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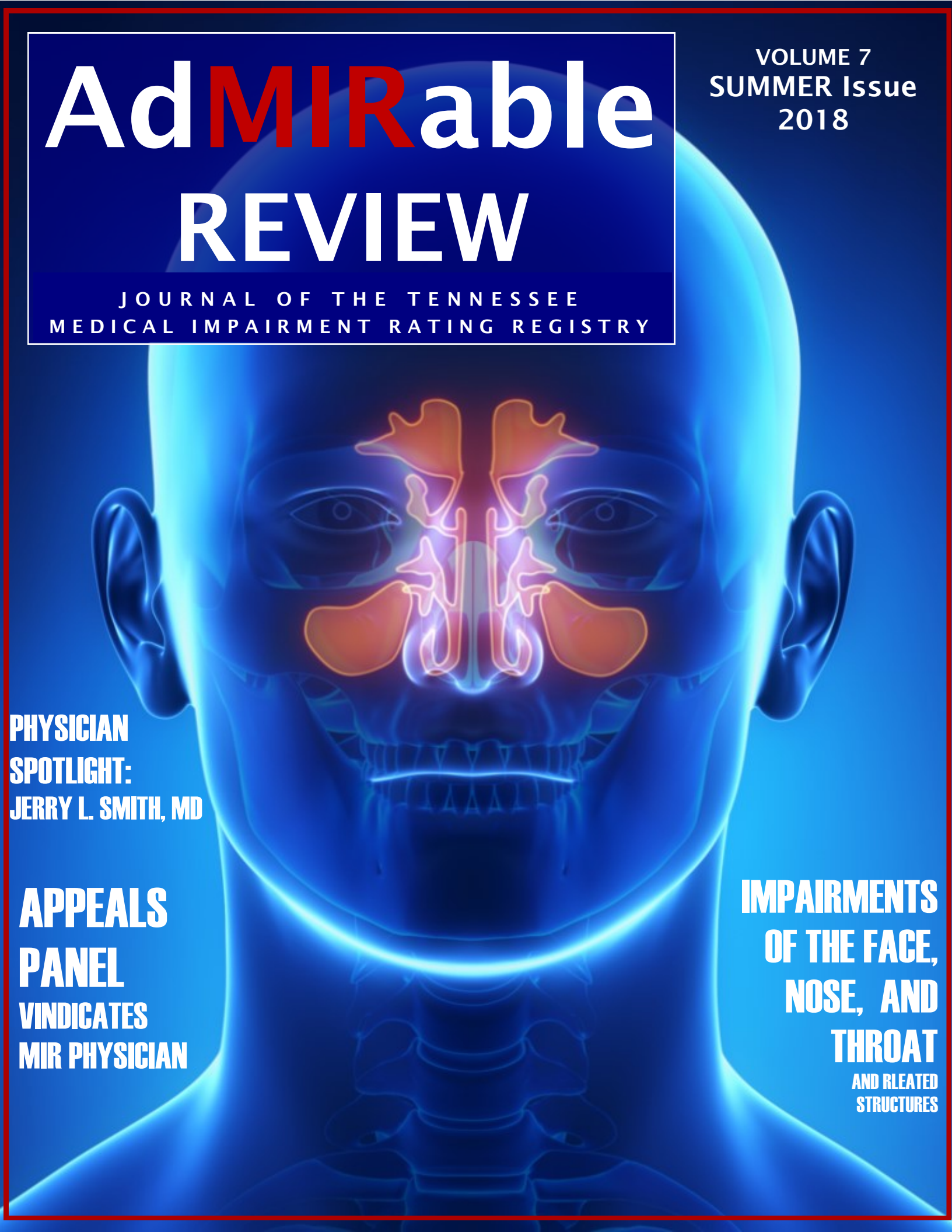

PHYSICIAN SPOTLIGHT: JERRY L. SMITH, MD

APPEALS PANEL VINDICATES MIR PHYSICIAN

IMPAIRMENTS OF THE FACE, NOSE, AND THROAT

AND RLEATED STRUCTURES

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BUREAU ANNOUNCEMENTS

BWC ANNUAL REPORT

The Tennessee General Assembly requires the Bureau to produce an annual report on the effects of the 2014 Reform Act per TCA 50-6-134. This year, we highlight the expediency of our court system, the added assistance of an ombudsman attorney for unrepresented parties, new educational materials, and the start of the new "Next Step" program. We report how our mediations resulted in settlements 77% of the time. Read more by downloading the report.

