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AdMIRable REVIEW

JOURNAL OF THE TENNESSEE MEDICAL IMPAIRMENT RATING REGISTRY

VOLUME 10
Fall Issue
2021

Common Mistakes: Upper Limb Impairment Ratings

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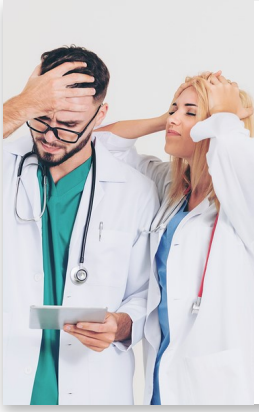

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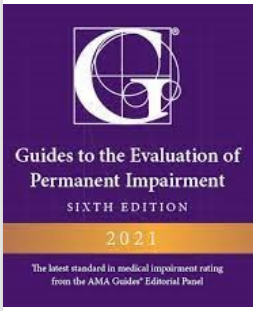

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MIR Physician Spotlight: Jeffrey A. Uzzle, MD

Dr. Jeffrey A Uzzle is a Board-certified physical medicine and rehabilitation physician who has practiced medicine in Tennessee since 1991. Based in Oak Ridge, Dr. Uzzle's clinic is called Cumberland Medical Evaluation Services. He specializes in independent medical evaluations, substance abuse treatment, physicals, and life care plans. He particularly "has a heart for people with substance abuse problems" and has "been treating them for almost five years now."

A member of the MIR Registry since its beginning in 2005, Dr. Uzzle evaluates MIR patients in Oak Ridge, Maryville, Sevierville, Tazewell, Jacksboro, and Johnson City, as well as Princeton and London, Kentucky. He is also considering setting up shop somewhere in West Tennessee. Along with the array of geographic choices he offers his patients, he is proficient at rating from every chapter of the AMA *Guides*, Sixth Edition. Dr. Uzzle "loves" his work with the MIR Registry, as it gives him exposure to uniquely challenging cases and an opportunity to meet people with different backgrounds and experiences. He has offices throughout Tennessee and Kentucky because many of his patients are unable to travel long distances.

Dr. Uzzle's professional career includes medical directorships, as well as clinical and hospital appointments at institutions such as Free Medical Clinic of Oak Ridge, Tennessee Orthopedic Clinic, Patricia Neal Rehabilitation Center, Parkwest Medical Center, and Baptist West Hospital. His professional associations include the American Academy of Physical Medicine & Rehabilitation and the American Board of Independent Medical Examiners. He earned a Bachelor of Science in Chemical Engineering and a Doctor of Medicine, both from the University of Kentucky, Lexington.

When he is not practicing medicine, Dr. Uzzle enjoys yoga, meditation, traveling with his life partner, Lisa Bridges, and the great outdoors. "We love going to Loveland, Colorado and emerging ourselves in all the artistic flair it has to offer," says Dr. Uzzle. "We can get happily lost among all the sculptures and exhibitions." Dr. Uzzle and Ms. Bridges have canoed the Boundary Waters on the Canada-U.S. border and boated in the Florida Everglades. They love hiking remote trails with waterfalls and rock formations. Some of their

favorite places to hike are the Appalachian Trail, Red Woods National and State Park, Frozen Head State Park, Stone Mountain Park, and Big South Fork National River and Recreation Area. “Point Lobos State Natural Reserve, in California, was an unplanned stop,” says Dr. Uzzle. “That remains one of the ‘wow’ moments in our lives.”

Another memorable excursion was hiking up the cables of Half Dome of Yosemite National Park. The trip is sixteen miles roundtrip, with a rise in elevation of nearly 5,000 feet. It takes ten to twelve hours for most people to complete the hike. According to Business insider, “From 2005 to 2015, Half Dome's perilous climb has prompted at least 140 search-and-rescue missions, 290 accidents, and 12 deaths.” To attempt the ascent, a hiker must apply and secure a permit by lottery before starting, as only 300 hikers a day are allowed to ascend the cables. “It was a very difficult and treacherous hike,” recalls Dr. Uzzle. “But very worth it.”

Dr. Uzzle is a proud supporter of the Scott Hamilton Cares Foundation and attends his annual Scott Hamilton and Friends skating events each year. He also regularly attends Chris Tomlin’s Good Friday events, whose net proceeds are dedicated to Tennessee Kids Belong. “I admire the calling of these two men’s lives to help others.”

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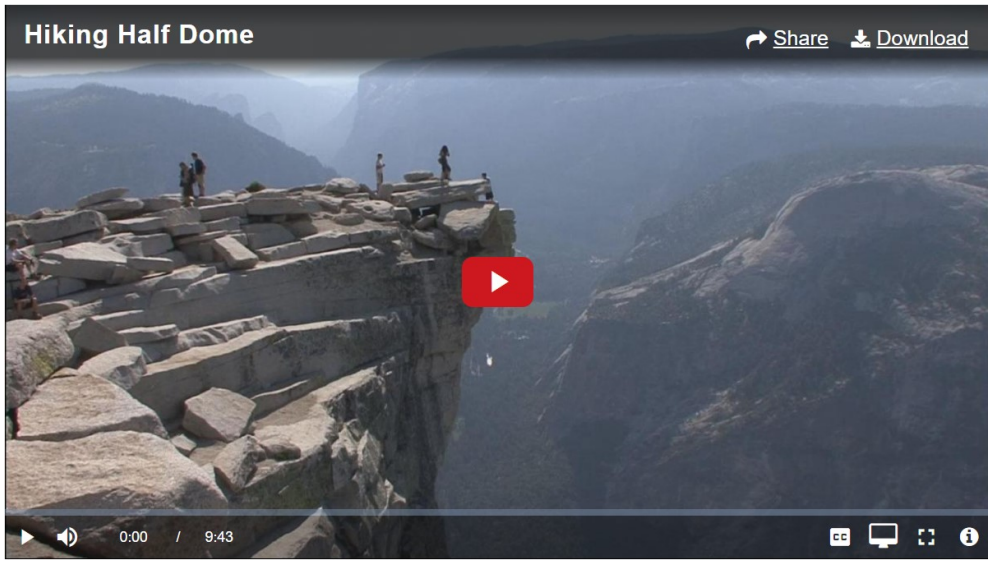
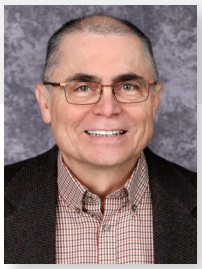


