findings with care.</p> <p>The problem with the tables for compression fractures is that the way it is written the rating can be based entirely on the depth of the compression without any consideration for the symptoms or radicular findings associated with that level or levels. As such with the current wording is possible to award up to 30% for an asymptomatic cervical compression fracture, 22% for an asymptomatic thoracic compression fracture, and 33% for a lumbar asymptomatic compression fracture.</p> <p>The guidelines for the different classes in relation to compression fractures should be consistent with other spinal injuries based on initial findings as compared to subsequent findings. Subjective complaints without objective physical findings or significant clinical abnormalities are generally assigned class 0 and have no ratable impairment.</p>	
	<p>3. Cerebellar tonsillar ectopia, CTE is a condition commonly seen with Chiari malformations. CDC can exert pressure on the medulla affecting cranial nerve function most obviously as diminished ability to swallow. This condition is not currently addressed in the Guides and considering that about one in four whiplash cases like this is identifiable on MRI it should be addressed. Since the medulla extends to the posterior surface of the dens at C2 this condition should be considered as a spinal impairment.</p>	<p>Action: None.</p> <p>Rationale: Considered in Nervous System proposed revision.</p>

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<p>Luers, Patrick</p>	<p>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.</p> <p>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)</p> <p>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.</p>	<p>Action: None</p> <p>Rationale:</p> <p>The applicants acknowledged this concept during the revision.</p> <p>Looked at the predictive ability of positive sagittal balance for the likelihood of a future surgery. As SB goes beyond 5 and increases, this likelihood further increases the side effects that come along with surgery.</p> <p>Carrying AOMSI forward because it's historic and a placeholder for a larger generalized concept that may require surgical intervention.</p> <p>Needed a category and placeholder and Class entry criteria.</p>
<p>Mueller, Kathryn</p>	<p>1. I have several major concerns regarding the changes to the spine chapter, having taught hundreds of students how to use the 6th edition as well as previous editions (which required more instructions because the chapters differed significantly in approach). One of the reasons the 6th edition was relatively easy to teach to physicians who had not previously performed impairment ratings was that the system was consistent throughout all chapters. Once the student learned to go to the middle number on the diagnostic grid or key determinant grid they then knew to move up or down within that classification based on the grades of clinical studies, functional history, and physical exam. This created a less complicated system for both medical examiners and the legal community. Once the diagnosis could be agreed upon there were only five choices maximum that could be used and those were determined by the grades. If the editorial committee chooses to change this system, it would be absolutely essential that it is changed in at least all of the most frequently used three musculoskeletal chapters at the same time. Many jurisdictions</p>	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p> <p>Rationale: The spine chapter deviates from the upper and lower extremity chapter. Spine has removed range of motion. There is not consistency as ROM is only applicable in upper and lower extremity chapters. Spine is the ideal chapter to revise first before making a change to upper and lower extremity at the same time to make them consistent.</p>

	<p>either require certification regarding expertise in impairment rating or use such certification when deciding upon medical experts in cases. The teaching necessary to certify physicians needs to be considered.</p>	<p>The change to 3-grade methodology in the spine chapter will be described in greater detail in either a bulletin or Guides Newsletter article.</p> <p>A patient can be Class 0 with 0 impairment OR could be in class 1-4. For example—if class 1 the 3 grades default as 1, next step up would be 2 or 3, next step up would be 4 to 5. This would result in no increase in the range of impairments considered when compared to the 6th edition 2008.</p>
	<p>2. Under the proposed system there may be up to five choices within a specific class category for the impairment rating. These are to be governed by the grade modifiers. However it is not possible to reach the highest numbers in the grade modifiers in some cases. For instance in the a OMSI or the fracture categories clinical studies cannot be used as a grade modifier. The functional grade table only allows a one point gradient and a physical exam table only allows a 2 point grade shift. Thus when you start from the lowest number you cannot reach the 4th number in the class. I would expect that there are several other examples of this in the chapter.</p>	
	<p>3. I don't believe we have any evidence to back up the numbers we use in the Guides. Theoretically one could use the highest quality studies on functional results from surgery or other studies to try and set 'evidence-based' numbers but I don't believe that is happening right now. Therefore it is going to be hard to radically change the % in the Guides for the same conditions we already have numbers for. I think that could be done for some areas where surgery has improved outcomes etc. but consideration needs to be given to the effects on the jurisdictions and pay outs. Changes are fine if there is real science behind it but if not, I think jurisdictions won't want to change editions.</p>	
	<p>4. Given these issues I believe that there would be many comments from the users of the Guides regarding how the new proposed numbers would alter the current ratings. It may be reasonable to change to a system where the rater begins from the lowest number but that , with any new numbers being considered, should be tried on many similar 6th edition cases to see if the ratings will radically change. Jurisdictions can't adopt a version that results in a radical change in ratings because it would significantly change the insurance premiums. As much as possible the new ratings should either reflect significant changes in scientific literature and outcomes, or they must be relatively consistent with the prior ratings. Since this chapter suggests significant changes in how the rating is arrived at, I believe there would be much discussion as to whether these ratings are lower overall then the prior ratings. Subjectively they appear to me to result in a lower rating because of the way the modifiers are created. I would strongly suggest that the many experienced impairment raters on the advisory and main editorial committees take recent cases that have been controversial and rate them using the proposed system to see how the numbers compare and how the higher numbers could be reached with the proposed system.</p>	

