



AMA Guides® Editorial Panel

Public Meeting

Thursday, April 14th, 2022

Please Mute Your Computer to Prevent Background Noise

Participants will be placed in the waiting room until the meeting begins at 9:30am CT

Schedule

- Public Meeting
 - 9:30am – 12:30pm CT
- Break
 - 12:30pm – 1:00pm CT
- Executive Session (*Closed to the Public*)
 - 1:00pm - 2:30 pm CT

Agenda

- Kids' Chance of America
- Tinnitus Proposal Update
- fPROMs Update
- Chapter 15- Range of Motion
- Spine
- Neurology
- Public Meeting Closing



Attendance

- Attendance will be taken to establish a quorum.

Panel Members

Helene Fearon, PT
Steven Feinberg, MD
David Gloss, MD
Robert Goldberg, DO
Rita Livingston, MD, MPH

Doug Martin, MD
Kano Mayer, MD
Mark Melhorn, MD
Lylas Mogk, MD
Marilyn Price, MD

Noah Raizman, MD
Michael Saffir, MD
Jan Towers, PhD

Panel Advisors

Chris Brigham, MD
Hon. Shannon Bruno Bishop, JD
Barry Gelinas, MD, DC

Abbie Hudgens, MPA
Hon. David Langham, JD

Confidentiality/COI Reminders

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 - You are here because of your interest and/or experience with the AMA Guides®, but your affiliations could pose a potential conflict of interest. Please mention all of your disclosures if they are relevant to the topic being discussed or the opinions you hold and express.
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Professional.

Ethical.

Welcoming.

Safe.

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- This is what we expect of our members and guests at AMA-sponsored events.
- We take harassment and conflicts of interest seriously. Read our policy or file a claim at **ama-assn.org/codeofconduct** or call **(800) 398-1496**.

Meeting Mechanics

- This meeting is being recorded.
- Webcams are optional but may be used if Panel Members and Advisors wish to do so
- Panel members and advisors are open-line participants and may speak at any time throughout the duration of the event.
- Please consider muting your phone to prevent background noise and raising your hand to pose a question or comment. Staff may mute you if there is too much background noise.
- Hand raise or chat feature encouraged to indicate desire to speak.
Please unmute yourself prior to speaking.

Meeting Mechanics (con't)

- Co-chairs will introduce the proposal(s).
- Presenters will provide an overview of the proposal.
- Primary and secondary reviewers will be called upon first to lead discussion and recommend action.
- Editorial panel members and advisors are encouraged to contribute to discussion.
 - Oral disclosures are not required of panel members and advisors during the meeting but might be helpful when expressing a strong opinion.
- Public participants are invited to participate towards the end of discussion and are asked to disclose any conflicts of interest when introducing themselves.

Kids' Chance of America

- When a worker is seriously or fatally injured on the job, it doesn't just affect them. It impacts the entire family.
- Kids' Chance provides educational opportunities and scholarships for the children of workers seriously or fatally injured on the job.
- **Your help is needed to find the kids** – regardless of age – eligible for a Kids' Chance scholarship. Kids' Chance will make sure they are connected to their state organization when it's time to apply for college.



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Guides 6th, 2022

Guides 6th, 2021

Guides 6th (2008)

AMA Guides Newsletter

Featured Content

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Impairment, Sixth Edition is the latest standard in
medical impairment rating, emphasizing the
fundamental skills physicians need to evaluate and



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Help kids impacted by a workplace injury of a
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Planning for Your Child's Future

When a worker is severely injured or killed on the job, it doesn't just affect them – it affects their entire family. Thinking about the future is put off, and when the time comes, the cost of higher education can be well out of reach.

That's where Kids' Chance can help. Our Planning for the Future initiative is designed to identify potential scholarship applicants, especially those who are not yet of college age.

We collect and maintain their contact information so we can reach out when the time comes to consider options for higher education. We then connect these students to the appropriate Kids' Chance state organization to begin the scholarship application process.

If you are the parent or guardian of a child who may qualify, complete this card and return it to Kids' Chance of America. We're here to help your child achieve their educational dreams and succeed in creating a bright and productive future.



Child Name: _____ Date of Birth: _____
First Middle Last

Parent/Guardian Information

Name: _____
First Middle Last

Relationship to Children: ☐ Father ☐ Mother ☐ Guardian Permanent Telephone #: _____

Permanent Address: _____
Street City State Zip

Email Address: _____ State Where Workers' Comp Claim Filed: ☐ Referral Source _____

Insurance Carrier _____ Claim Number _____

Signature: _____ Date: _____

If you have more than one child, please fill out individual forms. Please return your completed forms to Kids' Chance of America at the address below.