Common Mistakes in Upper Limb Impairment Ratings

James B. Talmage, MD, Robert B. Snyder, MD, J. Wills Oglesby, MD



The Medical Directors for the Tennessee Bureau of Workers' Compensation see many impairment rating reports. The medical records submitted with a Medical Impairment Rating Registry request and Utilization Review appeals contain reports by authorized treating physicians and independent medical examination reports. Correctly issuing a permanent impairment report requires the physician to be very conversant with the *AMA Guides* philosophy and criteria for rating disorders. This article will review frequently seen errors in upper limb impairment ratings, so that hopefully future evaluations will be more consistent with the *AMA Guides*, 6th Edition.

Chapter 15 is devoted to Upper Extremity Disorders. By middle age, when shoulder pathology often becomes symptomatic, there are commonly multiple simultaneous shoulder aging changes (pathologies). Thus, at shoulder surgery, several different procedures are performed during a single surgery; combinations are rotator cuff repair, subacromial decompression, labrum debridement/repair, and long head biceps tenotomy/tenodesis. Each of these could be considered the on-the-job injury and basis for rating. Interestingly, when patients with unilateral shoulder pain claims have bilateral shoulder MRIs, the contralateral asymptomatic shoulder frequently has similar or worse pathology (Goncalves et al., 2019; Liu et al., 2017).

One Diagnosis

The *Guides,* 6th edition, pages 387, 389, 390, and 409 repeat that only one diagnosis is to be rated from the shoulder table. Mistakenly, doctors will rate two shoulder diagnoses and combine ratings, when the instructions are clear that only one diagnosis should be rated, and the physician accounts for the presence of additional pathology by increasing the GMCS (Grade Modifier Clinical Studies).

In most shoulder surgery cases, the pre-op medical records are clear that the surgeon suspects the work injury is a rotator cuff tear, a labrum injury, or impingement. At surgery, a distal clavicular excision or AC joint Mumford type arthroplasty is also done, potentially to avoid a second operation for AC joint osteoarthritis. Published studies of surgery for middle-aged shoulders indicate the distal clavicle excision prevents the need for the second surgery in about five patients out of every 100. Thus, this added procedure is rarely the primary cause

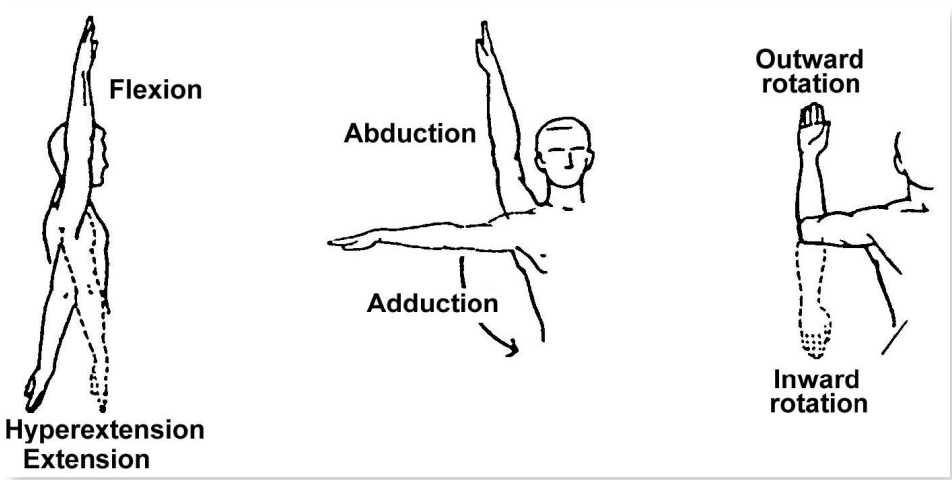
for shoulder surgery. Unless the AC joint injury and subsequent resection (distal clavicle excision) are the first diagnoses listed in pre-operative office notes, and the operation report, this is incidental surgery, and the *Guides*, 6th ed. page 387 clearly indicate such incidental AC joint surgery is NOT rated. Additional confirmation frequently comes from the office notes, where no provocative physical exam maneuvers for acromioclavicular pain, and no diagnostic injection of the AC joint, were documented.

AC Joint

When the AC joint is the primary injury, with healing of the joint resulting in persisting localized pain and symptomatic subluxation or dislocation of this joint, this becomes the primary diagnosis and should be rated as "acromioclavicular joint injury or disease," with choices of a Class 1 or Class 2 impairment listed in Table 15-5, page 403. However, if the AC joint resection arthroplasty is an "add on" or incidental prophylactic procedure, age-related arthritis on imaging should not be the basis for rating the work injury. Therefore, the primary pathology is the rotator cuff tear, the biceps tendon subluxation/pathology, or the labrum tear, and that diagnosis should be the diagnosis chosen for impairment rating.

Range of Motion Rating

Rating the upper limb injury by diagnosis is the preferred method (Guides, 6th ed., p. 389), but the instructions on page 390 indicate that if the diagnosis in the table being considered has an asterisk (*), rating by range of motion may be used instead of diagnosis. Most of the diagnoses in the Upper Extremity Chapter tables have the



asterisk, shoulder arthrodesis and multidirectional instability being among the few exceptions. Principle #12 in Table 2-1 (6th ed. p. 20) indicates when there are two potential methods to rate a single condition, the higher of the ratings should be used.