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	<p>5. Currently this chapter reflects the use of the PDQ to reflect the functional history. I understand this is because there has not been a final decision regarding the functional measures to be used. However if there is no change and the PDQ will continue to be used in the chapter, the APA and ACOEM committee would disagree with the sentence which asserts that the PDQ is a validated tool for these purposes.</p>	<p>Action: None</p> <p>Rationale: This issue is currently being addressed by applicants from the APA and ACOEM.</p>
	<p>6. Table 17- 19 has an error in the footnote. It reminds the reader that only one of the two columns may be used but in the final sentences it says” ... do not use the image column” when in fact it should say “do not use the electrodiagnostic findings”. This is because the image column is already used in certain diagnostic categories to create the Class.</p>	<p>Action: Refer comment for edit</p>
	<p>7. I do not think the idea of whole spine x rays as part of the process is reasonable. From a health point of view we should not be advocating for further unnecessary radiation exposure and they are not routinely obtained for most cases.</p>	<p>Action: None</p> <p>Rationale: Not a mandated test; this is specific criteria for a higher class. This will apply to a very small number of patients. This is the only test that is predictive across a population that will have future surgery.</p>
<p>TN BWC – Talmage</p>	<p>1. The proposal resurrects from the Guides 5th Edition the concepts of “spasm”, guarding, and asymmetric range of motion which were not incorporated in the 6th Edition.</p> <p>The AMA Guides Newsletter has labelled these concepts NOT reliable, and leading to dueling doctors. Yet these are in the proposed text and rating tables as if these had recently become reliable? [See The Guides Newsletter attachment at the end of this document.] Box 17-1 and the text need a MAJOR rewrite, if the stated goal of “getting the medicine updated and right” is to be achieved.</p>	<p>Action: Refer for Spine applicants for acknowledgement/consideration.</p> <p>Rationale: Spasm cannot be easily clinically confirmed. Help the evaluating physician understand that concept or consider removal from the revision.</p>
	<p>2. The proposal does NOT provide clear guidance to distinguish true, objectively verifiable radiculopathy from “non-verifiable radicular complaints”. This distinction is a very frequent source of disputes in the Workers’ Compensation system. This determines what row in the spine rating table is used, with higher impairment values for the “true radiculopathy” than for the “non-verifiable radicular complaints” table row. The term “non-verifiable radicular complaints” is disparaged on proposal page 15, and supposedly “eliminated” from the text, but the term still appears in the proposal in Table 17-3, Class</p>	<p>Action: Refer for spine group acknowledgement / consideration.</p> <p>Rationale: Consider the Admirable Review article in addressing this issue.</p>

