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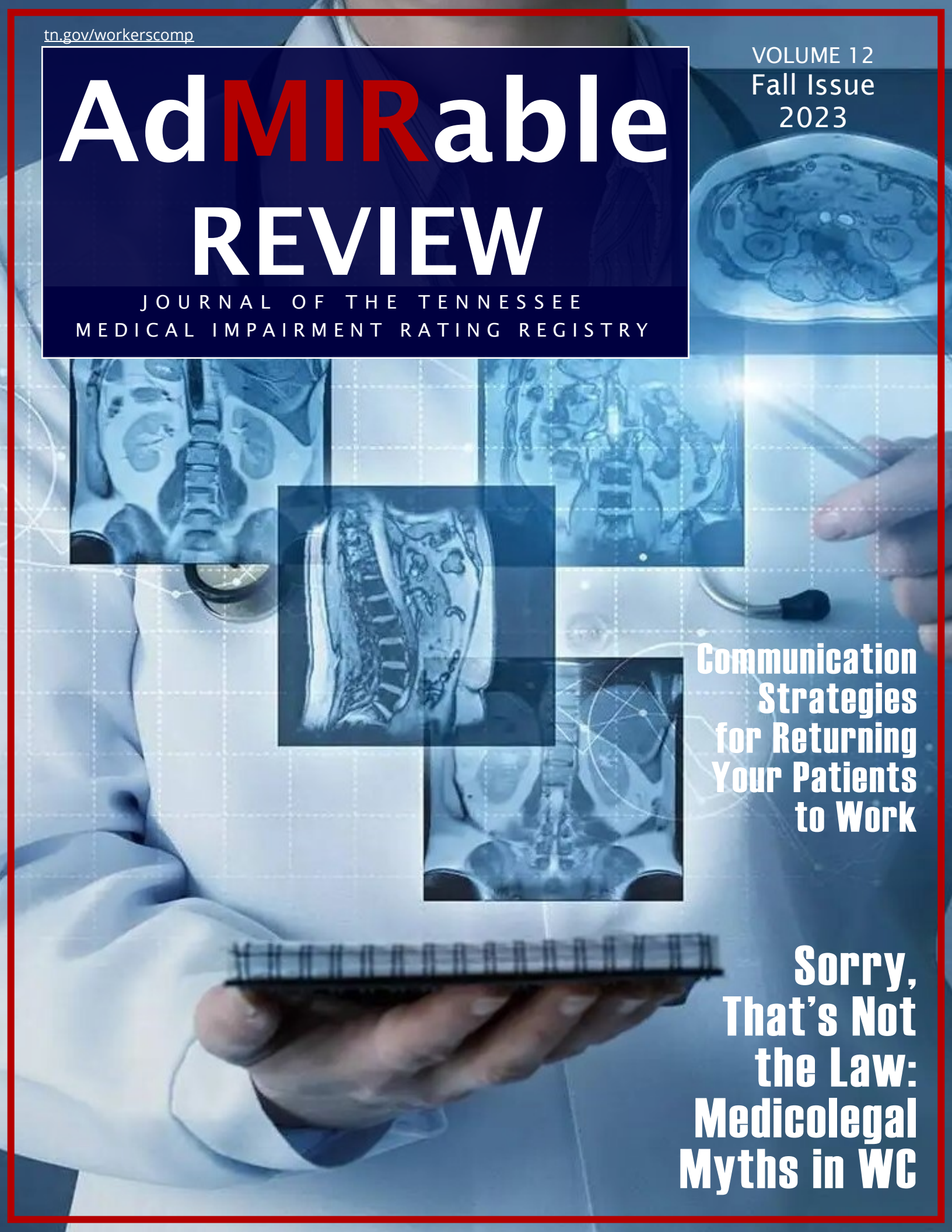

Communication Strategies for Returning Your Patients to Work

Sorry, That's Not the Law: Medicolegal Myths in WC

In This Issue of AdMIRable Review

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Sorry, That's Not the Law:
Medicolegal Myths in Workers' Compensation

Jane Salem, Staff Attorney, Nashville

Probably everyone reading this has played the "telephone game" at some time. One player whispers a phrase in another's ear; then that player whispers it to the next. The purpose of the game is to see if the starting message is the same as stated by the last person. That rarely happens and usually results in some humorous miscommunications.

