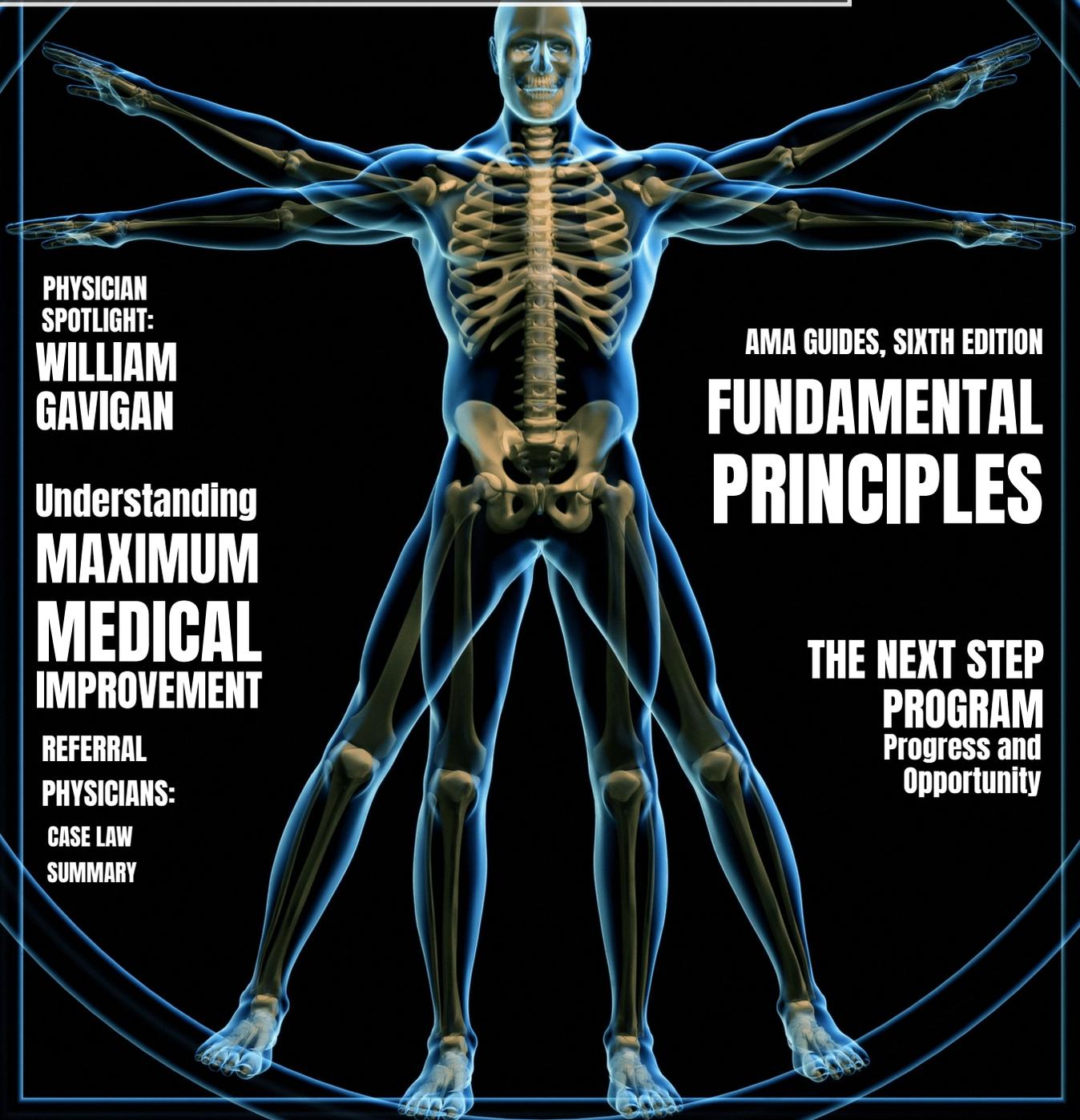


Ad**MIR**able REVIEW

JOURNAL OF THE TENNESSEE
MEDICAL IMPAIRMENT RATING REGISTRY



PHYSICIAN
SPOTLIGHT:
**WILLIAM
GAVIGAN**

Understanding
**MAXIMUM
MEDICAL
IMPROVEMENT**

REFERRAL
PHYSICIANS:
CASE LAW
SUMMARY

AMA GUIDES, SIXTH EDITION
**FUNDAMENTAL
PRINCIPLES**

**THE NEXT STEP
PROGRAM**
Progress and
Opportunity

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Tennessee's first "Workmen's Compensation Act" was passed by the General Assembly and signed into law by Governor Albert Roberts in April 1919. It took effect on July 1, 1919.