Kids' Chance of America: 800 Boylston Street, Lobby, #990251 • Boston, MA 02199-9998 • 401-405-4028 • admin@kidschance.org • www.kidschance.org



Proposal Status Updates



Tinnitus

- The AAO-HNS endorses the use of the THI tool in the Guides to standardize ratings related to tinnitus. However, shortcomings of most patient reported questionnaires include failure to address onset, frequency, consistency, intensity, modifying effects of environment/medications/etc.
- Questionnaires can smooth out and verify physical exam findings and history, but no single instrument or method will provide the same quantifiable score as hearing loss.
- Tinnitus can occur SEPARATE from hearing loss and should be ratable as such; patients with severe tinnitus are often more impaired/disabled than hearing loss.
- **Next steps:** ENT SMEs to provide some explanatory language on how to do the history and physical for tinnitus to help inform how clinicians administer the THI and when it is appropriate to do so (ie, ground rules that establish criteria for when it should be rated such as duration and bothersome-ness).

fPROMs Proposal Update

- The AMA Guides Panel:
 - Approved adding PROMIS-29 Profile v2.1 (P-29) **as an fPROM option** for a grade modifier in impairment ratings moving forward.
 - Encouraged the AMA to explore licensing and other processes to allow physicians to adopt the P-29 as a tool as a component of impairment guidelines where applicable.
- Before editing to the AMA Guides can occur, clarification is needed from the Panel about what it means to have the PROMIS-29 as “**an fPROM option**” and how this impacts the implementation of other fPROMs.
- Adopting the fPROMs criteria and PROMIS-29 in AMA Guides means that it would be recommended across chapters for all conditions and that no other tools should be mentioned. Multiple tools, while permitted, may undermine defensibility of certain chapters

Expanding the Use of fPROMs in the Guides — The Path Forward

Stephen Gillaspy, PhD

Kathryn Mueller, MD, MPH, FACOEM

Robert Glueckauf, PhD

Daniel Bruns, PsyD, FAPA

Are These Tests Valid and Reliable?

- **MRI**
- **CT scan**
- **X-ray**
- **Ultrasound**



Saying that a test is valid and reliable is an oversimplification.

Medical test interpretation has a lot of nuances

The same is true of psychometric tests

In Our Review of Measures We Considered:

- **Validity**

- Content validity
- Construct validity
- Factorial validity

- **Reliability**

- Internal reliability/
unidimensionality
- Test-retest stability

- **Norms**

- **Fairness**

- No age, gender, racial, educational, etc. bias

- **Correspondence with ICF**

- **Forensic Defensibility**

Content Validity: AMA Guides fPROMs Define Function Differently

Measure	Percent of items on measure referring to:				Example items from these measures illustrate their nonequivalence
	Pain	Basic ADLs	Instrumental ADLs	Advanced ADLs	
Lower Limb Questionnaire	43%	71%	0%	0%	How difficult is it for you to put on or take off socks? [Items are 71% basic ADLs and 29% physical symptoms]
QuickDASH	18%	27%	27%	27%	Has your arm, shoulder or hand problem interfered with your normal social activities with family, friends... [No community norms: What is an unusually high score?]
PDQ	100%	33%	7%	40%	Has your income declined since since your pain began? [Note: No impairment rated unless associated with pain]
THI	0%	4%	0%	12%	Because of your tinnitus, do you feel depressed? [This is best THI item]. “[The] quality of THI in its current form is not satisfactory” (Gos 2020). THI is 88% psych/sensory items, & 12% about function. Subscales are not valid. IRT says items about work & hearing loss should be dropped from scale.