Occasionally, judges in our courts have had cases where they suspect a version of the telephone game has occurred, where a physician gives a causation opinion that isn't legally correct. Possibly, that doctor attended a seminar where the speaker gave incorrect information, the doctor misunderstood, or both. Or maybe the physician read something, somewhere, that gave them the wrong impression about what the Workers' Compensation Law says in Tennessee.

This article will recap a few of the myths *about the law* we've come across in recent years, since the Reform Act took effect in 2014.

Rest assured, we're not poking fun. The goal is to help doctors phrase their opinions in a way that makes them persuasive and clear. A carefully-worded written medical opinion might eliminate the need for a doctor to be deposed. It might also remove the need for trials and appeals and can bring finality to parties sooner.

Myth #1: An injury arises "primarily" out of employment if the employment contributed "more than 51%" in causing the injury.

Lawmakers added "primarily" to the definition of "injury" in the Reform Act and explained in relevant part it means that an employee must show "that the employment contributed *more than fifty percent (50%)* in causing the injury [.]" (Emphasis added.) Somehow, that number has been extrapolated to mean "51%."

For example, in *Blevins v. Southern Champion Tray, LP,* an employee bent over to clean a jammed machine when she felt sudden back pain. In the emergency room and later an occupational medicine clinic, providers documented she reported bending over a machine when she felt a sudden pop and pain.

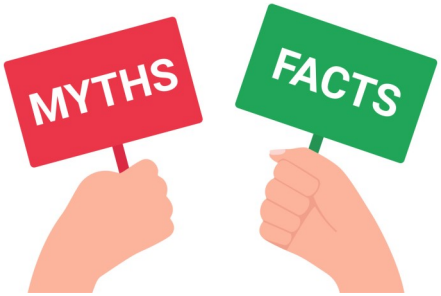
The employee then saw a panel physician/orthopedist. The doctor concluded, "[G]reater than 51% of the causation is more related to her degenerative preexisting process and not a work-related injury, in that there was no event that occurred at work. I feel that she just has an aggravation of a preexisting condition."

The employee then treated on her own with a physician, who noted the "bending incident" and found it "more likely than not" that the work event caused her need for treatment. The trial judge accepted his causation opinion.

In a 2019 opinion, the Board affirmed, reasoning that the authorized doctor's "opinion is inconsistent with undisputed facts and does not take into account that an aggravation of a pre-existing condition can be compensable under certain circumstances."

Myth #2: An aggravation of a preexisting condition isn't compensable.

The authorized doctor in *Blevins* suggested that an aggravation of a preexisting condition isn't compensable under any circumstances. While the statutory definition of "injury" excludes "the aggravation of a preexisting disease, condition, or ailment," it later includes an "aggravation [that] arose primarily out of and in the course and scope of employment" if "shown to a reasonable degree of medical certainty."



In *Edwards v. PeopLease,* both an authorized treating physician and an unauthorized doctor used "greater than 51 percent" to describe causation. The former said the work incident, a motor vehicle accident, was not the cause of an employee's need for knee replacements, while the latter said it was.

The treating doctor testified as follows: "I determined that her primary pathology is end stage tricompartmental arthritis of both knees and that that particular finding was not work related or injury related, that she had an exacerbation of symptoms caused by the accident, and, that is not, according to my understanding of the law, compensable or something that should be considered for treatment under Workers' Compensation."

The trial judge accepted the unauthorized doctor's causation opinion, and the

Board affirmed that aspect of the decision.

"[W]e conclude the trial court did not err in determining Employee is likely to prevail in establishing a compensable aggravation of her pre-existing condition," they wrote. However, "[A]lthough the authorized physician incorrectly stated his understanding of the law as it applies to the aggravation of pre-existing conditions, his testimony nevertheless supports the conclusion that the need for bilateral total knee replacements was not caused primarily by the work accident."

Myth #3: Repetitive stress injuries aren't compensable.

The statute defines "injury" to include "cumulative trauma conditions including hearing loss, carpal tunnel syndrome or any other repetitive motion conditions, arising primarily our of and in the course and scope of employment[.]"

In *Abdelshahaed v. Taylor Farms,* after working as a product handler for about three years, the employee developed pain in his hand. The authorized treating physician noted a three-month history of finger pain and diagnosed trigger finger. But he also wrote: "[T]here is no evidence that this is specifically work related. He has no specific history of injury and under Tennessee law this is not work related."

The trial court found the opinion "unreliable," pointing out that "no specific history of injury and under Tennessee law this is not work related" was an inaccurate statement of the law. But the other physician's opinion wasn't persuasive, either. He wrote, "Trigger finger is most likely work related. (51% more likely)." That statement didn't address whether the injury was primarily caused by the work or merely related to it. So the judge denied benefits.