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William M. Gavigan.

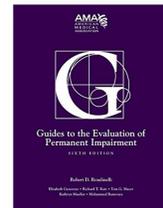
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Medical

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MIR Physician Spotlight

William M. Gavigan, MD

"I have enjoyed the opportunity to perform Medical Impairment Rating evaluations over the years. I have found many of the cases to be challenging and definitely had to improve my understanding of the impairment rating system."



Dr. William M. Gavigan grew up in New York City as the oldest of six children. He attended Xavier High School. He then went to the University of Notre Dame for his pre-med program and graduated in 1966. He went to St. Louis University Medical School and completed a surgery internship in 1971. After spending two years at Camp Pendleton as a navy doctor with the Marines, he went to the Mayo Clinic to complete a four-year orthopedic residency. There he "met a Nashville girl who brought [him] to Tennessee."

He and his partners at Orthopedic Surgical Associates merged with Tennessee Orthopedic Alliance in 1994.

"I enjoyed my practice as a general orthopedist. Over time, I developed interests in spine, hand, Workman's Comp, total joint surgery, and arthroscopic knee and shoulder surgeries."

Dr. Gavigan retired from surgical practice with TOA in March 2011 to start a new medical practice performing independent medical exams and medical reviews, which he has continued to this day. He is the past president of the Nashville Academy of Medicine and the Nashville Orthopedic Society. He is also the past chief of orthopedic surgery at Baptist Hospital.

Dr. Gavigan has four children and nine grandchildren. In his free time, he enjoys cooking, traveling (recently to Florida), and swimming for exercise.

"Because I have a thirty-year old daughter, Jeanne, with Down Syndrome, I have been an advocate for people with intellectual disabilities. I helped my wife start the Hand in Hand Program at John Paul II High School in Hendersonville for inclusion of high-school children with intellectual disabilities. I have also been involved with the Vanderbilt Next Step Program, which is a college inclusion program for students with intellectual disabilities."



Dr. Gavigan and his family.

Principles of the AMA Guides, Sixth Edition

Jay Blaisdell, MA, and James B. Talmage, MD



Introduction

Reading all 600-plus pages of the *AMA Guides*, Sixth Edition, is not a practical endeavor, even for treating physicians and independent medical evaluators who frequently conduct impairment rating evaluations. A physician may choose to focus on a few select chapters depending on the physician's treatment specialty and referral preferences. For example, an orthopedic surgeon who treats only pathologies of the hand and wrist may list only the upper extremities chapter as a competency for MIR referral purposes. She may feel she needs to read only Chapter 15, The Upper Extremities. An orthopedic surgeon who is more of a generalist may want to receive MIR referrals for all of the musculoskeletal chapters. As a result, she may read only the three musculoskeletal chapters of the *Guides*—Chapters 15 (upper extremities), Chapter 16 (lower extremities), and Chapter 17 (spine). This focused approach is obviously necessary, considering the time-restraints and treatment specialties of most physicians who accept workers' compensation, but it can also cause a physician to be ignorant of some very basic rating principles.

Prerequisites

To be competent to utilize any given chapter in the sixth edition, the physician must also, at minimum, read Chapter 1, "Conceptual Foundations and Philosophy," and Chapter 2, "Practical Applications of the *Guides*." These chapters provide the necessary context to understand the rationale and overriding principles that are common to all chapters. If you, as an evaluating physician, have ever wondered whether a rating may be expressed as a fraction or decimal, how ratings from different extremities and organ systems are combined, whether a patient with a chronic, and likely fatal, disease was at Maximum Medical Improvement, or what the relative whole person value of the upper extremity is to the lower extremity, then these chapters are for you. This article uses the salient points listed in Table 2-1, "Fundamental Principles of the *Guides*," as an analytical framework for achieving a holistic understanding of the Sixth Edition (p.20). Its goal is breadth not depth.