"NEXT STEP" PROGRAM

In the 2017 legislative session the General Assembly enacted Public Chapter 344, which established a Subsequent Injury and Vocational Recovery Fund for payment of educational benefits for injured workers who were unable to make a meaningful return to work after suffering a work injury. This assistance program is available for injuries on/after July 1, 2018. Rules have been drafted to establish the processes and procedures for the program, which has been named the "Next Step" program by the Bureau. A rulemaking hearing was conducted in the Tennessee Room at the Bureau's Nashville office on June 21, 2018. The Attorney General has now signed the final version of the rules, and the Bureau will seek the approval of the joint Government Operations Committee on November 14, 2018.

ADJUSTER CERTIFICATION PROGRAM

Adjusters who handle workers' compensation claims for Tennessee employers have already begun to accept our offer to facilitate a voluntary educational program. We designed the program to educate adjusters about the requirements of Tennessee's workers' compensation laws, rules and regulations. The purpose of this program is two-fold: to assure that injured employees are treated fairly, and to assure that Tennessee workers' compensation claims are handled in an appropriate and uniform manner. For more information, contact B.Jeff.Francis@tn.gov.

NEW CLAIMS HANDLING STANDARDS (EFFECTIVE AUGUST 2, 2018)

Revisions to the Claims Handling Standards include requirements for adjusting entities to designate a liaison to the Bureau as a primary point of contact, clarification on the steps to file claims if the SSN is missing or unknown, deletion of the requirement to have a claims office in the state, and new requirements for making contact with the injured employee.

FOLLOW THE BUREAU

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Tennessee Bureau of Workers' Compensation
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MIR PHYSICIAN SPOTLIGHT
JERRY L. SMITH, MD

Dr. Jerry L. Smith has faithfully served the Tennessee Medical Impairment Rating Registry since the program started in 2005. An expert in musculoskeletal and nervous system impairment ratings, he is currently one of two active physiatrists on the registry who serve the Chattanooga area. His vast experience in the workers' compensation arena provides him the ability to review complicated impairment ratings, keep up-to-date on the latest editions of the impairment rating guides, and translate that information into a comprehensive and accessible report.

As one of the founding partners of Siskin Physical Medicine & Rehabilitation (formerly Siskin Spine & Rehabilitation Specialists), Dr. Smith is a true advocate for patients and their wellbeing. His philosophy of care centers on creating customized care plans unique to each patient and helping them develop lifelong health habits. He is a strong advocate for smoking cessation and intervenes as needed to stop or correct unnecessary medication regimes. He also enjoys helping residents of senior living centers in long-term care settings.

Dr. Smith is board certified in Physical Medicine & Rehabilitation by the American Board of Physical Medicine & Rehabilitation and board certified in Pain Medicine by the American Board of Pain Medicine. He has advanced training in the 4th, 5th, and 6th editions of the *AMA Guides* as well as pain management (acute and chronic) and traumatic brain injury. He is a Fellow in the

JERRY L. SMITH, MD

American Academy of Physical Medicine & Rehabilitation. He graduated from the University of Kentucky, School of Medicine in Lexington and completed his internship through Baptist Medical Center in Birmingham, Alabama. He finalized his residency in Physical Medicine

& Rehabilitation at the Medical College of Virginia, Richmond. He began his medical practice in 1995.

Passionate about his family and traveling, Dr. Smith tries to combine the two whenever possible. His brother and sister-in-law live in Taiwan, which gives Dr. Smith and his wife, Tanya, a registered nurse, and their children the opportunity to learn about Taiwanese culture and food on occasion.