The Board affirmed in a 2022 memo opinion on other grounds. Notably, though, in a footnote, the Board agreed with the trial judge about the expert evidence.

Myth #5: Carpal tunnel syndrome isn't compensable.

As noted above, the statute specifically includes carpal tunnel.

In *Lamb v. KRM Thrift Store, LLC,* a doctor wrote that the employee "seems very well versed into the year and date of when Tennessee [law] stated that repetitive motion was not related to work type injury nor was typing or utilizing the keyboard." He added, "I explained that her carpal tunnel syndrome was not greater than 51% related to her work activity. We discussed that carpal tunnel syndrome

[may] be very multifactorial such as genetic and especially in light of the fact that she has underlying diabetes and hypothyroidism."

The trial court wrote that the doctor misstated Tennessee law when he said that "repetitive motion was not related to work type injury" and that he used the wrong standard when he stated that the carpal tunnel syndrome wasn't "greater than fifty-one percent related to her work[.]" The judge found another doctor's opinion more persuasive. The Appeals Board affirmed in a memo opinion in 2017.

Conclusion

The difference between "fifty percent" and "fifty-one percent" isn't high. It's a small mistake. But the fact remains that fifty-one percent isn't in the statute. When a physician voices an incorrect statement of the law, the judge might have less confidence overall in the doctor's opinion.

Of course doctors are human. As time passes and understanding of the law increases, fewer of these gaffes will likely occur.

And, to be fair, doctors might read an opinion from our courts and similarly think, "That judge doesn't understand the medical aspects of this case at all." All I can say on behalf of our judges, is if they get it wrong, it's not for lack of trying. (And organic chemistry weeded out many of us from a career in your field.)

The biggest takeaway, I hope, is that your words matter. Be cautious and clear, and stick to the medical not legal aspects of the case.

Leave the Logic at Home:

Changing the Emotional Value of Return-to-Work

Brian Holmes, MA

Workers' Compensation physicians are well-versed in the benefits of return-to-work on an injured worker's recovery. The Bureau's newest tool for the REWARD Program, "Return-to-Work: It's Good for You and Your Family," will soon be available on the Bureau's website. This tool reiterates what we all know. So, why is it we know return-to-work is good for everyone – yet it continues to frequently meet resistance?

Oftentimes it's because the injured worker or employer unintentionally values the emotions associated with the situation more than logic. When that occurs, consider enhancing the emotional value of return-to-work using the techniques below, to help persuade a reluctant individual.

Build Credibility.

The Bureau's educational outreach can make anyone well-informed. The Bureau website informs through webpages, booklets, videos, calculators, tutorials, forms, and many other resources. The Bureau's classes, seminars, and conferences educate employers, physicians, case managers, and claim professionals. And unrepresented employers and injured workers can receive education through the ombudsman program.

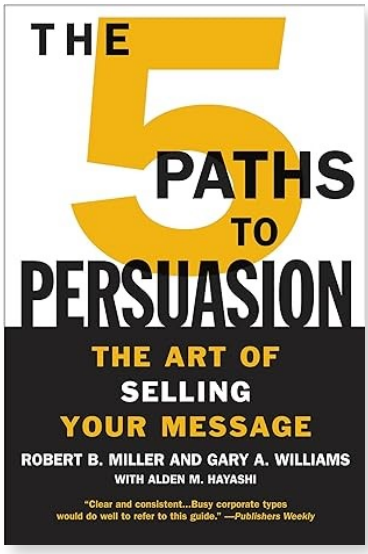
Robert Cialdini, PhD is an academic, author, and well-known expert on influence and persuasion. Although his research is largely centered in marketing and business, it can be applicable in the return-to-work context as well. Cialdini cites principles to influence and persuade people to make the decision that is best for them. Authority as a form of expertise is one of the key principles he teaches. If you are a physician encouraging return-to-work, consider your influence as a credible authority on workers' compensation, recovery, and work disability prevention.

Plaques, awards, or certifications hanging on the wall lend credibility. Word of mouth, even from an assistant, improves your image. Cialdini frequently cites a study that showed real estate agents were

viewed as more credible when the front desk lauded praise on the agent as the customer checked in. Ways to portray yourself as a credible authority are numerous. The effectiveness of the authority tools you choose will depend upon whom you're trying to persuade.

