

15.6 DRE: Cervical Spine

15.6a Criteria for Rating Impairment Due to Cervical Disorders

For cervical problems localized to the cervical or cervicothoracic region, use Table 15-5. If the cervical spine problem also leads to isolated bowel and/or bladder dysfunction not due to corticospinal damage, obtain the appropriate estimates for bowel and

bladder dysfunction from the gastrointestinal and urology chapters (Chapters 6 and 7) and combine these with the appropriate cervical spine DRE category from DRE I to V, listed in Table 15-5. If the cervical spine problem is due to corticospinal tract involvement, use Table 15-6 alone.

The DRE cervical categories are summarized in Table 15-5.

Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders

DRE Cervical Category I 0% Impairment of the Whole Person	DRE Cervical Category II 5%-8% Impairment of the Whole Person	DRE Cervical Category III 15%-18% Impairment of the Whole Person	DRE Cervical Category IV 25%-28% Impairment of the Whole Person	DRE Cervical Category V 35%-38% Impairment of the Whole Person
<p>No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity, and no other indication of impairment related to injury or illness; no fractures</p>	<p>Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity</p> <p>or</p> <p>individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment</p> <p>or</p> <p>fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement</p>	<p>Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings</p> <p>or</p> <p>individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery</p> <p>or</p> <p>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 is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition</p>	<p>Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm 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); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity</p> <p>or</p> <p>fractures: (1) more than 50% compression of one vertebral body without residual neural compromise</p>	<p>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</p> <p>or</p> <p>fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement</p>