The Smiths have a blended family. The oldest child, Ryan, will graduate next year with a finance degree from the University of Kentucky and is a former gymnast, swimmer and diver. His daughter Alex, also a swimmer and former gymnast, is a high school senior exploring college destinations. Stepdaughter Riley is a talented singer, attending a magnet school for aspiring singers and musicians in her junior year of high school. The youngest, Trey, is a sophomore in high school playing soccer and working as a lifeguard. Tragical-

ly, their son Sumner died from drowning in 2016. He was a gymnast, swimmer, and diver who placed in finals at the State championship. He was also "a great wake boarder and daredevil," says Dr. Smith. "We miss him dearly."

When not attending his children's extracurricular events, Dr. Smith enjoys kayaking, fishing, and the occasional Master's National swim competition, including a 10-mile swim in the Tennessee River. He placed fifth in 2011.

IMPAIRMENTS OF THE FACE, NOSE, AND THROAT AND RELATED STRUCTURES

AMA *Guides*, 6th Edition

Jay Blaisdell and James B. Talmage, MD

Facial disfigurements, as well as nose and throats impairments, may result from burns (thermal, chemical or electrical) or trauma caused by motor vehicle accidents, falls, assaults, dog bites, and gun shots. Injured workers who already have bones weakened by dental disease or procedures may be more susceptible to upper jaw (zygomatic maxillary) fractures. Occupational overexposure to sunlight, airborne chemicals, heavy metals, and allergens may cause head and neck melanoma, sinus and larynx cancer, chronic rhinosinusitis, and cancers of the mouth and salivary glands. As a result, the ability to breathe, chew, swallow, smell, or speak may become significantly impaired. Injured workers may also suffer from a significantly altered self-image and quality of life.

SCOPE

Impairments of the structural integrity of the face are rated in section 11.3 on page 260. Impairments of the nose, throat, and related structures are rated in section 11.4 starting on page 265, with upper respiratory impairments rated in section 11.4a (p.265), mastication and deglutition rated in 11.4b (p.268), and voice and speech impairments rated in 11.4d (p.270). Burns that occur to places other than the face are rated in Chapter 8, The Skin, starting on page 159. Upper respiratory impairments are those related to dysfunction of the upper airways, including the nasal cavities, nares, trachea, and larynx. Lower-respiratory impairments, which are those that affect the lungs and lower airways, are rated in Chapter 5, The Pulmonary System, starting on page 77. This article covers impairments of the face, nose, throat, and related structures as provided in Chapter 11, Ear, Nose, Throat, and Related Structures. For guidance on rating skin, pulmonary, or hearing impairments, please see the Winter 2018 , Spring 2016 , or Spring 2017 issues of *AdMIRable Review* respectively.

DEFINITIONS

Dyspnea: shortness of breath; difficult or labored breathing; "a cardinal factor that contributes to an individual's diminished capacity to carry out ADLs [Activities of Daily Living] and also contributes to permanent impairment [. . . It] may be produced by pharyngeal stenosis, vocal fold paralysis or fixation, laryngeal stenosis, or tracheal stenosis" (Rodinelli, 2009, p.266).

Impairment Class: for the purposes of this article, one of five categories of impairment percentages within a table or grid ranging from Class 0, indicating least impaired, to Class 4, indicating most impaired, with each Class further subdivided into three to five distinct percentage values to allow for more nuanced ratings.

Key Factor: marked with a footnote within the relevant rating table or grid, one of three variables (Physical Exam, History, and Diagnostic Findings) used to assign the impairment class.

Non-key Factor: also known as a modifier, the variables among Physical Exam, History, and Diagnostic Findings other than the key factor that are used to modify the rating within its impairment class.

Phonation: "The production of voice through the vibration of the vocal folds of the larynx coupled with airflow directed upward from the lungs" (Phonation, 2009).

Speech: "refers to the shaping of sounds into intelligible words" (Rondinelli, 2009, p.270).