Know Your Patient.

The injured worker's personality plays a role in their ability to listen, what they listen to, and how they can be influenced and persuaded. In their book, "The Five Paths to Persuasion," Robert Miller and Gary Williams discuss five personality types: charismatics, thinkers, skeptics, followers, and controllers. Not coincidentally, five influence styles work best with each personality type respectively: inspiration, rationalization, bridging, assertion, and negotiation. Miller and Williams summarized their findings in an article in the Harvard Business Review. They, too, developed theories designed for the business world, and like Cialdini their findings are transferable.



In my nineteen years of experience, I've found utility in this framework. Each personality type is described below .

"Charismatics" respond best to information that inspires them. They do poorly when others try to assert their thoughts and feelings. Charismatics are identified by their confidence, warmth, strong opinions, passion, conviction, and ability to hear diverse opinions. They are prone to allow emotions to influence them more so than thinkers.

"Thinkers" respond better to rationalizing, or explaining the pros and cons. Return-to-work literature might be an effective tool for thinkers. Thinkers sometimes struggle with negotiating in the gray areas because they see things in black and white. Thinkers are often introverted, observant, quirkily humorous, curious, and self-learning planners. Thinkers like to put together the information from a trusted resource for themselves. This differs from skeptics, who are not likely to trust a resource.

"Skeptics" might be either faux or genuine. Both react best to bridging, described below. However, the structure of the bridge is different. Alfie Kohn, a prolific author, lecturer and independent scholar on human behavior, wrote "What Makes a True

Skeptic." He outlined the difference between the two quite well. Genuine skeptics are willing to learn; it just takes convincing evidence. "Bridging," or connecting activities or information to the desired results, often leads to compliance. "Social proofing," or conforming to societal norms and expectations, can be effective here. Faux skeptics are those who are entrenched in their ideology. While they will not likely be convinced, they can be influenced to take actions that help them save face and protect their ideology, by bridging their motives to the outcome that best serves those motives. Social Proofing, or societal norms, is not effective, as other people are often viewed as sheep following the evil shepherd.

"Followers" are not likely to be resistant to return-to-work. Authority figures trained in the benefits of return-to-work, such as claim coordinators, return-to-work professionals, and certified physicians, have experience and credentials that are likely to be meaningful to the follower. Asserting return-to-work facts or directing followers to report for work assignments is usually all that is necessary. Followers have little to no desire to control the outcome of their care. Rather, they want the care to happen to them.

"Controllers," on the other hand, will not be happy with being told what to do. They want to have a say, feel in control, or at least have some choice in their care and return-to-work options. Controllers respond well to negotiation, where there is an exchange of information and their opinion is shared, considered, and valued. The panel of physicians creates a choice, and an ADA accommodation conversation allows for input and respect. These built-in system requirements help controllers feel like they have input and respect.

Help it Feel Right.

Maya Angelou once said: "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." Cialdini calls it using the principles of liking and unity. Physicians often refer to it as "bedside manner."

Whatever it is called, at the end we know how it looks: everybody has a positive demeanor and a good feeling.

Two key components to helping return-to-work feel right include (1) creating return-to-work expectations *before* return-to-work is possible (a/k/a "priming" or "foreshadowing"); and (2) building a progressive return-to-work model.

"Priming" has many different looks. It can include setting expectations by talking return-to-work immediately after the injury. Making return-to-work the default option is another way. Preemptively identifying problems and identifying common light-duty options before asking the injured worker to return-to-work are other priming methods.

The key to priming is to make return-to-work the shortest path to the recovery goals. Build upon positive steps and make a series of small, agreeable asks. Then add recommended or preferred language to options, such as "I've seen this work," or "Some patients have liked doing these light-duty activities."

A progressive return-to-work plan is critical. A physician or a return-to-work coordinator is likely just beginning to build a relationship with a newly injured worker. Requesting a large commitment, such as return-to-work immediately after a significant injury, may raise caution flags. Instead, build trust by making small requests to escalate their commitment. With additional, gradual requests, the injured worker is reminded of what they have accomplished before making a significant return-to-work request. By asking an injured worker to complete a series of innocuous requests, they begin to invest in their recovery. This empowerment encourages engagement, leads to familiarity, better questioning, and understanding of the benefits.

An example is to provide a panel of physicians and request a selection. Then seek a medical waiver and request the injured worker to bring the work status report in. Ask that they take time to consider return-to-work options for themselves, talk to coworkers, and share their thoughts with the return-to-work coordinator.