There are several caveats about range of motion testing and rating. Any joint for which motion is measured should have measurements of EVERY direction the joint moves. The shoulder motion must be measured in all six directions, the elbow four directions (including pronation and supination), and the wrist in six directions (including pronation and supination – ratings found in the "elbow" table, as both the wrist and elbow joints determine pronation and supination). The active motion loss should be due to joint pathology, and not due to neurologic deficit which is rated in a different section (nerve injury).

"Calculate the impairment for the injured joint and the impairment for the uninjured contralateral joint, and subtract the impairment of the contralateral joint from the impairment of the injured joint to derive the impairment of the injured joint due to the injury."

Each direction of motion is to be measured three times, and the greatest measurement is rounded to the nearest integer ending in zero, which is used to derive the impairment. Page 407 points out that, assuming the person is at maximum medical improvement, the measurements recorded should be similar to those of other examiners, or the same examiners on different occasions. This requires comparing the current measurements to prior measurements. Then a statement must be added that the results are fairly reliable and acceptable for use in rating, or that the results are inconsistent and range of motion cannot be used either to determine a Grade Modifier Physical Exam or an impairment.

Page 461 states that if the contralateral joint is neither involved nor previously injured, the contralateral joint should be measured and used to establish this person's normal based on age and genetics. Stated another way, calculate the impairment for the injured joint and the impairment for the uninjured contralateral joint, and subtract the impairment of the contralateral joint from the impairment of the injured joint to derive the impairment of the injured joint due to the injury.

Optional Use of Range of Motion

Instead of using Range of Motion as the rating method, range of motion measurement can be the basis for the Grade Modifier Physical Exam (GMPE) in the Diagnosis Based Impairment (DBI). It should be noted that many impairment rating reports do not document upper limb atrophy, or joint stability as part of the physical exam. This failure may lead to an underestimate of the GMPE.

Nerve Injury

Another area of incorrect impairment assessments is Upper Extremity Nerve Injury. Motor strength in muscles potentially denervated by injury should be assessed by

the criteria in Table 15-14, which were derived from the British Medical Research Council/Mayo Clinic criteria. The criteria are for active motion of muscles (joints) affected by nerve injury or nerve disease. The grades of nerve injury weakness are not correctly used for non-nerve injury conditions like rotator cuff tears. When there is a nerve injury in a limb, the impairment report physical exam section should state the strength demonstrated in muscles expected to be weak (innervated by the injured nerve distal to the level of injury) as well as the muscles expected to be normal (innervated by uninjured nerves in the same limb or innervated by the injured nerve but proximal to the level of nerve injury). In nerve injury testing, muscle strength should not be painful, unless there is another injury also present. The *Guides* point out (6th ed., p. 425) that valid strength testing is subjective and requires full voluntary cooperation, and if full effort is given, the results are consistent between two observers or one observer on multiple occasions. Documenting reliability (consistency) requires documenting from medical records the results of manual muscle testing by other examiners or three tests separated by time during the evaluation

Pain During Muscle Strength Testing

Muscle strength testing should not be painful if there are no other injuries or diseases in the limb. The Guides (6th ed., p. 425) points out that pain or fear of pain during testing makes interpretation of the results very difficult. This was stated more strongly in the Guides, 5th Edition (p. 508), which disallowed strength testing if testing was painful. Examples of this "uninterpretable finding" would be pain on testing thumb abduction strength in a patient with both carpal tunnel syndrome and painful thumb carpal-metacarpal joint osteoarthritis, or testing deltoid muscle (abduction) strength in a patient with an axillary nerve injury from a shoulder dislocation who also has a painful rotator cuff tear. In these circumstances, the examiner should declare the manual muscle testing for strength after nerve injury is not validly measured, and either disallow that portion of the rating or adjust the strength estimate to a guess of (apportionment) what would have been the effect of the nerve injury on the strength test if the other problem were not present.

Testing Sensation

In Upper Extremity nerve injury or nerve entrapment, Table 15-14 requires the examiner to have tested digit sensation by both monofilament and two-point discrimination testing for Severity Grades 0, 1, and 2. For Severity Grades 3 and 4,

sharp versus dull stimulus recognition (Grade 3 – failure to distinguish the sharp stimulus from the dull stimulus), failure to perceive many of the sharp stimuli (Grade 3), or failure to perceive any of the sharp stimuli (Grade 4), must be tested.

Electrodiagnostic Testing

In the section on Upper Extremity Nerve Entrapments, Table 15-23 requires the physician to place the electrodiagnostic testing into one of five categories: Normal, Conduction Delay, Conduction Block, Axon loss (partial death of the nerve), or "almost dead" nerve. There are definitions of these terms and criteria on pages 446-7, and in Appendix 15-B, pages 487-490.

Physicians should realize that when the 6th Edition was written in 2007, NO national organization had defined "normal" in nerve conduction testing. Each physician doing electrodiagnostic testing chose definitions of normal for each nerve in latency (time between the electric stimulus and the measured response) and amplitude (voltage recorded). Imagine if no national organization defined diabetes, and each physician chose a value for fasting blood sugar or for Hemoglobin A1c that would differentiate normal from diabetes. In that case, there would be marked variability in the incidence and severity of diabetes as evaluated by different physicians.

Finally in 2016, the American Association of Neuromuscular and Electrodiagnostic Medicine published consensus definitions of "Normal" nerve conduction tests after reviewing 7,500 published articles (Chen et al., 2016). Happily, the AMA Guides, 6th Edition values in Appendix 15-B for carpal tunnel syndrome are identical to the AANEM criteria (latency and amplitude), and for the other nerves they are very similar. Unhappily, few physicians doing electrodiagnostic testing have converted to the AANEM definitions, and thus different physicians still would have different diagnostic impressions from the same numbers for latency and amplitude on the test report.

The nerve entrapment section of the Upper Extremity chapter requires the impairment rating physician to compare the latencies and amplitudes measured to the criteria in Appendix 15-B to place the Test Findings into one of the 5 Grade Modifier categories. This is a required step, and reading and using just the conclusion on the electrodiagnostic test report may result in serious misclassification of the diagnosis and severity, invalidating the physician's

impairment rating. This required step is frequently omitted by impairment rating physicians.