	<p>1. The IASP (International Association for the Study of Pain) Special Interest Group on Neuropathic Pain published a 2016 revision to criteria to distinguish “possible” neuropathic pain, from “probable” neuropathic pain [Finnerup et al. Pain 2016; 157 (8): 1599-1606 ATTACHED as a pdf]. In medical-legal matters doctors testify or opine “within reasonable medical probability”, or “more likely than not”, or “probable and not just possible”; thus the Guides spine proposal should conform to the definitions of “probable neuropathic pain” for true radiculopathy, and “possible neuropathic pain” for non-verifiable radicular complaints. Most often this would require a detailed, and time consuming sensory exam with detailed documentation, which will not be popular with doctors, as to demonstrate reliability of the sensory exam is time consuming. The next issue of the Tennessee Bureau of Workers’ Compensation physician newsletter (AdMIRable Review) will review the concept of radiculopathy in the Guides editions 1 through 6. This will be submitted as an attachment.</p>	
	<p>3. The proposal discusses radiculopathy (which can manifest as radicular pain or neuropathic pain – injury to the nervous system) as opposed to other spinal pain. However, the previously accepted dichotomy of nociceptive pain (nervous system functioning normally and “reporting” a pain generator in another tissue –e.g., fracture, sprain, arthritis, etc.) versus neuropathic pain (other tissues normal but nervous system malfunctioning due to neuron injury or disease) has now been modified (2017) by IASP to include a third category of pain, “nociplastic pain”. Nociplastic pain is conceptualized as the peripheral tissues and Lower Motor Neurons function normally, but non-structural processes in the brain amplify the pain presentation, in the absence of upper motor neuron injury. This is unconscious. This has been published in high impact journals [Kosek et al. Pain 2021; 162 (11): 2629-2634 & Fitzcharles, et al. Lancet 2021; 397: 2098-2110 – both attached – 20 additional articles on nociplastic pain are available for submission on nociplastic pain if the committee wishes additional information]. This nociplastic pain concept will be adopted by ICD-11 which is scheduled to “go live” in Europe in 2023.</p> <p>Nociplastic pain has major implications for treatment. To the degree it is present, treatment aimed at peripheral nerves and spinal structures (medications, injections, nerve ablations, spinal surgery) will be ineffective, which must be considered when addressing the “has maximal medical improvement has been achieved?” question. In addition for rating purposes distinguishing neuropathic pain from nociplastic pain when rating persisting radiculopathy should be an issue addressed in a spine chapter revision.</p> <p>With the AMA goal of revising the Guides to reflect current best medicine, this concept must be dealt with. This would require a multidisciplinary committee to review all</p>	<p>Action: None</p> <p>Rationale: Nociplastic pain was considered and should be considered in the pain chapter.</p>

	<p>literature and provide guidance on how this nociceptive pain would be recognized in the patient history, physical exam, and testing, and most importantly how this concept should factor into spinal impairment ratings.</p>	
	<p>4. Fourth, the proposal increases the actual rating (integer) assigned for many conditions without stating a rationale for the increases. States that require legislative action will likely require a fiscal impact study before considering legislation to change to the Guides, Digital edition. Regardless of science, many states may reject a Guides edition with this spine chapter proposal based solely on its projected increased cost to the system. References explaining why in 2022 spinal treatment outcomes are worse than they were in 2007 should be clearly cited. Spine surgery has advanced since 2007 with widespread adoption of minimally invasive approaches, and there should be clear evidence submitted of outcomes of our spine surgery techniques are now worse than they were in 2007.</p> <p>For example, in the cervical spine (Table 17-2) the proposal would increase the current non-specific spinal pain rating from a maximum permitted rating of 3 %WPI to 5% WPI. The rationale for the Sixth Edition (2008 book) capping this rating at 3% WPI was the 3% maximal rating for pain from Chapter 3 (pain without demonstrable organ dysfunction) and the Section 2.5e paragraph permitting up to a 3% WPI with articulated “change from pre-injury status” but still normal by the criteria in Chapters 4-17. Absent documentation of treatment results being worse today than they were in 2007 when the current hardbound book was written, there is the question of why the increase, and what will be the cost to businesses and insurers, since spinal claims in this category are so common. This same increase from at most 3% to now 5% is in the proposed Table 17-4 for the lumbar spine.</p> <p>An aside is the current hardbound book states (page 563, third paragraph under general considerations), there are by definition no physical exam or imaging findings that correlate with non-specific spinal pain. Despite this the proposal lists clinical findings that would score points to increase the rating from 3% to 5% with no reference to current literature on the reliability or validity of the physical exam findings to support the change. Actually, high impact peer-reviewed journals echo the “no clear physical exam or imaging findings to explain most spinal pain” current text statement. [Hartvigsen et al. What Low Back Pain Is and Why We Need to Pay Attention. Lancet 2018. 391 (10137): 2356-67. http://dx.doi.org/10.1016/S0140-6736(18)30480-X & Brinjikji et al. Systematic Literature Review of Imaging Features of Spinal Degeneration in Asymptomatic Populations. AJNR Am J Neuroradiol. 2015 Apr;36(4):811-6. doi: 10.3174/ajnr.A4173. -both ATTACHED.]</p>	<p>Action: Refer to Spine group to acknowledge and/or address this comment; as necessary, a bulletin or Guides Newsletter article can be developed to expound upon this issue.</p> <p>Seek clarification from the commenter on the example interpretation.</p>