Request the injured worker have a face-to-face meeting with the employer. Tell the injured worker you have appreciated their putting thought into their return-to-work and they made your job easier. This positions them to better hear and consider light-duty. Provide evidence of success after a return-to-work option is selected. Statements like, "That is an excellent choice," "I think this is going to work out nicely," or "I am appreciative of your doing this important work," help the injured worker feel important and valued. Identifying their unique skills and strengths that add value to the light-duty work also bolsters an injured worker.

Making return-to-work feel right should improve self-esteem and allow the injured worker to identify as part of a group of people that are held in high regard for their efforts to recover. Compliment the injured worker for being who they see themselves as, such as a provider for the family, someone who makes a smart choice, or a good teammate.

Two-way open and honest communication is necessary for return-to-work to feel right. An employer must be open and honest regarding expectations, performance measures, and recovery. Likewise, the injured worker must be able to report to a return-to-work coordinator how they feel and how they are doing in their work and personal lives, emotions, finances, and family. This information can help create demand for return-to-work.

Create Demand.

The recovery itself should be sufficient to create demand. Unfortunately, sometimes the logic cannot overcome the emotions. Loss aversion, anchors, accusation audits, breaking and framing emotional connection, and reframing are several techniques that add emotional value to return-to-work.

"Loss Aversion" is the idea that people tend to make decisions based upon what they will lose, rather than what they will gain. A quicker, better recovery is nice, but returning to work to avoid financial problems, miss an opportunity for a promotion, or forego contributions to a 401k are more likely to resonate with some injured workers.

"Anchoring" results in the worker making decisions based upon an anchoring point that can be irrelevant. For example, an injured worker might anchor their light duty based upon a friend's experience, without regard to whether their situation or injury is similar. The return-to-work professional can set the anchoring point before an injury occurs or shortly afterward, so that the return-to-work negotiation begins on the right "playing field" and in a lawful and logical manner.

"An Accusation Audit," is where the physician explains the elephant in the room and clears the way forward to a more reasonable request. Examples are: "I am sure you think I am just trying to get my safety bonus," or "I am sure you think I am just trying to save the company money." They are a trust building tool . The injured worker has an emotional reaction derived from a feeling of reciprocity or need to contribute something.

"Breaking, and Reframing Emotional Connections" can be explained as follows. A logical emotional connection exists for injured workers to rest and recover. They want to take a break for a few weeks, and then come back. For example, an athlete goes on the disabled list during their healing period.

Breaking this logical coherence is critical to breaking emotional coherences that prevent return-to-work. Football players regularly return to play while not being one hundred percent. They also return-to-work through the rehab process. The quarterback who tore his Achilles tendon on the fourth play of the season is working light duty on the sideline, coaching, game planning, mentoring, and rehabbing the injury.

This story of a quarterback's recovery utilized a communication tool called "reframing." This is another technique to break self-defeating behaviors. Mindfulness, self-compassion, acceptance, and comfort with failure are others. In my experience, these tools may be more likely to be utilized naturally by someone with higher resiliency levels. Those with lower resiliency might benefit emotionally by more intentional connections.

Identify the Easiest Path.

Setting the expectation and building toward a return-to-work outcome does not always succeed. A disconnect may still exist. "Yes or No" questions, and "How and What" questions often create connection between recovery goals and the easiest way to achieve them.

"Yes or No" questions can be used to deliver a message. The first type, "push polling," puts the idea in someone's mind. For example: "Have you ever wondered how light duty works? Would you like to talk to your employer about options?"

You can also get an injured worker to agree to the nature of the implications in your question. "Did you know that injured workers are less likely to fully recover when they don't work light-duty ?"

Third, the question can be used to present evidence. "Did you know that in this plant, injured workers have recovered faster when they've worked light duty?"

Finally, a question can put doubt in an injured worker's mind that staying home is a better alternative. The question should avoid naming staying at home. For example: "I don't know of a better way to recover than working light duty; do you?"
"How and What" questions are great ways to inspire creativity. These open-ended questions shift responsibility to the injured worker to think of solutions. How does recovery look without returning to work? What kind of recovery is it if it does not involve returning to work? What are things you think you can do? What does life look like if you never return to work?

Pay it Forward.

The additional benefit of these questions is that they acknowledge the injured worker is doing you a favor. Benjamin Franklin is credited with the "pay it forward technique," which uses liking and unity. It gives the impression that the injured worker is gifting their actions, is trustworthy, and is someone that can be relied upon.