Normal Electrodiagnostic Testing

An additional concern is sometimes the nerve conduction tests are normal by AANEM and AMA Guides, 6th Edition criteria. There is specific instruction in the Guides, 6th Edition, pages 444-45: "If nerve conduction testing has not been performed or does not meet this section's diagnostic criteria [Appendix 15-B], there is no ratable impairment from this section [Section 15.4f] [clarifications added]. These cases may still be rated in Section 15.2, Diagnosis-Based Impairment, and with the appropriate regional grid, using the diagnosis of non-specific hand, wrist, or elbow pain, depending on the affected region."

This is stating that if the nerve conduction test does not meet the diagnostic criteria in Appendix 15-B (Guides, 6th Edition, pages 487-490), then even if the treating physician diagnosed a nerve entrapment (like carpal tunnel syndrome), and even if the worker had carpal tunnel release surgery, the diagnosis for the purpose of impairment rating should use the table for "non-specific … pain," as the diagnosis of carpal tunnel syndrome has not been objectively established.

After Carpal Tunnel Surgery

The concept of having a permanent impairment after surgical treatment of carpal tunnel syndrome needs further discussion. It is possible to have very early, very mild carpal tunnel syndrome. Surgery for this condition should be universally successful, and the decompression of a minimally compressed nerve should have yielded a normal person, absent a surgical complication that should be easily recognizable. Carpal tunnel release surgery results in a very small increase in the width of the carpal tunnel from radial to ulnar, and a larger increase in tunnel height (anterior to posterior), resulting in an average increase in carpal tunnel volume of 24%, thereby decreasing the abnormal pressure on the nerve in the canal (Brooks et al., 2003). Doctors should think critically about alleged permanent impairment after carpal tunnel release for disease so early the nerve conduction tests were normal. Again, absent a surgical complication, this does not make sense.

Multiple published studies have looked at the pre-operative nerve conduction test as a predictor of surgical outcome (Higgs et al., 1997; Dennerlein et al., 2003;

Bland, 2001). These were published before the AANEM gave definitions of normal. Each study used a different definition of normal, but each found that those with normal, or very nearly normal, nerve conduction studies had a significantly worse average surgical outcome compared to those with clearly abnormal studies. In the two studies that reported on outcomes in percentage form, those with normal or near normal nerve conduction studies had a 30-40% chance of persisting pain, dissatisfaction with surgery, job change, etc. (suboptimal outcomes).

The conclusion should be that those with clearly abnormal nerve conduction studies are having an operation for a disease they actually have. Most recover. Those with more severe or prolonged nerve compression may keep some residual symptoms.

Paradoxically, those with normal or almost normal tests are much more likely to have poor outcomes. This is logically due to the "normal or near normal" nerve conduction group being composed of two different patient populations. One group is those who actually have very early, very mild carpal tunnel syndrome. They are appropriately operated for a disease they have, and since this is discovered and treated early, before permanent nerve damage occurs, they typically recover fully.

The other group is those who do not have carpal tunnel syndrome, but who are normal, or just a bit slower than average on nerve conduction testing. When this group has carpal tunnel release for a disease they do not have, they do not improve. The persisting symptoms are frequently erroneously rated for impairment as if due to carpal tunnel syndrome, when they never had carpal tunnel syndrome.

Thus, one issue is the impairment rating for a disease the person did not have. The other issue is the persisting symptoms used in the "carpal tunnel syndrome" rating are reflective of a disease that has not been diagnosed or treated. A misdiagnosed patient is not at maximum medical improvement.

Physician Bias

A recent review of physician biases in orthopedic surgery discusses several physician biases that lead to diagnosis and treatment errors (Janssen et al., 2021). Confirmation bias is present when the physician has a preconceived diagnosis, elicits only the history (symptoms), and performs only the physical exam tests that fit the preconceived diagnosis. Thus, many of the medical records do not record the

presence or absence of symptoms or exam findings that would be consistent with other diagnoses, and not consistent with the preconception, for example, carpal tunnel syndrome as the diagnosis.

The ACOEM Practice Guidelines have stated for over a decade that the dominant symptom in peripheral (non-spinal) nerve compression syndromes is numbness, and that pain without numbness is rarely a peripheral nerve compression syndrome. If pain is also present, it is typically not the dominant symptom. Yet often medical records indicate that pain before and after carpal tunnel release with normal or near normal nerve conduction tests is the only symptom listed. Physicians should consider this when they do their ratings.

Conclusion

As outlined above, many traps for the unwary exist when rating a worker's upper limb impairment if the physician is unfamiliar with the Guides. Hopefully this article will help physicians make more accurate ratings going forward.

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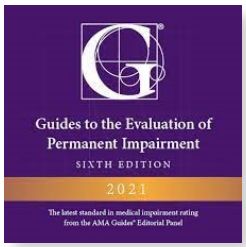
Do Not Use the AMA Guides, Sixth Edition, 2021

James B. Talmage, MD, Robert B. Snyder, MD, Troy Haley, Esquire

The American Medical Association has begun a new process to update the impairment guides. Newer and better treatments frequently yield better outcomes, and the advances in medical diagnosis and treatment are the AMA's rationale for the changes in editions. They have committed to publishing yearly updates.

Since the AMA Guides Sixth Edition 2021 is now "on sale" and being marketed by the AMA, doctors, insurers, and attorneys may wonder about which edition of the impairment guides should be used in Tennessee workers' compensation cases.

Tennessee workers' compensation law authorizes the use of the *AMA Guides, 6th Edition* for permanent impairment ratings. The *AMA Guides to the Evaluation of Permanent Impairment, 6th Edition* has a copyright date of 2008. It was written in 2006-2007. Medicine has changed over the years; however, many states still use earlier editions of the impairment guides and variation among states is widespread



Importantly, the AMA will no longer publish the impairment guides as a hardbound textbook. Instead, the *Guides* will now be available as an online subscription, with a yearly fee. The AMA's plan is for yearly updates to the *AMA Guides, 6th Edition* content, which will come with names such as "*AMA Guides Sixth Edition 2021*" and "*AMA Guides Sixth Edition 2022,*" etc.