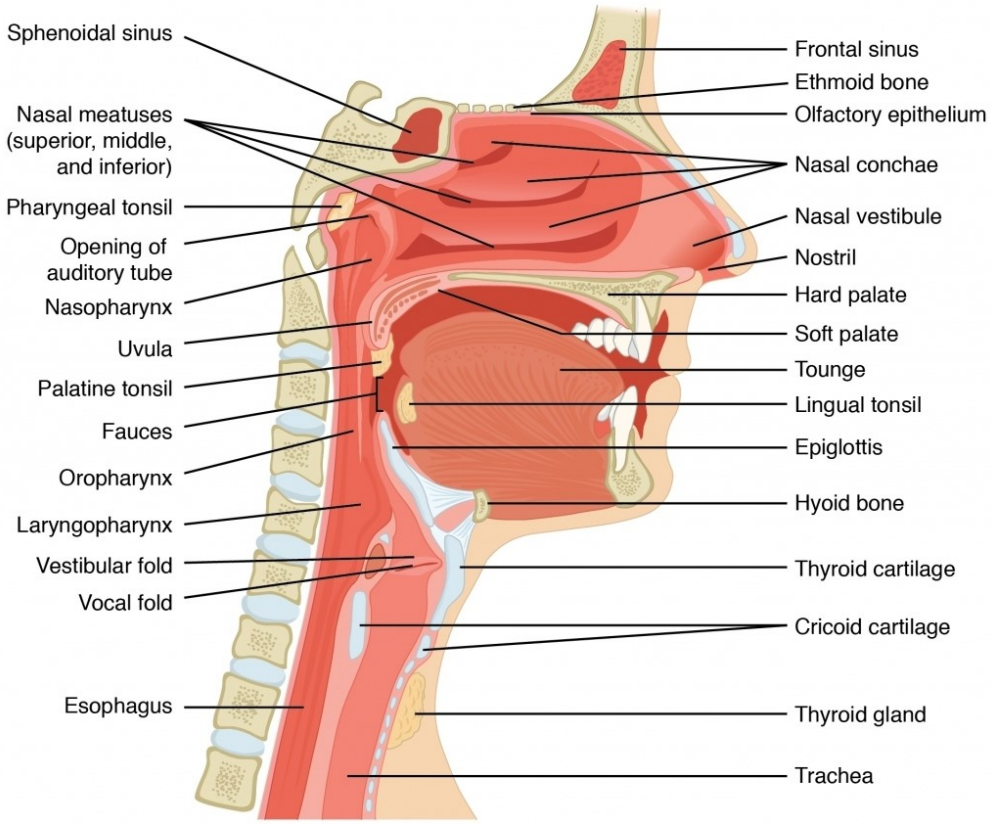
Strobovideolaryngoscopy: The use of stroboscope in video recordings of disease of the larynx and vocal cords (Strobovideolaryngoscopy, 2009).

Voice: "Refers to the production of sound of a given quality, ordinarily using the true vocal folds" (Rondinelli, 2009, p.270).

Voice Handicap Index (VHI): A useful instrument for quantifying the biopsychosocial impact of a voice disorder, and is able to monitor changes in self-perception of voice handicap after treatment. Essentially, it "measures the influence of voice problems on a patient's quality of life" (Maertens, 2007).

THE FACE

Disfigurements related to the structural integrity of the face are rated in section 11.3a, starting on page 261, and Table 11



(Continued from page 4)

-5 on page 262. The table is organized as a grid system with impairment classes ranging from "Class 0," with an impairment of 0%, to "Class 4," with an impairment ranging from 25% to 45%, listed in the top row, and modifying variables of "History," "Physical Exam," and "Diagnostic or other Objective Findings" listed down the left column. The patient's history, at the top of the left column is the key factor, and is therefore used to assign the impairment class based on facial abnormalities, loss of supporting structure, loss of an anatomic part of the face (such as an eye or nose), and disruption of social activities. Each impairment class is subdivided into 5 discrete percentages organized from the lower value starting at the left and graduating to highest value to the far right (except for Class 1, which only has 3 Grades/percentages). The default value of each impairment class is the center value among the 5 discrete percentages. Once the impairment class is assigned based on the patient's history, the default percentage may be increased or decreased depending on the net difference in the values of "Physical Exam" and "Diagnostic or other Objective Findings" modifiers, as assigned within the grid. Essentially, the value of each modifier is subtracted from the impairment class and then added together for the net adjustment from the default value.

