

Spinal Impairment DRE Classifications - P&S Report Checklist

AMA Guides Clinical & Rating Criteria - Substantial Medical Evidence Standards

Impairment Factors must be present On The Date Of Examination For The MMI/P&S Report.

Muscle Spasm: A sudden, involuntary contraction.	Y/N	Reflexes: <u>Considered valid</u> , if the involved & normal limb <u>show marked asymmetry between arms or legs on repeated testing</u> . Once lost (previous radiculopathy) it rarely returns. Babinski Signs/Clonus may indicate corticospinal tract involvement.	Y/N
Common after acute spinal injury; rare in chronic back pain. Findings: Visible as a contracted paraspinal muscle; diagnosed by palpation (a hard muscle). Spasm should be present standing/supine & frequently causes a scoliosis. Test: Patient should place weight first on one foot & then the other while physician palpates the muscles. (b) The individual normally relaxes the paraspinal muscles on the weight-bearing side. If relaxation is witnessed, true muscle spasm is not present.		Motor Weakness and Loss of Sensation - To be valid , the sensory & motor findings must be in a strict anatomic distribution consistent with the affected nerve structures. i.e., follow dermatomal patterns (Figures 15-1 & 15-2). Atrophy accompanies significant, long-standing weakness.	
1. Muscle Spasm Is Present ?		1. Reflexes: Normal, increased, reduced, or absent?	
2. Properly Evaluated (Weight bearing Test)?		2. <u>Sensory Loss</u> In Anatomical Distribution?	
3. On testing, patient unable to relax the contractions?		4. <u>Weakness</u> follows affected nerve dermatomal pattern?	
		Atrophy:	
Muscle Guarding: Contraction of muscle to minimize ROM		1. Both Limbs tape measured <u>at identical levels</u> ?	
1. Muscle Guarding Is Present ?		2. Difference in circumferences not due to dominance ?	
2. Guarding is the Cause for the ROM Abnormalities?		3. 2 cm or greater in the thigh	
3. Not muscle spasm <u>because</u> the contraction can be relaxed?		4. 1 cm or greater in the calf?.	
4. Loss of Lumbar Lordosis due to contraction?			
5. Associated with reproducible loss of spinal motion?			
Asymmetry of Spinal Motion in one of the <u>three principal planes</u> . <u>If an individual attempts to flex the spine, he or she is unable to do so moving symmetrically; rather, the head or trunk lean to one side</u> . Finding must be reproducible and consistent to qualify as true asymmetric motion.		Radiculopathy: Significant alteration in the function of a nerve root or nerve roots usually caused by pressure on one or several nerve roots. <u>Diagnosis</u> requires a distribution of pain, numbness and/or paresthesias in a dermatomal distribution. <u>Root tension sign is usually positive</u> . <u>Imaging Finding</u> in and of itself does not make the diagnosis of radiculopathy.	
1. ROM Measurements Provided ? (Not Percentages!)		1. Imaging Study substantiate herniated disk at the right level?	
2. Asymmetry of Flexion/Extension?		2. Ancillary tests are positive for anatomical alteration of function?	
3. Asymmetry of (R/L) Rotation?		3. Ancillary testing are negative?	
4. Asymmetry of (R/L) Bending?		4. Imaging study not indicative of nerve root involvement?	
5. Asymmetry Caused muscle spasm or guarding.?		5. Clinical findings of nerve root involvement present at MMI?	
6. Physician comments on effort and individual's cooperation?		6. Diagnosis supported by both imaging and positive tests at MMI?	
7. Motion is Not Voluntary Restricted?			
8. Examiner comments on effort and cooperation?			
Nonverifiable Radicular Root Pain that is in the distribution of a nerve root but has no identifiable origin; i.e., no objective physical, imaging or electromyographic findings.		Electrodiagnostic Verification of Radiculopathy – EMG does not detect all compressive radiculopathies or cannot determine the cause of the nerve root pathology. However, electromyography can detect non-compressive radiculopathies, which are not identified by imaging studies. <u>Repute of the person performing/interpreting the study is critical</u> .	
1. Pain in the distribution of a nerve root without an identifiable origin?		1. <u>Unequivocal</u> electrodiagnostic evidence of acute root pathology?	
2. Figure 15-1 Distribution?		2. Multiple positive sharp waves or fibrillation potentials in muscles innervated by one nerve root?	
3. Figure 15-2 Distribution?		3. More than one nerve root involvement?	
		4. Tester meets AMA Guides Qualification Requirements?	
Alteration of Motion Segment Integrity		5. Prior Studies Were Negative? (Red Flag?)	
1. Increased Motion Due to Translational or Angular Motion?		6. Nerve Conduction Studies ? EMG ?	
2. Decreased Motion due to:		7. Prior Tester a Qualified/Licensed Physician?	
3. congenital or developmental fusion?		Cauda Equina Syndrome	
4. Healing Fracture?		1. Unequivocal Central Nervous System Pathology?	
5. Healing Infection?		2. compression of the nerves in the lower portion of the spinal canal	
6. Surgical Arthrodesis? (Red Flag) – Automatic DRE Category IV		3. Clinical Imaging Studies Supporting the Diagnosis?	
7. Flexion/Extension X-Rays used to determine segment motion?		4. CT scan with lumbar myelogram?	
Causation Apportionment LC § 4663		5. muscle weakness in the legs and anal sphincter	
1. Pre-existing degenerative disc disease?		6. Babinski sign negative?	
2. Pre-existing Comorbidities?		7. Saddle & perineal hypoesthesia or anesthesia?	
3. Congenital or Body Habitus Variances?		8. muscle weakness in the legs and anal sphincter	
4. Prior Awards under the 97PDRS?			
Notes:			

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Impairment Factors must be present on MMI/P&S date of examination.	DRE Category	Impairment Rating (%)
No clinical findings, no documented neurologic impairment, no change in structural integrity or fractures, <u>only symptoms.</u>	I	0
Pre Surgery: Findings Compatible with a specific injury. Muscle spasm alone. / Muscle guarding alone Asymmetry of spinal motion – Does not mean reduced motion in all planes. Non-verifiable radicular root pain alone (without objective findings). Individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment. Fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal.	II	≥ 5% - 8% (LS & CS)
Pre - Surgery: Reflex abnormalities or marked asymmetry between arms or legs. Weakness or sensory loss in dermatomal distribution, caused by spinal pathology. Atrophy, caused by spinal pathology when compared to the contralateral side – same location. Electrodiagnostic verification of radiculopathy. Individual has a history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy with alteration in the function of a nerve root or nerve roots present on MMI/P&S date of examination. Fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	III	≥ 10%-13% (LS) ≥ 15%-18% (CS)
Post Surgery: - Radiculopathy now asymptomatic. (Laminectomy, Discectomy) Or History of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic	III	≥ 10%-13% (LS) ≥ 15%-18% (CS)
Post Surgery – Single Level Fusion Bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b) Radiculopathy as defined in cervical Category III need not be present if there is alteration of motion segment integrity. May have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis. Fractures: (1) more than 50% compression of one vertebral body without residual neural compromise	IV	≥ 20%-23% (LS) ≥ 25%-28% (CS)
Post Surgery – Single Level Fusion + continued radiculopathy. Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; Upper Extremities: Significant upper extremity Impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction Lower Extremities: significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain, and/or sensory changes within an anatomic distribution (dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumbosacral category IV Fractures: Cervical: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity Involvement. Lumbar: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise	V	≥ 25%-28% (LS) ≥ 35%-38% (CS)

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