How will this affect physicians making impairment ratings in Tennessee workers' compensation cases? Looking at the statute itself, Tennessee Code Annotated (T.C.A.) §50-6-102(2) provides that the "AMA guides" means the 6th edition of the American Medical Association Guides to the Evaluation of Permanent Impairment "**UNTIL** a new edition is designated by the general assembly in accordance with § 50-6-204(k)(2)(A). The edition that is in effect on the date the employee is injured is the edition that shall be applicable to the claim." [Emphasis added].

The legislature created a measured, step-by-step approach to determine how to proceed when a new version of the *Guides* becomes available. Specifically, T.C.A. § 50-6-204(k)(2)(B) states that "the medical advisory committee shall, within six (6) months of the release of a new edition, conduct an evaluation of the new edition, report the committee's findings to the administrator and recommend to the admin-

istrator whether the new edition should be designated for application to this chapter. The administrator shall report the committee's findings and recommendation to the general assembly. The AMA guides, as defined in T.C.A. § 50-6-102, shall remain in effect until a new edition is designated by the general assembly.

So, in the coming months, some careful study and recommendations are necessary, and they will be undertaken diligently and thoroughly, as the law requires.

Until the legislature authorizes the use of a newer edition of the *AMA Guide*, the 2008 hardbound book "*6th Edition*" appears to remain the proper method of evaluating and reporting permanent impairment in Tennessee workers' compensation cases.

> *"For now, do **not** use the AMA Guides, Sixth Edition, **2021**."*

Another possibility is that a case might raise the issue, and an appellate court might ultimately be tasked to rule on the question. The lawyers in your cases might recognize this as an issue, and will likely NOT ask you to use the new online version just yet. Time will tell how this all plays out. For now, do **not** use the AMA Guides, Sixth Edition, **2021**.

Guest Contributor Robert B. Snyder, MD

Dr. Snyder was appointed Medical Director for the Bureau of Workers' Compensation in January, 2014 after 37 years of Orthopaedic private practice. A graduate of Wayne State University School of Medicine in Detroit, he completed two years of general surgery training at the University of Pittsburgh before coming to Nashville to complete a residency in Orthopaedics and Rehabilitation at Vanderbilt University. His activities with the Bureau include Medical Treatment Guidelines, the Drug Formulary, Utilization Review, Case Management, Fee Schedules and physician/provider communication .

Guest Contributor Troy Haley, Esquire

Troy Haley is Legal Services Director for the State of Tennessee's Bureau of Workers' Compensation. He has been with the Bureau since 2007. Since June 2014 he has served as administrative counsel for the Bureau and legislative liaison for the Bureau and Governor's office. He provides legal counsel to the Bureau Administrator and Medical Director and to other Bureau program areas. He drafts rules and legislation and works with the Governor's Office and the General Assembly to advance the administration's legislative agenda.

Administrator Appoints a New Assistant Medical Director: J. Wills Oglesby, MD

Bureau Administrator Abbie Hudgens has appointed J. Wills Olgesby, MD, as the Bureau's second Assistant Medical Director. Dr. Oglesby will serve alongside Bureau Medical Director, Robert B. Snyder, MD, and Bureau Assistant Medical Director, James B. Talmage, MD.

A Native Nashvillian

Dr. Oglesby graduated from Hillsboro High School and Vanderbilt University. He graduated from the University of Tennessee School of Medicine in Memphis in 1978. His orthopaedic residency was served at the University of North Carolina at Chapel Hill. He completed his training as chief resident of that program in 1983. Dr. Oglesby is certified by the American Board of Orthopaedic Surgery.

Practices with TOA

Dr. Oglesby returned to Nashville in 1983 and began his practice with Tennessee Orthopaedic Alliance (TOA) at that time. His practice focuses primarily on problems of the shoulder that are amenable to arthroscopic treatment. This includes rotator cuff repair, labral repair, and stabilization. He also performs both traditional and "reverse" total shoulder replacement. He has served as an instructor for courses in fracture management supervised by the Swiss AO Group, and as an instructor at the Masters course on shoulder arthroscopy presented by the Arthroscopy Association of North America. He has made scientific presentations to the American Orthopaedic Society of Sports Medicine and American Academy of Orthopaedic Surgeons national meetings. He has also written papers regarding problems of the shoulder which have been published by the *Journal of Bone and Joint Surgery, Arthroscopy*, and the *Journal of Shoulder and Elbow Surgery.*

Memberships and Associations

Dr. Oglesby is a member of the medical staff at Saint Thomas Midtown Hospital and Centennial Medical Center. He is also a member of American Academy of

Orthopaedic Surgeons, the Arthroscopy Association of North America, the Nashville Academy of Medicine, the Nashville Orthopaedic Society, the Nathan A. Womack Surgical Society, the North Carolina Orthopaedic Alumni Association Tennessee Medical Association, and the Tennessee Orthopaedic Society.

Training Program Fosters Return-to-Work Program Best Practices

Brian Holmes, MA

Michael Jordan entered the NBA in 1984 and quickly became a superstar. When Phil Jackson became his head coach, he and his teammates became champions. Historians argue whether either would have been so successful without the other, but they agree that the Zen Master (Jackson) and the GOAT (Greatest Of All Time, Jordan) helped each other improve. Together, they contributed to the development of a team that won six NBA championships.

Adopting a Team Model

Applying a similar team model can help return-to-work programs benefit employers and injured workers. The Bureau of Workers' Compensation estimates return-to-work programs reduce average claim costs by almost $16,000. These programs shorten the time for injured workers to recover, decrease the number of doctor visits, and reduce workers' disability. A successful return-to-work program also means employees get back to work, their full paychecks, and their pre-injury lives sooner. Just like winning NBA titles, successful return-to-work programs result in great rewards for all "players," and they require teamwork.