Earlier, this article mentioned using a series of commitments to increase one's investment. Each step involved either something being presented to the injured worker (like a panel of physicians) or asking the injured worker to do something (like carefully selecting a physician and returning it). Framing the request as a favor changes the view of the activities from a task to an exchange.

Conclusion

I've picked up these techniques over the years and have used them in mediation with good intention to help people make informed, beneficial decisions.

I recently watched a series that described techniques to influence and persuade that can be both good and bad. The concept of "Evil by Design" was noted throughout the presentation. One should be conscious of using these techniques for the benefit of the injured worker and employer, rather than to manipulate an injured worker to perform work that is damaging to his health.

We have read the literature and seen the studies. We have experienced the success of return-to-work. We know it is logical. Unfortunately, when people are emotionally tied up, they are not able to see or think with their logical brain.

I hope this article conveyed an idea or two on how to connect with the emotional brain and make a positive change for those who think they do not want to return-to-work.

What I Wish Physicians Knew When Treating Workers' Compensation Patients (Or, A Thank-you Note)

Adrienne B. Fazio, Esquire

As I write this, it is Thanksgiving week, and I've been in a rather contemplative mood. It's likely related to the holiday season, darkness positively *engulfing* me at 5:00 p.m., the colder weather, and probably my age. One thing is for certain: it *is definitely* due to the fact that I've been asked to write an article for you, dear doctor, on the subject of what I wished physicians knew about Tennessee workers' compensation when treating injured employees. This is the start of the wishing season, after all, if my children's Christmas list is any indication. However, rather than *wishing* for what I do not have, I'm going to tell you, instead, what I am *thankful for.*

Thank you for treating workers' compensation patients.

As you know, we have an urgent need across the state for all types of specialists, from psychiatrists, to neurologists, to cardiologists, dermatologists, neurosurgeons, and more, who will agree to treat workers' compensation patients...I could really go on and on about this. Today and every day, I am so truly thankful when I and my clients can properly form a three physician C-42 panel with doctors who accept workers' compensation patients. This is one of our charges as employers: to provide an employee with a C-42 panel of three independent physicians when they request treatment. We need more specialists, like you, to accept workers' compensation patients. It cannot be stressed enough.
Please continue treating our Tennessee employees, and recruit your colleagues.

Thank you for familiarizing yourself with the Tennessee workers' compensation system: standards of causation, the AMA Guides, and Bureau rules related to utilization review and medical payments.

You, dear doctor, take time to understand the concepts of our complex workers' compensation system.

Please continue signing up to attend Bureau educational courses, and taking the time to look at Bureau bulletins (like information on how to understand and

respond to questions on causation) and Best Practices in Treating and Evaluating Workers' Compensation Patients. Continue signing up for the Physicians' Certification courses, and for training courses on the AMA Guides, 6th Edition. When you know these concepts and can crystalize your supported opinions of causation, treatment plan, permanent impairment rating, and work restrictions, both temporary and permanent, with expertise, we notice it and are so grateful for you.

Thank you for the timely conclusion of a patient's treatment.

There comes a time in an injured patient's treatment where his injury plateaus, and active treatment is no longer needed. According to the AMA Guides, 6th Edition, maximum medical improvement (MMI) is the point in which a condition is stabilized and unlikely to change substantially in the next year, with or without treatment. Thank you for recognizing this point and releasing your patient at that time.

Once you release an employee at MMI, we truly need and appreciate when physicians complete the C-30A and clearly explain how an impairment rating is calculated, whether an employee will need medical care in the future *for the work injury*, and whether a patient is released with no work restrictions or permanent restrictions. We have been known to cheer upon receipt of the C-30A and explanation of rating.

Unfortunately, *often* we do not receive the C-30A for *many months*. I mean—as really oddly long time after a patient is placed at MMI. We are forced to follow up obnoxiously, because an employee is waiting for some fiscal relief and, frankly, for a decision from his employer whether he/she can return to work. As you may know, per Tennessee Bureau Rules & Regulations (0800-02-17-.25 specifically), a workers' compensation physician is *required* to give the impairment rating within 21 days of placing an Employee at MMI and may charge up to $250.00 to provide this information. Send us an invoice, and we'll get you paid.

Thank you for the gift of communication.

Doctor, as you are well aware, the parties to a workers' compensation claim frequently need your medical opinions in writing to help understand what is causally related to a work accident, and therefore compensable under the statute. Thank you for understanding that we need these opinions to determine the appropriate workers' compensation benefits, and to ultimately resolve our cases.

