Resolution Grid – MSK CRPS, Peripheral Nerve, Select Spine, Pelvic DBI, Vignettes (January 2024)

Commenter	Comment Received	Resolution (from authors/panel) - TBD
American Chiropractic Assn	The American Chiropractic Association (ACA) and the ACA Council on Forensic Sciences reviewed the proposed documents and do not substantially disagree with the presented changes.	
John Hopkins, MD	Regarding to elbow, DBI table 15-4 page 399 under medial epicondylitis, in number of cases, they do have cubital tunnel syndrome (ulnar motor entrapment neuropathy) across elbow as a result of medial epicondylitis, would you make a clarification in the new AMA edition on how to make decision on medial epicondylitis verses cubital tunnel syndrome, do we use peripheral nerve section or just zero out the nerve under the clinical study such as nerve conduction study with decrease amplitude, and nerve axonal demyelination at elbow for grading medical epicondylitis.	
	Regarding to DDX distal biceps tendon rupture, I know we use 2 methodologies, DBI and ROM. But in the new publication, do you suggest the DBI model and the high priority verses ROM model even if ROM model was higher for some reason?	
	Would you consider changes for hip in table 16-4 pages 515? We need clarification or maybe separate partial verses total hip replacement. I think total hip replacement should have higher value than partial hip replacement on page 515. Also would you consider changes on page 514, under hip arthritis? One of the biggest challenge is we get MRI , X-rays report all the time from radiologists across the country, problem, they classify arthritis in the report as mild, moderate , severe. It is hard and very time consuming to locate later on the radiologist across the country and ask them to measure 3mm cartilage verses, 2mm or 1 mm or no cartilage etc.. with mild, moderate, severe and very severe language for arthritis, we can do the rating much faster etc..	
	The chapter 17, under Pelvis DBI model pages 593, we had case that the patient had bilateral fracture of pelvis, can you address in the new AMA publication book , what if we have bilateral Fracture, do we do the value X 2 or do we do combine value of right pelvis verses left pelvis?	
	Table 16-12 page 543, One of the challenge for consideration is when patient has chronic diabetes neuropathy (pre-existing) and lower extremity entrapment neuropathy such as tarsal tunnel syndrome with low axonal amplitude and slow conduction velocity(axonal demyelination) in your new edition, can	

	you address the chronic metabolic condition and peripheral entrapment neuropathy as a result of an occupational injury and **bimalleolar** ankle ORIF. would you be kind and address that ?	
	Another challenge we have with AMA 6th edition is after hip total replacement we see a number of peripheral nerves affected as a result of surgery such as femoral(anterior femoral cutaneous) or lateral femoral cutaneous) do we grade and combine it under new edition as a compensable injury in IR?	
	In this part of spine, chapter 17, would you consider to expand on spine and federal cases? As you know DOL/ Department of Labor does not recognize the spine since congress act of 1974. So Dr. Christopher Brigham published advisory AMA newsletter back in July/august 2009 by using AMA disability Guides 5th edition to use nerve root/ peripheral nerve to address the spine rating. But it is still not clear for many DMA/ Department of Labor medical examiners. I wish it was a much better clear way to show an easy calculation for spine in federal cases in your new book AMA Guides 2024.	
Steven Mandel, MD	CRPS Is the criteria the same for the UE and LE? Is there an entity as CRPS limited to a joint?	
	Peripheral nerve – Where is the Autonomic nervous system addressed – should that be referred to the CRPS chapter? Neurology chapter ?	
	Thoracic spine – r/o intercostal neuralgia	
	Thoracic strain- muscle or nerve … is the location of the pain at the level of the spine – above or below	
	Pubic Rami and Pelvis pain and Hip Pain – r/o sports hernia , radiation from the spine L1 or S1	
IAIME	Lower limb sensory standards are different than upper limb standards. Sensory evaluation of the feet in Diabetics is a standard that could be considered by the authors when examining limb sensation. Diabetes is a disease that affects multiple body systems: Endocrine, Lower Limb, Nervous System, and Skin. It may be a good condition to compare across chapters to improve consistency across various chapters in the Guides.	
	The Nervous System Chapter uses Activities of Daily Living to address motor system strength and loss after neurological injury. It may be useful to compare Table 13.5e, Station and Gait, with impairment rating for peripheral nerve injuries in the lower limb.	
	The Upper Limb Chapter includes the Brachial Plexus. The Lower Limb is also innervated by the Lumbar Plexus (the Lumbar Plexus is not mentions in the Lower Limb Chapter). Lumbar Plexus injuries are rare; but for completeness, and to meet the goal of evolutionary improvement of the Guides, adding the Lumbar Plexus to the Lower Limb Chapter should be considered.	

Mitchell Silverman, MD	Using R.O.M.for both upper and lower extremities impairments is always fraught with the ability of the examiner to determine full effort of exertion, patient participation and disparate subjectives vs.objectives. This is independent of PDQ, DASH an/or other functional questionaires. The use of the Range of Motion tables as an alternative rating system is examiner dependent. There may be a great disparity in rating the same patient. I guess there is no real “rule book” to make this determination except perhaps by the examiner experience. I would image the experience and training (i.e. Examination in the Certification of the 6th Edition) may have some bearing on the outcome of the evaluation.	
Kathryn Mueller, MD	I don’t have significant details to add or reconfigure the proposal. They appear to be following the new guidelines. I do think this update does meaningfully change the original 6th, however it does stick to the main categories. I have already expressed my disappointment that the international model regarding function is not being given a higher status in the rating. I think for jurisdictional acceptance it will be important to show that the ratings remain essentially the same in terms of overall numbers.	