It takes a coach, or company leader, to establish program goals, assemble the right team members, and clarify tasks. The coach must provide the vision for successfully returning injured employees to work. Return-to-work teams also need members outside the company: physicians, nurses, therapists, case managers, and insurance adjusters. It is important that these persons are on the same page as the employer about the goals of the return-to-work program.

Success also requires having the right person, with the right mindset on the ground — a "Jordan-esque" leader to hold team members accountable for effort, training, messaging, and direction. This person is known as a return-to-work coordinator. Just like Jordan, a return-to-work coordinator motivates, sets the example, and leads without the title of head coach.

Introducing the Return-to-Work Coordinator Series

The Bureau has initiated the R.E.W.A.R.D. Program to help companies who are ready to have a championship-quality return-to-work program. As part of REWARD, we have developed a free training program for Return-to-Work Coordinators consisting of six 90-minute online sessions, that helps return-to-work coordinators learn how to build successful return-to-work teams. The inaugural training launched on July 15, 2021, with 39 students from 29 different employers. The first series will continue until the end of September. The series will be repeated several times during the next year.

Workers' Compensation 101

The first class in the series covers the basics of workers' compensation: the law and regulations for documenting and reporting injuries, how to begin medical care with the right panel of physicians, and educating injured workers on what workers' compensation does and does not include. The logic behind this first class is that getting a claim started on the right foot is key to successfully returning an injured employee to work. It starts trust and rapport-building among the return-to-work team and the injured worker. These easy first steps build a foundation for a strong program.

The Role of the Return-to-Work Coordinator

The second class breaks down each of the team members' and coordinator's role in making them successful. For example, a coordinator ensures that the company uses physicians who prioritize return-to-work as part of the recovery process. The role of the panel physician is so significant that the third class is devoted entirely to this topic. It covers the studies showing the effectiveness of return-to-work programs and the role of the appropriate approach to medical care. It also offers a physician's view on how to best work with physicians.

Working With Physicians

One of the barriers to effective medical care is unnecessary delays. Timely approval of tests, medicine, physical therapy, and surgery is important for a successful return -to-work program. The smooth delivery of treatment makes it easier for injured workers to return to work and participate in modified-duty programs. From the beginning of a claim, the team must emphasize to the employee that work is a part

of the treatment process, and it is in the injured worker's best interest to return to work when modified-duty assignments are offered.

Job Demand Analysis

A Job demand analysis (JDA) is essential to understand the physical demands of a job. A JDA is often used in work injury prevention and can play an essential role in recovery. This is why JDAs are the topic of the fourth class. This class provides examples of useful JDAs and compares them to those that are overly complicated or lack sufficient details. In addition, the class covers the use of JDAs to make appropriate business decisions regarding the ADA and FMLA, explaining how those laws might also impact return-to-work programs.

Legal Issues Outside of Workers Compensation

The fifth session explores other employment laws. Attorneys explain how they interact with workers' compensation, because the right legal approach combined with the right personal touch strengthens a return-to-work program.

Effective Communication

The sixth and final class helps return-to-work coordinators become better communicators. This class teaches communication strategies to help coordinators build and maintain relationships with team members and the injured worker. Establishing credibility and trust, managing emotions, and choosing the best approaches to effect change are introduced.

The Return-to-Work Coordinator Training Series provides the framework to develop a better team and establish the leadership to create and maintain a successful return-to-work program. The physician's role on the team is critical. This training helps employers and physicians understand the bigger picture and encourages them to take an active role in helping injured workers recover faster and better. Two common results of these programs are improved medical outcomes for injured workers and reduced periods of disability. These benefits can improve patient and physician relationships and possibly lead to winning six championships for customer satisfaction.

"Everybody has talent, but ability takes hard work."

- Michael Jordan

Certified Physician Program Has a New Website

Jay Blaisdell, MA

Information on the Certified Physician Program is now available online as a component of the Bureau's R.E.W.A.R.D. Program. The Bureau's newest webpage gives an overview of the Certified Physician Program and answers frequently asked questions.

If you are an MIR Physician and are also interested in becoming a Bureau-Certified Physician, you have already fulfilled the impairment-rating training requirement for certification. In addition to impairment-rating methodology, as a Bureau-Certified Physician, you will learn about return-to-work best practices, causation, utilization review, treatment guidelines, billing procedures, claim processes, permanent work limitations, and communication with Return-to-Work Coordinators. Physicians who take the online training and pass the comprehensive tests will earn the distinction of being a Bureau-Certified Physician.

Return Employees to Work And Reduce Disabilities

REWARD Toolkit

RTW Coordinator Training

Certified Physician Program

Benefits of Becoming a Bureau Certified Physician

As a Bureau Certified Physician, you will receive enhanced fees for initial visits, follow-up visits, and filling out the C-30 A, final medical report form. You will also be listed on the Bureau's website, along with your specialty and board certification, making you easier to find for employers and insurance carriers who must provide three-physician panels for injured workers. (Employers are required by law to provide injured workers with a physician panel within three business days of the injury being reported.) The increased visibility within the workers' compensation community makes becoming a Bureau-Certified physician the single most important action you can take to expand your workers' compensation practice.

Bureau certification will also give you the confidence that you have the knowledge and skills to successfully treat workers' compensation patients and return them to work as soon as possible. A quick return to employment has medical value, often leading to better medical outcomes.