(Physical Exam Grade – Impairment Class) + (Diagnostic Findings Grade – Impairment Class) = Net Adjustment

A net adjustment of +1 or +2 will increase the default percentage value by 1 or 2 increments, or grades, respectively. Likewise, a net adjustment of -1 or -2 will decrease the default percentage value by 1 or 2 increments. However, a net adjustment greater than +2 or less than -2 may not move the the rating into another impairment class.

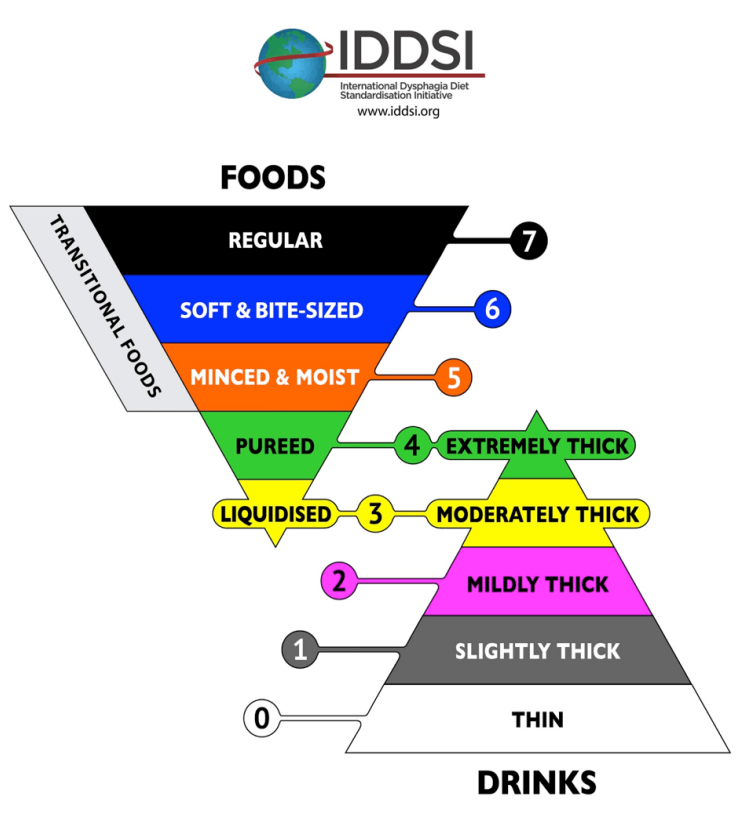
UPPER RESPIRATORY AIR PASSAGES

Respiratory impairment due to defects of the upper air passages, including the "nares, nasal cavities, mouth, pharynx, larynx, trachea, and bronchi" are rated using section 11.4a (p.265) and Table 11-6 (p.267), "Air Passage Deficits" (Rondinelli, 2009, p.265), with the patient's history—namely the occurrence of dyspnea with other activities—serving as the key factor for assigning the rating's impairment class. Once the impairment class is assigned, the default value is then modified by the remaining non-key factors, Physical Exam class and Diagnostic Findings, in the manner as described above with the exception of when Class 4 is assigned. When this happens, the rater advances a one percentage increment or grade above the default for every non-key factor also found in Class 4.

Since dyspnea is a subjective symptom, the examiner should be sure there is no co-morbid cardiopulmonary disease to produce dyspnea, and that it really is present based in upper airway obstruction. The examinee can be asked to walk in the office, and to walk up and down a nearby staircase while wearing a pulse oximeter and having respiratory rate quantified to verify that dyspnea is in fact present.

