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Sixth Edition of the AMA Guides: An Overview of Changes

In December of 2007, the American Medical Association’s Guides to the Evaluation of Permanent Impairment, 6th Edition, was released. Per section 50-6-102 of the Tennessee Code, this edition is now applicable to all injuries arising on or after January 1, 2008. Below are the notable changes regarding the assignment of impairment ratings in various categories of injuries:

I. SHOULDERS

Several changes have been made to the method of calculating impairment of shoulders. First, range of motion can no longer be combined with any other rating method. Second, impingement syndrome, rotator cuff partial thickness, rotator cuff full thickness, SLAP tears, biceps tendon dislocation/subluxations, multi-directional shoulder instability, and unidirectional shoulder instability are now specifically listed as impairment diagnoses. Third, AC resections are still given a default rating of 10% to the upper extremity, but range of motion may not be added. This rating may be increased by using the modification non-key factors. Fourth, in certain circumstances, multiple diagnoses in the shoulder may each be rated. For example, if an individual suffers from a rotator cuff tear and AC joint changes, both injuries may be rated and combined.

II. NECK/CERVICAL SPINE

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Several significant changes have also been made to the method of calculating impairment of the cervical spine. The most significant change has been to the DRE rating methodology. Under the Sixth Edition, the classes of impairment have changed from 1 - 5 to 0 - 4. Further, different types of injuries have been separated out in a much larger grid. For example, there are separate sections in the DRE category grid for: (1) non-specific chronic, or chronic recurring neck pain (also known as chronic sprain/strain, symptomatic degenerative disc disease, facet joint pain, chronic whiplash, etc.); (2) intervertebral disc herniation and/or AOMSI, where AOMSI includes instability, arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those at multiple level conditions; (3) Pseudoarthritis only after spinal surgery intended for fusion with resultant documented motion (not necessarily AOMSI by definition) with consistent radiographic findings or hardware failure; with or without surgery or repair; (4) Spinal Stenosis that may also include AOMSI, where AOMSI includes instability, arthrodesis, failed arthrodesis, dynamic stabilization or arthroplasty, or combinations of those at multiple level conditions; and (5) Compression fractures of 1 or more vertebral bodies. The range of impairment ratings have changed as well. Under the first class, the range stays the same at 0. Under the second class, the range widens from 5 to 8% under the Fifth Edition to 1 to 8% under the Sixth Edition. The third class changes in range from 15 to 18% to 9 to 14%. The fourth class changes from 25 to 28% to 15 to 24%. Finally, the last class changes from 35 to 38% to 25 to 30%.

When rating under the new Sixth Edition, once an impairment class has been determined based on the diagnosis, certain grade modifiers for functional history, physical exam, and clinical studies, as applicable, are used to modify the

default value within the class but do not allow movement into a different class. Each category has five possible ratings for that specific class and type of injury. The default rating is the third (median) rating in the grid. Based on the modifiers, the assigned rating may go up two points or down two points.

However, the most significant change that has taken place is the lowering of possible ratings for certain injuries. For example, if an individual suffered from non-specific chronic, or chronic recurrent neck pain, the individual could have a rating assigned from 5 to 8% under the Fifth Edition. Under the Sixth Edition, the highest rating that person could have assigned is 3%. Additionally, under the Sixth Edition, if an individual has intervertebral disk herniation or documented AOMSI at a single level or multiple levels with medically documented findings; with or without surgery and with documented resolved radiculopathy or non-verifiable radicular complaints at the clinically appropriate levels present at the time of examination, the highest rating that individual could be assigned is 8%, with a default level of 6%. Under the Fifth Edition, this individual would be assigned a much higher rating. Further, an individual with a cervical fracture with 25 to 50% compression of a vertebral body would be assigned between 9 and 14% with a default rating of 11% under the Sixth Edition. The individual would be assigned a 15 to 18% impairment rating under the Fifth Edition.

III. UPPER EXTREMITIES

Under the Sixth Edition, certain changes have been made to the calculation of certain injuries to the upper extremities, including common injuries such as carpal tunnel syndrome and tennis elbow, or epicondylitis. One change concerning carpal tunnel syndrome is that “post-operative nerve conduction

studies are not required to rate impairment for focal nerve compromise syndromes.” Rather, “the pre-operative electro diagnostic test should be used in the impairment rating unless post-operative studies were done for a clinical indication of failure to improve surgery and the post-operative study is clearly worse than the pre-operative electro diagnostic study.” Additionally, epicondylitis is now graded as a DBI (diagnosis-based impairment). If epicondylitis is not repaired surgically, an impairment rating can be given only once during an individual’s lifetime. If the condition is repaired surgically with the release of the flexor or extensor ending with residual symptoms, the default rating is 5%, with a high rating of 7% and a low of 3%.

IV. LOWER EXTREMITIES

There are also a number of changes to the lower extremities section of the Sixth Edition. For instance, the lower extremity is now divided into three regions, as opposed to six. Those regions are defined as (1) foot to ankle (midshaft of the tibia to the tips of the toes), (2) knee (midshaft of the femur to the midshaft of the tibia), and (3) hip (articular cartilage of the acetabulum to the midshaft of the femur). Overall, this is not a drastic change from the Fifth Edition; however, the Fifth Edition specifically extended the lower extremity to the “pelvis” for evaluation purposes, rather than limiting the pelvic involvement of the lower extremity to the articular cartilage of the acetabulum, which is a part of the hip joint.

As with other lower extremity injuries or conditions, the Fifth Edition allows for assessment utilizing three categories – anatomic, functional, and diagnosis based. Within those categories are 13 methods used to evaluate LE impairments. However, as with other areas of the Sixth Edition, impairment for lower extremities is calculated utilizing the DBI grid. The classes and

corresponding LE impairment ratings are as follows: Class 0, 0%; Class 1, 1-13%; Class 2, 14-25%; Class 3, 26-49%; Class 4, 50-100%.

Both editions allow for evaluations based on range of motion; however, the Sixth Edition utilizes Range of Motion ICF Classifications, which are found at Table 16-25.

Additionally, the Sixth Edition no longer evaluates vascular problems as an element of impairment to the lower extremity. Vascular problems are now rated separately pursuant to Section 4.8 of the Guides. That section distinguishes between impairment secondary to lower and upper extremity diseases. Lower extremity peripheral vascular disease is evaluated for impairment pursuant to DBI grid classifications. Those classifications and their corresponding impairment ranges are found at Table 4-12.

V. LOWER BACK

Pursuant to the Fifth Edition, lower back, or lumbar spine, impairments were calculated utilizing either the DRE (diagnosis-related estimate) or ROM (range of motion) methodologies. Under the Fifth Edition, the DRE categories range from I-V. The Sixth Edition changes those classes to range from 0-4 on the DBI grid. The Fifth Edition DRE classifications are as follows: Category I, 0% PPI; Category II, 5-8% PPI; Category III, 10-13% PPI; Category IV, 20-23% PPI; Category V, 25-28% PPI. The DBI grid changes the impairment ranges as follows: Class 0, 0% PPI; Class 1, 1-9% PPI; Class 2, 10-14% PPI; Class 3, 15-24% PPI; Class 4, 25-33%.

Quite notably, the Sixth Edition has deleted the ROM methodology for evaluating impairment of the back. This is a marked change from previous

editions, which allows for more consistency in rating the back, as the ROM method was generally much more liberal.

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