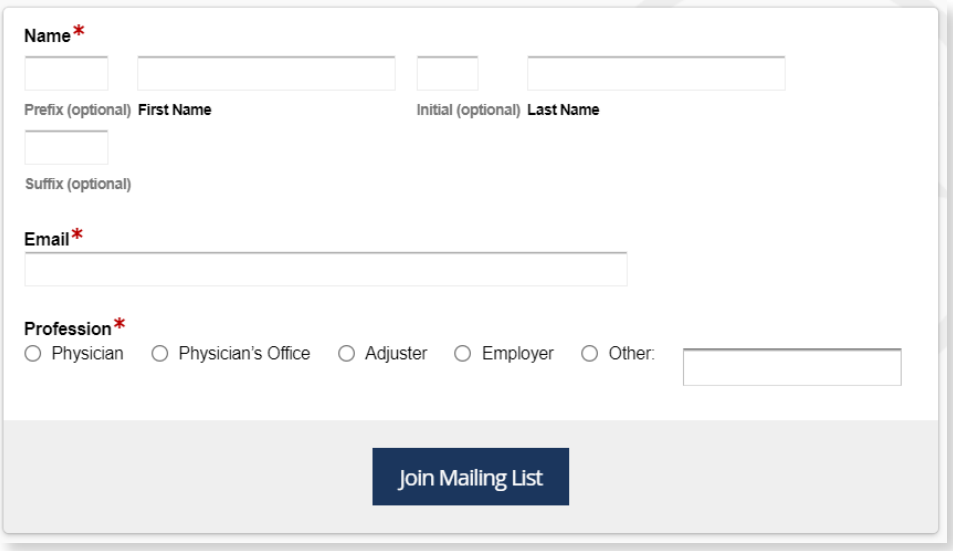
The Benefits of Using Bureau-Certified Physicians

First and foremost, certified physicians agree to accept workers' compensation. If a physician's name is on the Bureau's listing, employers and insurers can be reasonably assured that the physician welcomes workers' compensation cases.

Secondly, certified physicians have been formally trained to do all that is required under workers' compensation, from the initial evaluation to the final medical report form. This makes the process better for everyone involved. Finally, certified physicians might help injured workers return to employment more quickly, resulting in better medical and psychosocial outcomes for patients and potentially lower medical costs for the employer and carrier.

Interested in the Certified Physician Program?

If so, please consider joining our mailing list to get the latest updates. We anticipate the online training curriculum to be available in the next year.



Appeals Board Offers Guidance on Panels

Jane Salem, Esquire

The Appeals Board recently affirmed a trial court order that an employer must provide a panel of physicians, in a case presenting unusual medical proof as its defense.

Hawes v. McLane Company, Inc.

In *Hawes v. McLane Company, Inc.,* the employee alleged a back injury. When he reported it, he participated in a "triage call" arranged by McLane in which a doctor said he needed an "electrodiagnostic functional assessment" test, or "EFA."

The test was later performed by a technician under the remote supervision of Dr. Naiyer Imam, a Tennessee-licensed neuroradiologist located out of state. The technician also performed an examination under Dr. Imam's supervision using "EFA guided technology."

Dr. Imam noted that "both evaluations demonstrated chronic changes as evidenced by the bilateral inappropriate muscle usage" and "hyperactivity with range of motion and positional changes as well as inappropriate muscle usage." Dr. Imam compared the post-injury EFA test results with a baseline EFA that was performed when Hawes was hired. He found "no acute pathology or change in [Employee's] condition," and, "there does not appear to be a need for treatment on an industrial basis."

The results were included in a report signed by MaryRose Reaston and Clay Everline. Dr. Reaston's undergraduate degree, Master's, and Ph.D. are in psychology, and she holds a Certificate of Electromyography and Clinical Neurophysiology. Dr. Everline is a medical doctor located in Hawaii who isn't licensed in Tennessee.

Both doctors agreed the EFA demonstrated no acute pathology or change in Hawes' condition from the baseline test but cautioned that "[c]linical correlation and screening for any contraindications to suggested treatment modalities is recommended."

Based on the report, McLane declined to provide workers' compensation benefits, so Hawes requested an expedited hearing.

Dr. Reaston testified at the hearing that she is the "chief executive officer, co-founder, and chief science officer" of Emerge Diagnostics, a company "in the business of providing better diagnostics for musculoskeletal disorders and performing electrodiagnostic functional assessment services." She explained that an EFA "measures muscle function [and] indirectly measures nerves and [the] clinical significance of disc pathology." Dr. Reaston confirmed that "medical personnel" place electrodes on patients but stated the test is ordered by a medical doctor. The trial court ordered McLane to provide a panel of physicians, and it appealed.

The Opinion

The Board began its analysis by reminding that both Section 50-6-204(a)(3)(A)(i) and Rule 0800-02-01-.06(1) require an employer to provide a panel of physicians on receipt of notice of a workplace injury and the employee expressing a need for medical care.

McLane argued that Rule 0800-02-01-.06(4) allows employers to direct injured employees to onsite, in-house or other similar employer-sponsored medical providers before providing a panel.

The Board wrote: "[W]hile an employer may direct an employee to see an 'employer-sponsored medical provider' prior to the provision of a panel, this examination does not replace a panel or relieve that employer of its obligation to provide a panel of physicians[.]"

McLane contended an employer has an "absolute right" to decline providing a panel of physicians when it has evidence establishing a defense. The Board agreed an employer has a right to investigate and deny a claim based on its factual assertion that the alleged work accident didn't occur as reported, or as the result of asserting an affirmative defense.

But, "an employer's assertion that an employee has no medical evidence supporting his or her claim does not, standing alone, excuse it from the statutory obligations

under section 50-6-204(a)(1)(A)." The Board held that early on in *McCord v. Advantage Human Resourcing*.

The Board cited *Berdnik v. Fairfield Glade Cmty. Club*, where an employee alleged a back injury. She wasn't provided a panel and sought treatment on her own. The employer denied the claim and several months later scheduled an examination with an orthopedic physician it chose. The doctor concluded that no objective evidence showed the employee's complaints were related to a work injury. The trial court ordered the employer to offer a panel, but the Board reversed, reasoning that there was an uncontradicted medical opinion addressing causation.