CHEWING AND SWALLOWING

Mastication and deglutition are rated using section 11.4b on page 268 and Table 11-7 found on page 269. Restrictions in diet are the most objective way to rate these impairments. Per Table 11-7, a diet limited to semisolid or soft foods may have



a whole person impairment of 5%, 10%, or 15%, depending on the range of foods that can be consumed. A diet limited to liquid foods is given a whole person impairment of 20%, 25%, or 30%, again depending on the range of foods that can be consumed. Definitions related to the consistency of food vary among practitioners, but attempts at establishing an international standard are underway through the International Dysphagia Diet Standardization Initiative. Tables 6-1 & 6-2 (page104) can be consulted to verify that the individual is, or is not, able to maintain a normal body weight. Examinee statements about restrictions in diet should be confirmed in the medical records of the treating physician.

OLFACTION AND TASTE

Since impairments of sense of smell and taste rarely significantly affect a person's ability to perform activities of daily living, the rater simply assigns an impairment value of 1% to 5%, depending on the severity as explained in section 11.4c one page 270. If the examiner suspects the symptom of impaired sense of smell or taste is exaggerated, the Guides references more sophisticated testing to verify the impairment is organic (medical) and not "non-organic."

VOICE AND SPEECH

For rating purposes, although medically distinct, voice (phonation) impairment is examined in tandem with speech impairment in the context of three factors: (1) audibility, (2) intelligibility, and (3) functional efficacy. Audibility refers to the ability of the average listener to hear the patient over background noise. Intelligibility refers to the patient's ability to enunciate in a manner that the average listener can understand. Functional efficacy refers to the patient's ability to satisfactorily produce and sustain a rate of speaking necessary to

(Continued from page 5)

communicate with the average listener. The rater evaluates only phonation and articulation, not vocabulary and syntax (Rondinelli, 2009, p.271).

The rater examines audibility and intelligibility by interviewing the patient while the patient stands approximately eight feet away, with the patient's back facing the evaluator. The "Smith House" reading passage test may be used at this time. The patient should be able to talk in a loud voice occasionally, sustain phonation for at least ten seconds after a single breath, complete sentences of at least ten words in a single breath, and "form all the phonetic units of American speech and join them intelligibly, or those of the individual's primary language." Thus, it is preferable that the evaluating physician speaks the same language of the patient.

In regard to evaluating the functional efficacy of speech, the patient should be able to "maintain a speech rate of at least 75 to 100 words per minute, and sustain a flow of speech for a reasonable length of time." For additional comparison, a speaker who is able to read a double-spaced page of text in two minutes has a speech rate of about 125 words per minutes. Alternatively, functional efficacy may be measured by recording the time it takes for the patient to count to one-hundred by ones. Sixty to 75 seconds may be accepted as normal (Rondinelli, 2009, p.271).

When considering objective tests, special consideration should be given to the results of strobovideolaryngoscopy, as administered by a trained physician, usually an otolaryngologist. The results of the VHI questionnaire should also be reviewed. Other recognized objective measurements of voice and speech, such as laryngeal electromyography (EMG), may also be helpful for diagnostic and rating purposes.

With the objective test results in hand, and the interview and physical evaluation completed, the rater consults Table 11-8, Voice and Speech Impairment, on page 274, to assign the patient's impairment. The key-factor, which is used to choose the patient's impairment class, is "Voice/ Speech Performance Measures," and is organized into three categories of performance measurements: (1) audibility, (2) intelligibility, and (3) functional efficiency. The rater is to "choose the class corresponding to the highest," or most severely impaired, of these three performance measurements. For injuries with an impairment rating greater than zero, this initial selection places the rating at the default value, or middle value, of the three distinct percentage values expressed within the impairment class. The rating may be modified either up or down depending on numeric value assigned to "Objective Tests" within the same grid. If the "Objective Tests'" numeric value is lower than the impairment class numeric value, then the rating is lowered within its class to the lowest of the three percentage values within the impairment class. Likewise, if the "Objective Tests'" numeric value is higher than the impairment class numeric value, then the rating is raised within its class to the highest of the three percentage values.

THE SMITH HOUSE

"Larry and Ruth Smith have been married nearly 14 years. They have a small place near Long Lake. Both of them think there's nothing like the country for health. Their 2 boys would rather live here than any other place. Larry likes to keep some saddle horses close to the house. These make it easy to keep his sons amused. If they wish, the boys can go fishing along the shore. When it rains, they usually want to watch television. Ruth has a cherry tree on each side of the kitchen door. In June they enjoy the juice and jelly."