Developing Measures of Function: Norm Groups

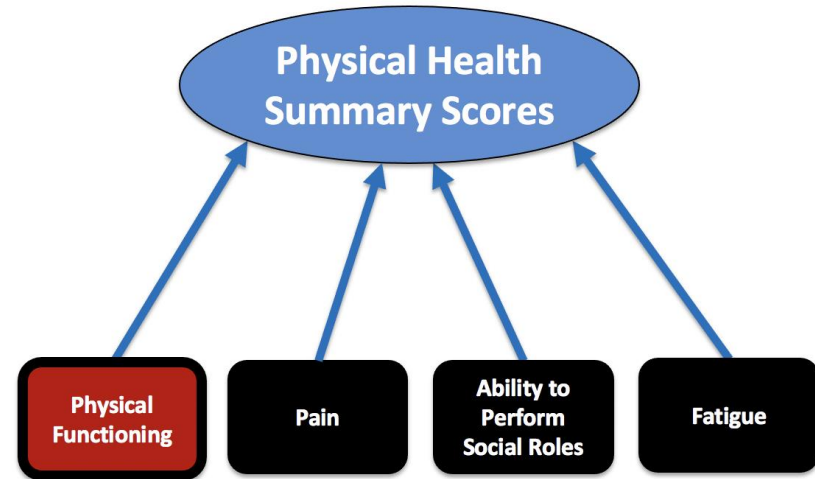
Measure	Development Group Subjects	Community Norm Subjects	Patient Norm Subjects
QuickDASH	407 + 200 Patients with shoulder/ wrist/ hand disorders	None	No cross validation Uses development sample
Lower Limb Questionnaire	Not empirically developed? Expert consensus only?	None	None
PDQ	N= 230 Patients with chronic pain	50 community subjects Subjects: 70% Female; 1 Black & 2 Hispanic subjects	No cross validation Uses development sample
THI	N = 88 + 66 [studies on 2 THI versions]	None	No cross validation Uses development sample
PROMIS 29 Physical Function [NOTE: This row describes only part of the process used to develop one P29 scale. Each P29 scale has a similarly strong empirical basis]	N = 21,133 National development sample of patients with numerous Dx	<u>Scientific national sample</u> of community members matching US Census data for age, gender, race, education	<u>Scientific national sample</u> of Patients matching US Census for age, gender, race, education; broad cross-section of Dx (N = 5000)

NIH Patient Reported Outcome Measure System (PROMIS) Was Designed to Promote Data Harmonization

- There are a “cacophony” of patient reported outcome measures of varying quality, complexity, and response burden
 - *This makes it difficult to compare findings across studies or across conditions using a single metric*
 - David Cella, PROMIS Author and Board Member, SBM presentation

Physical Functioning Is One of Four Components Of The PROMIS Physical Health Summary Score

- Development of PROMIS 29 Physical Functioning Scale (1 of the 8 P29 measures)
- Literature review identified 1728 items from 165 measures of physical functioning
- Expert review categorized and edited items
- Patient focus groups
 - What outcomes do patients value?
 - Sought patient feedback on item clarity and relevance
- (Rose, 2014; Dewalt 2007; Reeve, 2007)



Development of Physical Functioning Scale

- **Data:** 149 remaining items administered to 21,133 subjects
 - Both patients and community members
- **Analysis:** Extensive analysis of items
 - Biased items were eliminated
- **Results:** A four-item measure of Physical Functioning was developed and is used in the PROMIS 29
- To avoid bias, this scale was normed on a sample of community members matched to US census data
- (Rose, 2014; Dewalt 2007; Reeve, 2007)
- *Each scale on PROMIS 29 went through a similar process*

Our Review Concluded that the PROMIS 29 Physical Health Summary Score

- Is supported by the strongest science**
- Offers the best answer to the AMA Guides questions**
- Would allow for data harmonization across chapters**

We Propose That The Guides List Only PROMIS 29

- PROMIS 29 was intended for use with any diagnosis, and the Guides could allow this
- However:
 - The use of fPROMs is not required for any diagnosis
 - Clinicians can choose a different fPROM if in their judgement it is a better fit for a particular patient rating
 - Clinicians can disregard fPROM results if in their judgement the results appear invalid
 - fPROM results make only a small change in the rating

Discussion and Questions

Does this change things from the panel's perspective about implementing the fPROMs criteria and the PROMIS-29?

What about other fPROM measures?

Chapter 15: Range of Motion (ROM)

Gary Pushkin, MD, (ORS), CMLE, FIAIME

Barry Gelinas, MD, DC, FIAIME, CMLE



Action Requested

- The words “with normal motion” be removed from all sections in which it appears in Tables 15-2 through 15-5.

Rationale

- Patients evaluated with these tables rarely if ever have normal range of motion post operatively and the implication is that one automatically must use the ROM-based impairment model.
- Range of motion goes **against** the goal of using more objective criteria that would lead to fair and equitable ratings and mandates the rater to use the very subjective ROM-based impairment model.
- The proposed change would remove uncertainty about using the DBI for these diagnoses and stays true to methodology to identify a diagnosis as the first step. DBI should be used and range of motion is part of the GMPE.