	<p>Another example is in the proposal page 14 which appears to state that spondylolisthesis and spinal stenosis have been removed from the update, yet “incorporated into Class 3-4”. In the current 2008 hardbound book these diagnoses, which are frequently used by treating physicians in workers’ compensation cases, have the options of Class 1 to Class 4. Class 1 is 5% to 9%. In proposed Table 17-4 Class 3 is 16% to 24% and Class 4 is 25% to 36%. Thus spondylolisthesis and stenosis that in the current hardbound book can be rated as Class 1 [5% to 9%] in the proposal would escalate to Class 3 or Class 4 [16% to 36%]? The word spondylolisthesis does not appear in Table 17-4. The words spinal stenosis appear in the Table in Class 2, but not in Class 3 or Class 4. The physician who follows the proposed new text (proposal page 14) would place a patient with a treating physician diagnosis of spondylolisthesis or spinal stenosis in at least Class 3 with a very large increase in impairment compared to the 2008 book. There is no reference to why current treatment results are so much worse than they were in 2007.</p>	
	<p>5. A Fifth, comment is on Saggital Balance. The proposal is correct that in adults with persisting congenital/developmental spinal deformity, this is an important surgical consideration. However, rarely do the common adult spinal work injury claims involve altered sagittal balance. Other than in the spinal deformity population, standing whole spine radiographs are not commonly obtained, so the typical injured worker’s file would not permit evaluation of this concept that rarely applies anyway. The exception in workers’ compensation would be the patient with a multilevel lumbar spinal fusion inadvertently fused with less than his/her usual lordosis who now has the increased distance (imbalance) shown in Figure 17-7b. This would be an objective radiographic finding documenting a reason for a poor surgical outcome. Otherwise, this section on saggital balance will not be used by or considered by the typical orthopaedic surgeon, neurosurgeon, or PM&R doctor rating spinal injury impairment. An aside is the proposal text (page 17) lists the linear distance defining loss of sagittal balance in the cervical spine as > 4 mm and in the thoracic or lumbar spine as > 8 mm, while Table 17-9 lists the cervical criterion as >8 mm and the thoracic and lumbar criteria as > 10 mm. Neither the text nor the table list a reference for where any of these numbers is supported by literature.</p>	<p>Action: None</p> <p>Rationale: Acknowledged this concept during the revision.</p> <p>Looked at the predictive ability of positive sagittal balance for the likelihood of a future surgery. As SB goes beyond 5 and increases, this likelihood further increases the side effects that come along with surgery.</p> <p>Carrying AOMSI forward because it’s historic and a placeholder for a larger generalized concept that may require surgical intervention.</p> <p>Needed a category and placeholder and Class entry criteria.</p>