AMA Guides, 6th Edition, pages 271-272

If the rating is raised within the impairment class due to "Objective Tests" findings, then that is the final impairment rating; however, if after adjusting for Objective Tests findings the rating remains at its default percentage or lower, it may be raised one more percentage increment (Grade) for each of the other performance measures (audibility, intelligibility, functional efficiency) that has the same value as the initial impairment class. This is unique to this section of the Guides.

CONCLUSION

Facial disfigurements, including those caused by burns, are rated in Chapter 11, Ear, Nose, Throat, and Related Structures, in addition to impairments of olfaction and taste, chewing and swallowing, voice and speech, and the upper respiratory passages. For upper air passage defects and voice and speech impairments, the evaluator assigns an impairment rating by selecting the relevant table/grid in Chapter 11 and then by assigning the appropriate impairment class, as determined by the key factor. The patient's history is the key factor for upper air passage deficits, while the performance measures of audibility, intelligibility, and functional efficiency collectively act as the key factor for voice and speech impairments. Once the impairments class is selected, the rating may by modified within the impairment class by remaining variables. When rating the patient's ability to smell and taste or chew and swallow, the rating process does not use impairment classes or modifiers; rather, impairment is assigned within an allowable range largely based on professional judgment complimented by objective findings and a well-documented rationale.

REFERENCES

Maertens K., & de Jong F.I. (2007). The voice handicap index as a tool for assessment of the biopsychosocial impact of voice problems. *B-ENT*, 3(3), 7. [PubMed]

Rondinelli R, Genovese E, Katz R, et al. (2009). *Guides to the Evaluation of Permanent Impairment*. 6th ed. Chicago, IL: AMA

Phonation. (n.d.) *Mosby's Medical Dictionary,* 8th edition. (2009). Retrieved August 15 2018 from https://medical-dictionary.thefreedictionary.com/phonation

Strobovideolaryngoscopy. (n.d.) *Medical Dictionary*. (2009). Retrieved August 15 2018 from https://medical-dictionary.thefreedictionary.com/strobovideolaryngoscopy

APPEALS PANEL VINDICATES MIR PHYSICIAN

Jane Salem, Esquire

In a foot-crush case, a Special Workers' Compensation Appeals Panel for the Tennessee Supreme Court recently reversed a Memphis trial court, holding that an independent medical evaluator affiliated with the MIR Program assigned the correct impairment rating. The Aug. 2 opinion stemmed from a case where the date of injury predated the Reform Act, but the statutory presumption the panel relied on wasn't changed in the 2013 amendments to the Workers' Compensation Law.

EXPERTS DISAGREE ON IMPAIRMENT

Zoran Andric worked for Costco Wholesale Membership. On May 3, 2012, he became injured when a rack fell on his foot. Andric received authorized treatment from Dr. Ana Palmieri several times over the coming months. Dr. Palmieri assigned a 17 percent impairment rating to the great toe, which equated to three percent to the foot, two percent to the lower extremity, and one percent to the body. Dr. Palmieri used a diagnosis-based impairment rating and considered range of motion, fracture displacement and hyperesthesia. Dr. Apurva Dalal later examined him. Using a range of motion impairment rating, Dr. Dalal assigned seven percent impairment to the lower extremity and three percent to the body as a whole. He equated a seven percent impairment rating to the lower extremity as 10 percent impairment to the foot. Dr. Dalal acknowledged the AMA Guides prefer a diagnosis-based impairment rating and a range of motion impairment rating is used when no other method is available. However, he used a range of motion impairment rating due to Andric's reduced range of motion, explaining that the impairment rating would be the same under either method.

Afterward, Dr. Claiborne Christian conducted an MIR Program evaluation, reaching different conclusions. Dr. Christian, like Dr. Palmieri, used a diagnosis-based impairment rating, and he assigned a three percent lower extremity impairment rating. According to Dr. Christian, three percent was the "default" rating, and "when you took into account physical exam findings, clinical studies, functional history, there was no change from that default rating." Dr. Christian testified that "no other examiner found the degree of range of motion loss that Dr. Dalal did." Although the AMA Guides required him to provide a rating for the lower extremity, Dr. Christian testified the impairment rating to the foot "would be 4 percent."