Example – Shoulder Regional Grid

TABLE 15-5 Shoulder Regional Grid

IMPAIRMENT CLASS	CLASS 0	CLASS 1
IMPAIRMENT RANGES (upper extremity %)	0	1%–13% UE
GRADE		A B C D E
LIGAMENT/BONE/JOINT*		
Rotator cuff injury, full-thickness tear*	0 No significant objective abnormal findings at MMI	1 2 3 4 5 History of painful injury, residual symptoms without consistent objective findings (this impairment can only be given once in an individual's lifetime) 3 4 5 6 7 Residual loss, functional with normal motion

TABLE 15-5 Shoulder Regional Grid: Upper Extremity

IMPAIRMENT CLASS	CLASS 0	CLASS 1	CLASS 2
IMPAIRMENT RANGES (upper extremity %)	0	1%–13% UE	14%–25% UE
GRADE		A B C D E	A B C D E
Fracture*	0 No residual findings: +/- surgical treatment	1 2 3 4 5 Residual symptoms, consistent objective findings and/or functional loss, with normal motion	
Loose bodies or osteochondral lesions*	0 No residual findings: +/- surgical treatment	3 4 5 6 7 Residual loss, functional with normal motion	
Posttraumatic degenerative joint disease (DJD)*	0 No residual findings: +/- surgical treatment	1 3 5 7 9 Posttraumatic DJD with documented specific injury, asymmetric arthritic changes noted on imaging	
Arthrodesis (fusion)			
Shoulder arthroplasty*			20 22 24 25 25 Implant with normal motion

Note: UE indicates upper extremity; MMI, Maximum Medical Improvement; s/p, status post; anterior to posterior.

* If motion loss is present, this impairment may alternatively be assessed using Section 15.7. A range of motion impairment stands alone and is not combined with diagnosis impairment.



Discussion

Primary and Secondary Reviewers

Panel Members and Advisors

Public Attendees

Spine Proposal

North American Spine Society

E. Kano Mayer, MD



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
 - ✓ AOSMI 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
<ol style="list-style-type: none"> 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). 3. Review clinical studies, as explained in Section 17.1a. 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. 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. 7. Apply the Net Adjustment Formula to calculate the net adjustment value to be applied to the default value C. 8. Use the regional grid to identify the numerical impairment value associated with the impairment class and grade. 	<ol style="list-style-type: none"> 1. Obtain detailed medical history and perform an appropriate physical examination, as explained in Section 17.1a. 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. 4. Determine the diagnosis or diagnoses to be rated. 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 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. 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.

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.

Since Manuscript Distribution...

- Figures 17-7c, 17-7d, 17-7e should be removed from the manuscript.
- Table 17-9, Clinical Studies Grade Modifier Adjustment Grid (Spinal Regional DBI Grids, incorrectly referenced figure 3, this should be Figure 17-5.
- Table 17-11 is NOT consistent with the Lower Extremity Chapter. Restriction of hip motion is not the basis for diagnosis class after acetabular fracture, and nondisplaced acetabular fractures are generally considered Class 1 impairments, not Class 0, based on Table 16-4. This will be cleaned up for consistency.
- Further definition around pelvic instability



Discussion

Primary and Secondary Reviewers
Panel Members
Public Attendees

Central and Peripheral Nervous System

April 14, 2022

Authors:

James Underhill, PsyD

Diana Kraemer, MD

Consultants:

Victor Barredo, MD (Neurology)

Les Kertay, PhD, Mental and Behavioral Disorders

Chapter 13

Central and Peripheral Nervous System

Key Factor:

The effect of a neurological disease
on basic and instrumental ADLs
that is consistent with
the natural history of that disease.

Chapter 13

Central and Peripheral Nervous System

Axioms of the 6th Edition:

Evolutionary

- Focus on ICF terminology:
- Focus on Diagnosis-based Impairment:
 - Brings subject matter in line with ICD (current version)
 - Stress Evidence-based evaluation
 - Emphasis on the neurological examination

Chapter 13

Central and Peripheral Nervous System

Consistency

Focus on Diagnosis-based Evaluation:

“Stroke” is not specific, requires a diagnostic foundation

Bring Chapter 13 and 14 into alignment

- GAF has been melded into the MSCHIF-E
- c/w 2008, 13.3f, “Emotional disturbances originating in verifiable neurologic impairments are assessed using the criteria in this chapter.”
- Reactive mood disorders as a response to a diagnosis are rated in Chapter 14
- Congruity within and between organ systems and other chapters
 - Reconcile how Ch 13 treats episodic disorders with other chapters (eg, sickle cell anemia, asthma, cardiac dysrhythmias)
 - Align impairment ratings to mimic similar disorders in other chapters
 - Adopted the BOTC methodology