Thank you for gifting us attorneys, employers, insurers, nurse case managers, and adjusters with insight into answers of causation, courses of treatment, MMI dates, permanent impairment ratings per the AMA Guides, work restrictions, and the need for future medical care. What is even better, thank you for doing this in a *timely manner*.

Speaking of communication, thank you, dear doctors, for your workers' compensation coordinators. These angels on earth help keep the train from derailing, put letters and forms under your noses, and deal with our needy letters and phone calls. This is even though they, like you, are managing a full load and may not have extra time to assist with our information requests and forms that are required by our Bureau and Court. We love your comp coordinators; we really do.

Thank you for thoughtfully evaluating causation for us, considering all causes.

As you know, you have a duty to convey your opinions within a reasonable degree of medical certainty. When you take this charge seriously and earnestly, thinking and explaining to us that you evaluated all contributing causes and used science to support your opinion, we appreciate it and understand your opinion. When we cannot understand how you came to your conclusions, that's when we need to follow up.

When you evaluate *all* information and documentation that is presented to you, you have a more holistic picture of your patient and his medical history. You begin to see whether any factors exist that may be contributing to a patient's condition, which helps you better assess whether a work accident is the primary cause of an employee's injury and need for treatment.

Thank you for taking *all possible causes and information* into consideration when determining whether an injury arose primarily out of and in the course and scope of employment. This includes considering the employee's job description, detailed report of injury, preexisting treatment, preexisting conditions that may not have been treated, co-morbidities, and events unrelated to the work injury. Please refrain from guessing, giving us an "It's possible" causation response, or speculating in determining your causation opinion. If you need additional information before you offer your opinion, we are here to help.

Thank you for understanding the differences between an *exacerbated* injury or condition, an *aggravated* injury, and an injury or condition that has been *primarily*

aggravated by a work accident when considering all causes. These distinctions in causation are so critical in determining whether an injury is compensable. Only you can help clarify these distinctions, which in turn helps the parties in the claim understand what is compensable under the statute.

Regardless of your medical causation opinion, thank you for responding to our questions, so that the employer, insurer and/or workers' compensation administrators can manage the claim according to the protocol of the Tennessee Workers' Compensation Act.

Conclusion

Doctor, I hope you can find yourself in more than one place in this "thank you list," and if not, you will commit in the future to working with employers, insurers, claims handlers, attorneys, case managers, and patients to ensure that the system runs more seamlessly (New Year's Resolution, maybe?). We thank you for understanding that the health of the Workers' Compensation system requires some checks and balances.

Ultimately, my clients and I all desire our injured employees in Tennessee to be cared for by physicians of your caliber and insight, who will treat them appropriately, discharge them at MMI, and provide us with the documentation needed to resolve the claim. **We thank you** for your care and treatment of workers' compensation patients in Tennessee.

Adrienne B. Fazio

Adrienne B. Fazio is a principal with Manier & Herod practicing primarily in workers' compensation. Ms. Fazio graduated magna cum laude with a Bachelor of Arts from University of Southern Mississippi and earned her Juris Doctor from Tulane University School of Law in New Orleans, Louisiana. After practicing civil litigation and workers' compensation law in Mississippi, Adrienne moved to Birmingham, Alabama, where she devoted her practice solely to assisting clients nationwide with Medicare Secondary Payer compliance, including Section 111 Reporting, conditional payment claim issues and Medicare Set-asides. In April 2012, Adrienne left private practice and took a position as a Workers' Compensation Specialist IV with the Tennessee Department of Labor and Workforce Development, Workers' Compensation

Division, in Nashville, TN. There, Adrienne represented several programs, including the Workers' Compensation penalty program, Uninsured Employers Fund and Employee Misclassification Fund, as well as briefly working with Utilization Review. Additionally, she was responsible for advising the Division regarding Medicare requirements involved in closing future medicals.

Ms. Fazio also assists the firm's surety and fidelity practice groups on lawsuits in Mississippi, Alabama and Washington, DC. Her extensive litigation experience includes serving as litigation counsel on matters involving commercial surety bonds, contract surety bonds and fidelity bonds and policies.

Ms. Fazio is admitted to practice in Tennessee, Alabama and Mississippi. She is a member of the Tennessee and Nashville Bar Associations, as well as a member of the Mid-South Workers' Compensation Association, the Tennessee Defense Lawyers Association and the Defense Research Institute.