	<p>6. The proposal changes the methodology. In the 2008 textbook edition, all 3 musculoskeletal chapters have for a given Class a choice of 5 possible integers for a diagnosis based impairment percentage. The default rating is Grade C, the middle integer. After assignment of the Grade Modifiers, it is possible to have a better than average result after time and treatment (Grade A or Grade B), the average or default result (Grade C), or a worse than average result (Grade D or Grade E). The proposal would ‘simplify’ the methodology by eliminating Grade A and Grade B choices, and the minimum rating would become Grade C in terms of 2008 textbook impairment percentages. To date debate on this proposed methodology change seems to have been framed in philosophical terms: “Should workers be penalized for recovering?” (favoring the new methodology in the proposal), or “Should the employer be penalized because the worker recovers?” (favoring the 2008 methodology). However, the practical problem of the second injury or second episode may not have been considered.</p> <p>If a worker has a spine injury in 2010 and was rated by the 2008 textbook edition as Class ‘whatever’ and Grade A or Grade B, and then after a state adopts the Guides Digital 20XX with the new spine methodology the worker has another episode of the same problem, there is a major issue. The new episode is an accepted claim, and the worker is treated for the same diagnosis and recovers fully after a 2 week duration episode. The workers is now back to the same symptoms, physical exam, etc, as they had for the 13-15 years after the first injury. With the new proposal eliminating the options of the integers for Grade A and for Grade B, the worker’s impairment rating for the new episode is now at least Grade C (by the 2008 textbook – the new proposal’s minimum rating for the accepted diagnosis), and the 2 week episode with full recovery would now result in a substantial impairment increase [current minimum default rating or Grade C 2008 rating minus the original Grade A or Grade B 2008 rating]. Under the new proposal there is no way to give the worker the same rating for the same diagnosis and a 2 week new episode.</p> <p>Recurrent injury with the same diagnosis is a problem that should be considered and debated, as this issue alone may prevent some/many jurisdictions from considering adopting the Digital Edition with this methodology.</p>	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p> <p>Rationale: A patient can be Class 0 with 0 impairment OR could be in class 1-4. For example—if class 1 the 3 grades default as 1, next step up would be 2 or 3, next step up would be 4 to 5. This would result in no increase in the range of impairments considered</p>
	<p>7. A major benefit for the 2008 textbook edition was the identical methodology in the 3 musculoskeletal chapters. If a physician understands the methodology for diagnosis based rating, that physician is able to understand all 3 chapters. With the new proposal, the spine chapter would have a different methodology. Tennessee has 2 programs that require the physicians in the program to have taken and passed a training course in the AMA Guides to be eligible for participation. The Medical Impairment Rating Registry</p>	<p>Action: Panel to develop guidance via Newsletter or other bulletin.</p> <p>Rationale: The spine chapter deviates from the upper and lower extremity chapter. Spine has removed range of</p>

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	<p>provides a neutral third IME to settle the issue of the correct rating when there are “dueling doctors” with different ratings. The Certified Physician Program requires a physician to take multiple training modules on workers’ compensation topics, a “third party” course on the Guides, 6th Edition, and then pays those physicians successfully passing the test over the modules a bonus for each office visit. Ninety percent of work injuries with permanent consequences (a.k.a. impairment) are musculoskeletal. Having the 3 musculoskeletal chapters revised but one at a time in different years, would likely result in a new requirement for our physicians in these programs must take 3 separate training courses in the AMA Guides. The organizations that offer training currently approved by the Tennessee Bureau of Workers’ Compensation currently have comprehensive courses in the Guides with fees ranging from about \$500 to about \$1500 for a course. Expecting physicians to take almost annual courses in the AMA Guides each year a new iteration of a musculoskeletal chapter is released would likely decrease physician interest and participation in our programs.</p> <p>Texas, Colorado, and California have training requirements that should be considered by the committee.</p>	<p>motion. There is no consistency as ROM only applicable in upper and lower extremity chapters. Spine is the ideal chapter to revise first before making a change to upper and lower extremity at the same time to make them consistent.</p> <p>The change to 3-grade methodology in the spine chapter will be described in greater detail in either a bulletin or Guides Newsletter article.</p>
	<p>8. While the concept of “spasm” in the common spinal injuries without quadriplegia or paraparesis was incorporated in the 4th and 5th Editions, it has been deleted from the 6th Edition as an erroneous concept. Consider the AMA Guides Newsletter publications on “spasm”. Copied and pasted below (in Dr. T’s comments) are sections of this AMA publication showing the AMA has already adopted the scientific evidence on this “spasm” issue.</p>	<p>Action: Refer for Spine applicants for acknowledgement.</p> <p>Rationale: Spasm cannot be easily clinically confirmed. Help the evaluating physician understand that concept or consider removal from the revision.</p>

Next steps: Develop a GNL article to discuss necessary changes to spine ahead of the LE and UE content. The article will include a discussion on spine being intentional methodology that will be applied to the other content.