Chapter 13

Central and Peripheral Nervous System

Simplicity, Ease of Application, Precedent

Precedent:

- Structure of 2008 Chapter 13 continued in 2022
- Chapter 13 Impairment Ratings are brought into alignment with other chapters

Simplicity:

- 4 Tables were Removed:
 - The GAF was removed and replaced with the MSCHIF-E.
 - The Table on Sleep and Arousal Disorders was placed in Chapter 14 to remain consistent with the DSM-5
 - Tables on Craniofacial Pain and Miscellaneous Peripheral Nerves were combined into Neurogenic Pain
 - A Worksheet was created to improve ease of use

QuickView Worksheet

Impairment Table	CLASS 1	CLASS 2	CLASS 3	CLASS 4	Comments
Table 13-5a: Disorders of Consciousness	80%	90%	100%	-	
Table 13-5b: Episodic Disorders	2%-10%	19-27%	35-45%	55-75%	
Table 13-5c: Aphasia	6-10%	13-20%	225-35%	40%-60%	
Table 13-5d: MSCHIF-E	1%-3%	5%-15%	20%-40%	50%-75%	
Table 13-5e: UE CNS Dysfunction	Dom 4-8 Nondom 3-5	Dom 10-18 Nondom 6-10	Dom 22-29 Nondom 16-24	Dom 45 60 Nondom 40-55	
Table 13-5f: Station and Gait Disorders	3%-5%	8%-12%	15%-25%	30%-40%	
Table 13-5g. Neurogenic Respiratory Dysfunction	6%-10%	17%-23%	32%-40%	55%-65%	
Table 15-5h. Neurogenic Bowel	5%-9%	16%-20%	30%-38%	45%-50%	
Table 13-5i. Neurogenic Bladder	3%-5%	7%-13%	16%-22%	24%-28%	
Table 13-5j. Neurogenic Sexual Dysfunction	3%-5%	8%-10%	13%-15%	-	
Table 13-5k. Neuropathic Pain	3%-5%	15%-20%	20-30%	35-45?	
Table 13-5l. Migraine	3%-5%	15%-20%	20-30?	35-45?	
Ratings in Other Chapters					
Combined Values Table					
BOTC (POINTS TBD) ADDED					

Chapter 13

Central and Peripheral Nervous System

Challenges:

-Progressive Disorders

- Considered neurologic progressive disorders in relationship to 2008 Guides, EEIOC, SSI Compassionate Allowance diagnoses

-Diagnoses without objective findings

- Migraine codified in ICHD-3

-Spinal Cord Injury: should the ASIA examination be specifically cited?

-Consistency of some Tables of Chapter 13 with other chapters:

- 13-5k: Neuropathic Pain Class 4 max 10-20%, but CRPS Class 4 is 100% UE
- 13-5l: Migraine Class 4 max 15-20%, but hypertension (1 med, nl labs + ECG) is 20%
- BOTC from Endocrine aligns well with some, but not all, neurological diseases

CLASS		CLASS 1	CLASS 2	CLASS 3	CLASS 4
WPI (%)		Mild	Medium	Severe	Very severe
Dysrhythmias	Range	2-10	11-23	24-40	45-65
Asthma	Median	6	17	32	55
Hypertension	Range	2-10	11-27	30-42	45-65
	Median	6	19	36	55
Vestibular	Range	1-9	11-27	30-42	45-58
	Median	5	19	36	54
Anemia	Range	1-5	7-15	25-45	55-75
	Median	3	11	35	65
Range	Range	1-10	7-27	24-40	50-75
	Median	6	17	32	57
Mode		6	17	32	55
MSCHIF-E		1-3	5-15	20-40	50-75
We recommend for Episodic		6 8 10 A B C	19 23 27 A B C	35 40 45 A B C	55 65 75 A B C

Discussion



Closing

- Thank you to today's presenters. This now concludes the public meeting.
- Summary of Panel Actions will be posted on the AMA Guides website.
- Next **Public** meeting will be a virtual meeting on Thursday, June 23rd at 6pm CT.
- Next **Panel** subcommittee/executive session schedule for May 19th at 6pm CT Virtual.
- Public meeting is adjourned. Panel members, please see instructions for accessing Executive Session that have just been sent by staff.