The Shelby County Court, Chancellor JoeDae Jenkins, didn't consider section 50-6-204(d)(5), which presumes that a MIR physician's impairment rating is accurate but may be rebutted by clear and convincing evidence. Instead, Judge Jenkins found Andric suffered injury only to his foot rather than the body as a whole, characterizing Dr. Dalal's opinion as "the most appropriate." Considering Andric's age of 52, education as a high school graduate in Bosnia and Herzegovina, work history and training, Judge Jenkins awarded 64 percent permanent partial disability to the foot. Costco appealed.

MIR PHYSICIAN'S OPINION PRESUMED ACCURATE

The panel had little difficulty affirming the lower court's disability apportionment to the foot. Costco fared better on appeal with its argument that Judge Jenkins erred in accepting Dr. Dalal's opinion over Dr. Christian's. The statute states that the permanent impairment rating given by the independent medical examiner under the MIR program is presumed to be the accurate rating, but this presumption may be rebutted by clear and convincing evidence. The appellate panel detailed Dr. Christian's findings in its analysis.

Writing for the three-judge panel, Senior Judge Don Ash wrote, "Like Dr. Palmieri, Dr. Christian used a diagnosis-based impairment rating for a 'first metatarsal, nondisplaced fracture diagnosis,' and he assigned a 3 percent impairment rating to the lower extremity. Dr. Christian further stated 'if [he] was going to assign an impairment rating to the foot it would be 4 percent.'" Although Dr. Christian's rating was entitled to the statutory presumption, Judge Jenkins didn't address the presumption or whether it was rebutted.

"Without elaboration, the trial court found 'Dr. Dalal's opinion is the most appropriate,'" wrote Judge Ash. "Our review of the record reveals no evidence indicating Dr. Christian used an incorrect method or incorrectly interpreted the AMA Guidelines." He continued, "Dr. Christian's findings and conclusions were consistent with those of the treating physician, Dr. Palmieri. Moreover, Dr. Christian, like Dr. Palmieri, used a 'diagnosis-based' impairment rating as required by the AMA Guidelines."

The panel therefore concluded the trial court erred in failing to presume the correctness of Dr. Christian's impairment rating. Costco also argued the trial court erred in awarding 64 percent permanent partial disability benefits. The panel agreed. Judge Jenkins found that Andric suffered "significant loss to the foot due to swelling, pain, and numbness" and noted "a decrease in jobs in the market" due to his "age, training and limited education." The panel deferred to these findings.

However, the trial court erred by applying Dr. Dalal's impairment rating of 10 percent and in failing to apply the statutory presumption with respect to Dr. Christian's rating as part of the MIR process. Dr. Christian's four percent rating was presumptively correct "absent clear and convincing evidence to the contrary." The panel found none, applied the four percent rating, and modified the award to 26 percent permanent partial disability to the right foot. They remanded the case for the recalculation of benefits.

A FEW TAKEAWAYS

For starters, impairment ratings for injuries after July 1, 2014, are now expressed to the body as a whole, so the ruling regarding the trial judge's apportionment has application only to pre-Reform Act cases.

In addition, the opinion is not recommended for publication. This likely means that the rulings did not address any new or novel legal issues. Rather, it reiterates the importance of the legal presumption afforded to the MIR physician's opinion. The statutory presumption and the high standard of proof to rebut it – clear and convincing evidence – mean the MIR rating is difficult to overcome. The Bureau's website explains that MIR physicians must cite the AMA Guides in their reports to show exactly how they obtained their impairment ratings. That's exactly what Dr. Christian did, as recognized by the appellate court.

The case is Andric v. Costco Wholesale Membership, Inc., No. W2017-01661-SC-R3-WC. Attorney Troy Hart of Knoxville represented Costco, while Christopher Taylor of Memphis represented Andric.