Hawes' case is distinguishable, the Board wrote. In *Berdnik*, the employee sought treatment on her own for several months and "had ample opportunity" to present medical proof at the expedited hearing to refute the employer's expert's causation opinion. Moreover, the employer's expert was a board-certified, Tennessee-licensed orthopedic surgeon who personally examined the employee and expressed an opinion that her complaints related to a preexisting back condition.

In this case, instead of providing a panel before denying the claim, McLane directed Hawes "to a particular medical technician who, under the supervision of a physician located out of state, conducted a single diagnostic test. Employer then relied on those findings as a basis to deny Employee's claim and refused to provide a panel of physicians."

The Board continued, "Importantly, the testing ordered by Employer's provider did *not* establish that no compensable work accident occurred; instead, it purported to show that there were no recent, acute physiological changes caused by the reported work accident.

"While the technology and test results relied upon by Employer may be relevant in determining the ultimate compensability of Employee's claim, it does not relieve Employer of its statutory obligation to provide a panel of physicians when a work accident has been reported, Employer has no factual evidence to contest the occurrence of the reported accident, no affirmative defense has been asserted, and medical treatment has been requested."

The opinion suggests two best practices.

First, the opinion is unambiguous about when an employer can deny a panel. The employer needs proof that either the accident didn't happen as reported or that supports an affirmative defense. Without that proof, an employer risks penalties and/or being responsible for the services of a physician chosen by the employee.

Second, rely upon Tennessee-licensed physicians, preferably located within the state, to perform thorough examinations, order more traditional diagnostic testing when appropriate, and most importantly *exercise their independent medical judgment* when evaluating a workers' compensation claimant.

Medical Director's Note about Electrodiagnostic Functional Assessment:

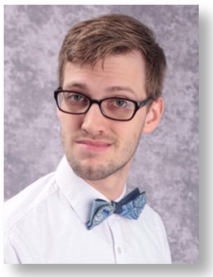
There are two articles from 2011. Further articles with scientific confirmatory studies of the assessment of this procedure were not found in a literature search.

Cusimano-Reaston, M., & Carney, B. (2011). Legal changes necessitate proactive management of Musculoskeletal Disorders: the role of electrodiagnostic functional assessment Soft Tissue Management program. *Annual International Conference of the IEEE Engineering in Medicine and Biology Society. IEEE Engineering in Medicine and Biology Society. Annual International Conference*, *2011*, 7570–7573. https://doi.org/10.1109/IEMBS.2011.6091866

Kulin, J., Reaston, M. (2011). Musculoskeletal disorders early diagnosis: A retrospective study in the occupational medicine setting. *J Occup Med Toxicol* 6, 1. https://doi.org/10.1186/1745-6673-6-1.

AdMIRable Review Editorial Staff

Kyle Jones



Kyle Jones is the Communications Coordinator for the Tennessee Bureau of Workers' Compensation. After receiving his bachelor's degree from MTSU, he began putting his skillset to work with Tennessee State Government. You will find Kyle's fingerprints on many digital and print publications from videos to brochures published by the Bureau. Kyle believes that visuals like motion graphics can help explain and break down complex concepts into something more digestible and bring awareness to the Bureau's multiple programs that are designed to help Tennesseans.

Sarah Byrne, Esquire

Sarah Byrne is a staff attorney for the Court of Workers' Compensation Claims. She has a bachelors' degree in journalism from Belmont University and a masters' degree in English from Simmons College in Boston. After working in religious publishing and then state government, she earned a law degree from Nashville School of Law in 2010. She first joined the Bureau of Workers' Compensation in 2011 as a mediator.

Jane Salem, Esquire

Jane Salem is a staff attorney with the Court of Workers' Compensation Claims in Nashville. She administers the Court's blog and is a former legal reporter and editor. She has run more than forty marathons.

Brian Holmes, MA

Brian Homes is the Director of Mediation Services and Ombudsman Services for the Tennessee Bureau of Workers' Compensation. In this role, he directs policy and leads twenty-three mediators and six ombudsmen as they educate the public about workers' compensation and help resolve benefit

disputes. He has had the privilege of helping thousands of injured workers, their employers, and insurance companies make informed decisions. A 16-year veteran of the Bureau, he has, of recent, created and implemented the Next Step Program, which assists unemployed workers' compensation claimants return to the workforce.

James B. Talmage, MD

Dr. Talmage is a graduate of the Ohio State University for both undergraduate school (1968) and medical school (1972). His orthopedic surgery training was in the United States Army. He has been Board Certified in Orthopaedic Surgery since 1979 and also was Board Certified in Emergency Medicine from 1987 - 2017. Since 2005 he been an Adjunct Associate Professor in the Division of Occupational Medicine, Department of Family and Community Medicine at Meharry Medical College in Nashville. In 2013 he was Acting Medical Director for the State of Tennessee Division of Worker's Compensation. In 2014 he became Assistant Medical Director for the renamed Bureau of Workers Compensation. He has been an author and co-editor of the AMA published books on Work Ability Assessment, and the second edition of the Causation book. He was a contributor to the AMA Impairment Guides, 6th Edition, and he has served as CoEditor of the AMA Guides Newsletter since 1996.

Jay Blaisdell, MA

Jay Blaisdell is the coordinator for the Tennessee Bureau of Workers' Compensation's Medical Impairment Rating (MIR) Registry. He has been the managing editor of *AdMIRable Review* since 2012, and is certified through the International Academy of Independent Medical Evaluators (IAIME) as a Medicolegal Evaluator. His articles are published regularly in the AMA *Guides Newsletter*.

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Submission Guidelines

AdMIRable Review accepts electronic submission for articles related to Tennessee Workers' Compensation. Manuscripts prepared in accordance with the American Psychological Association (APA) guidelines are preferred. Submission of a manuscript implies permission and commitment to publish in *AdMIRable Review*. Authors submitting manuscript to *AdMIRable Review* should not simultaneously submit them to another public-administration journal. Submission and inquires should be directed to *AdMIRable Review*, Editorial Staff, at Jay.Blaisdell@tn.gov.

AdMIRable Review

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