Spine Proposal

North American Spine Society

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Background

- North American Spine Society work team has addressed the feedback previously provided by the editorial panel to improve the manuscript.

- Manuscript has been delivered to the Panel, approval and/or specific direction is sought before proceeding to public comment period.

Methodology – Recap from Previous Presentation

➤ Clarification between spinal trauma and neurologic injury
  ✓ Change descriptor language in Grid for nerve injury OR AOSMI OR BOTH (Class IV)
➤ When injury-sequela crosses a spine-segment:
➤ Text *now* clarifies which level is referenced for rating (prevent 'double dipping')
  ✓ Retain legacy functional consideration of **lumbar spine=0.9 (WPI)**
  ✓ Change regarding MSK contribution of cervical and thoracic segments: (least functional decrement even when entire thoracic spine segment fused.)
  ✓ THEREFORE: in application **thoracic segment = 0.4 (WPI)** and **Cervical = 0.8 WPI**
➤ Incorporation of specific Patient Reported Outcome Measures for the spine
  ✓ Incorporation of PRO (TBD) in the Grade-modifier for each class (Muller vs. PDQ)
➤ Considerations for Radiculopathy vs. Radiculitis to calculate impairment.
  ✓ Define pain vs deficit class 0 vs. Class 1 with specificity of definitions for *non-verifiable radiculopathy* and additional precision around grade modifier radiculopathy (Fig 17-6).
➤ Editorial precision decisions to simplify chapter so ratings are reproducible
  ✓ AOMSI becomes class 3
  ✓ Axial Spine pain is class 0 or class 1
  ✓ WPI starts at *lowest* Class numerical rating and ONLY increases with GMA points
  ✓ Treatment sequela Grid in place of confusing 'surgical complication' section
  ✓ Non-ordinal numeric choice (based on GMA) to increase precision.

Changes to Spine Regional Grids - Recap

❖ Combine categorical descriptors that lacked evidence to split:
  - ✓ Axial Pain, Limb Pain, AOSMI, Fracture Dislocation
  - ✓ Combine *Spondylolysis*, *Spondylolisthesis*, *non-verifiable pain*, and *post-operative complications* into categories listed above (naturally fit without evidence for maintaining subcategories.

❖ Simplify Regional Grid table definition

❖ Addition of simplified AOMSI category that has strong evidence to predict future re-operation (Sagittal balance-SVA).

❖ Simplify Grade Modifier table to increase precision

❖ All ratings start lowest number of class and GMA increase

❖ Include ALL post-treatment sequela to improve precision.

❖ Non-ordinal numeric choice within a Class

Examples of Simplification - Recap

SIMPLIFICATION EXAMPLES:

✓ Fewer categorical choices for Spine regions (4) (Cervical, Thoracic, Lumbar) - down from 7
✓ Text to ease burden of Classification.
✓ Once Class chosen, default grade now assigned to the lowest rating.
✓ The initial default value may be modified up (ONLY) within a class multiple grade-modifier adjustment opportunities using simplified (GMA figures).
✓ Find the net adjustment by adding grade-modifier points from each of the 3 adjustment grids (Function Hx, Physical Exam, and Clinical Studies).
✓ For each consistent/reliable grade-modifier point, move 1 numerical choice to the right at the top of the cell to find the correct WPI.
✓ Once the adjustment points are sufficient to reach the maximum WPI value in the cell (top right), this is the maximum WPI permissible for that diagnosis and class.
➢ Clear direction PROHIBITING "jumping" to the next higher class simply because there are more net-adjustment points.

Other Notable Updates from Current AMA Guides Sixth Edition

- Addition of whole spinal impairment values to Table 17-1

- Net Adjustment Formula is no longer used to calculate the Net Adjustment Value

- For injuries lower severity (Class 1,2) there is not much variance to healing. When injury is greater severity (Class 3 or 4), there can be substantial variance, therefore greater number (up to 5)of Grade Modifiers in higher classes.

Spinal and Pelvic Impairment Rating Steps- Comparison

Current	Proposed
1. Obtain detailed medical history and perform an appropriate physical examination, as explained in Section 17.1a.	1. Obtain detailed medical history and perform an appropriate physical examination, as explained in Section 17.1a.
2. Record process and results using Spine and Pelvis Impairment Evaluation Record (Figure 17-2) and using the completed record as a guide (Figure 17-7).	2. Record process and results using the Spine and Pelvis Impairment Evaluation Record (Figure 17-2) and using the completed record as a guide (Figure 17-8).
3. Review clinical studies, as explained in Section 17.1a.	3. Review clinical studies, as explained in Section 17.1a.
4. Determine the diagnosis or diagnoses to be rated.	4. Determine the diagnosis or diagnoses to be rated.
5. Determine the DBI for each ratable diagnosis, using the regional grids, as explained in Sections 17.2 and 17.4. This includes selection of the appropriate impairment class for that diagnosis.	5. Determine the DBI for each ratable diagnosis using the regional grids as explained in Section 17.2. This includes selection of the appropriate impairment class for that diagnosis.
6. Use the adjustment grids for Functional History, Physical Examination, and Clinical Studies, as described in Section 17.3, to define the grade modifier for each factor. Functional History adjustment is performed only for the single most significant diagnosis unless otherwise specifically stated by a jurisdiction. Impairment related to radiculopathy is a grade modifier, rather than an additional value.	6. Use the grade modifier adjustment grids for FH, PE, and CS as described in Section 17.3 to define the grade adjustment for each factor. The FH adjustment is performed only for the single most significant diagnosis unless otherwise specifically stated by a jurisdiction. Impairment related to radiculopathy is a grade modifier, rather than an additional value.
7. Apply the Net Adjustment Formula to calculate the net adjustment value to be applied to the default value C.	7. Add grade adjustment points to increase from default (or lowest) impairment rating in the impairment class.
8. Use the regional grid to identify the numerical impairment value associated with the impairment class and grade.	8. Use the regional grid to identify the numerical impairment value associated with the impairment class and grade.

Previous Panel Concerns Addressed

1. Changes allow for an option of Flex/ex or sagittal balance imaging.

2. Additional verbiage was added on the removal of some categories in the Regional grids, and justifying changes in AOMSI, radiculopathy, MRI/EMG etc.

3. Clarification to "sprain/strain related to the contribution and re-assessing impairment for subsequent injuries. Sprain/strain diagnoses limited to a dingles region in a case where a claim of injury to multiple spine regions could potentially result in 3 separate DBI rating for the CS/TS/LS regions in certain injury claims.

4. Additional clinical examples have been written

5. Enhanced bibliography with up-to-date references added

6. With regard to spinal cord injury, the 6th edition moved this rating into the Neuro chapter. Work Group recommends leaving it there, with a plan for later modification of the Neuro chapter to improve the rating methods more consistent with the Spine chapter.

7. NASS recommends the DOL be presented with the opportunity to evaluate the simplicity, precision an objectivity of the new Spine chapter to simultaneously assess Spine/Radiculopathy.