[4]The term "primarily arises" has been defined as "more than fifty percent (50%) . . . considering all causes." Tenn. Code Ann. § 50-6-102(12)(B) (2022).

Revised AMA Guides® Competency Standards for CPP and MIR Physicians

Jay Blaisdell, MPA, Coordinator, CPP & MIR Registries

For appointments to the Medical Impairment Rating (MIR) Registry or the Certified Physician Program (CPP) Registry after November 1, 2023, the Tennessee Bureau of Workers' Compensation now requires physicians to be certified in the AMA Guides®, 6th Edition, through an approved vendor. This is in lieu of the previous standard, which was a certificate of training.

Physicians seeking appointments to either the MIR or CPP Registries must provide proof of certification issued by an approved vendor. Physicians who were MIR Physicians prior to November 1, 2023, are deemed to have already met the competency standard, should they wish to take the Bureau's free, online course, "Best Practices for Treating and Evaluating Injured Workers" and seek appointment to the CPP Registry.

Accepted AMA Guides®, 6th Edition, Certifications for the CPP and MIR Registries:

CIR (Certified Impairment Rater)

- Jointly Sponsored through eMedicolegal.com & IAIME
- 6th Edition Only
- $395 for TN Physicians and Chiropractors *(Normally $495)**
- Register

CMLE (Certified Medicolegal Evaluator)

- Sponsored through IAIME (International Academy of Independent Medical Evaluators)
- 6th Edition Only
- Exam cost: $875

CIME (Certified Independent Medical Examiner)

- Sponsored through ABIME (American Board of Independent Medical Evaluators)
- 6th Edition Only
- Exam cost: $995

Resources for Certification Exam Preparation

Certified Impairment Rater (CIR) Training

- AMA Guides, 6th Edition, Mastery
- 1 Month Access: $487 ($413.95 with 15% discount for TN Physicians and Chiropractors)*
- 1 Year Access: $1187 ($1008.95 with 15% discount for TN Physicians and Chiropractors)*
- Self-paced, 100% online

Certified Medicolegal Evaluator (CMLE) Training

- Self-Study using IAIME Core Competencies Study Guide
- AMA Guides, 6th Edition, Online Study Course

Certified Independent Medical Evaluator (CIME) Training

- ABIME weekend conferences with varying costs.

*Contact the CPP Coordinator to learn about special discounts for Tennessee Physicians.

Physicians who were MIR Physicians
prior to November 1, 2023, are deemed to have
already met the competency standard,
should they wish to take the Bureau's free, online course,
"Best Practices for Treating and
Evaluating Injured Workers"
and seek appointment to the CPP Registry.

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 2010 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 sixty 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 17-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.

Robert B. Snyder, MD

Dr. Snyder was appointed Medical Director for the Bureau of Workers' Compensation in January, 2014 after 37 years of private practice in Orthopaedics. He graduated from Wayne State University School of Medicine in Detroit and completed two years of general surgery training at the University of Pittsburgh before he came to Nashville, completing his residency in Orthopaedics and Rehabilitation at Vanderbilt University. Dr. Snyder has presented lectures for the American Academy of Orthopaedic Surgeons, Arthroscopy Society of Peru, the American Orthopaedic Society for Sports Medicine, the National Workers Compensation and Disability Conference, the National Association of Workers Compensation Judges, and in Tennessee: the Chiropractic Association, the Orthopaedic Society, the College of Occupational and Environmental Medicine, the Pain Society, the Neurosurgical Society, the Tennessee Medical Society, and Tennessee Attorney Memo. He has made numerous other presentations to attorneys, case managers, employers, adjusters and insurers. His activities with the Bureau have focused on Medical Treatment Guidelines, the Drug Formulary, Utilization Review, Case Management, Fee Schedules and physician/ provider communications.

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 WC. 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 co-editor of the AMA Guides Newsletter since 1996.

Jay Blaisdell, MPA

Jay Blaisdell, MPA, is the coordinator for the Tennessee Bureau of Workers' Compensation's MIR and CPP Registries. He has been the managing editor of *AdMIRable Review* since 2012. He is certified in public policy and medical impairment rating methodology. He earned a master's degree in humanities from California State University, Carson, and a master's degree in public administration from Tennessee State University in Nashville. His numerous articles for *AdMIRable Review* have been republished, with permission, by the *AMA Guides Newsletter*. Jay has been with the Tennessee Bureau of Workers' Compensation since 2005.

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