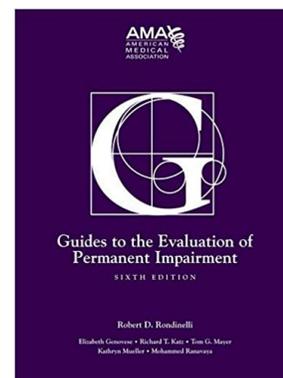
The Purpose of the *Guides*

The *Guides* serves foremost as "a tool to translate human pathology resulting from a trauma or disease process into a percentage as a whole" (p.19). This whole person impairment rating helps jurisdictional professionals determine "financial compensation" for people who "have suffered measurable physical or financial loss" (p. 20). Thus, one of the goals of the *Guides* is to bring consistency to the impairment rating process, and thus equity. Consistency starts with a formalized

philosophy underlying a standardized approach to interpreting objective factors. Subjective complaints, therefore, should ordinarily be accompanied with “demonstrable clinical signs” to be ratable under the *Guides*, with a few exceptions (p.24). In all cases, the physician should rely on objective clinical evidence as much as possible.

Table 2-1: Fundamental Principles of the *Guides*

Table 2-1 is a list of fourteen overarching principles that are consistent throughout the *Guides*, beginning with principle 1: “Concepts and philosophy in this chapter are the fundamental principles of the *Guides*” (p. 20). The table then lays the groundwork from which the rest of the chapters are built. Principles from this list can explain why, for example, the MIR Physician chose the Range of Motion (ROM) method rather than the the Diagnosis-Based Impairment (DBI) method—see principle 12: “If the *Guides* provides more than one method to rate a particular impairment or condition, the method producing the higher rating must be used.” These principles can explain why the MIR Physician chose a lower functional history grade modifier (GMFH) than either the treating physician or the IME physician—see principle 13: “Subjective complaints that are not clinically verifiable are generally not ratable under the *Guides*.” An impairment rating expressed as a fraction or decimal may be a good indication that the evaluator is not familiar with the *Guides*—see principle 14: “Round all fractional impairment ratings, whether intermediate or final, to the nearest whole number, unless otherwise specified.” An impairment rating report that summarizes and analyzes the patient’s history, the results of the physical examination, and provides a detailed, yet accessible, explanation as to how the physician calculated the rating may be indicate a highly trained evaluator—see principle 7: “A valid impairment evaluation report based on the *Guides* must contain the 3-step approach described in Section 2.7.”



According to principle 4, the MIR Physician must rate the impairment using the most relevant chapter “to the organ or system where the injury primarily arose or where the greatest dysfunction consistent with objectively documented pathology remains.” Additionally, regardless of which chapters are used, no impairment rating may exceed 100 percent (principle 2); all regional impairments of the same extremity should be combined at the same level first, then “combined with other regional impairments at the whole person level” (principle 3); permanency should not be quantified unless the injured worker has achieved Maximum Medical Improvement (principle 5); and only “physicians duly recognized by an appropriate jurisdiction should perform such assessments” within their field of expertise (principle 6) (p.20).

Appropriate Evaluators for Tennessee Claims

Let us start with who is qualified to give an impairment rating for Tennessee Workers’ Compensation Claims. Section 2.3a states that “the appropriate health regulatory agency in a given jurisdiction is the best-suited authority to determine

the definition of a doctor regarding who uses the *Guides* to rate impairment in that jurisdiction” (p.23). For Tennessee Workers’ Compensation Claims, Tennessee statutes and rules are controlling. Pursuant to Tennessee Rules and Regulations 0800-2-20-.04(1)(a), only medical doctors and doctors of osteopathy are candidates for appointment to the Medical Impairment Rating Registry (MIRR). Only a licensed psychiatrist may rate mental and behavioral disorders, either within the MIRR or as a treating physician or independent medical evaluator. While licensed psychologists may treat within the workers’ compensation system, their impairment ratings are not admissible in court. Similarly, while optometrists and podiatrists also may treat workers’ compensation injuries, neither can perform admissible medical impairment rating evaluations. Eye injuries usually require an ophthalmologist for rating purposes, but if acuity and periphery tests have already been completed (either by an ophthalmologist or optometrist), then physicians who specialize in occupational medicine or family medicine are perfectly capable—both legally and clinically—of rating visual impairment.

The Impairment Rating Report

The more detailed, accessible, and transparent the final impairment rating report is, the better. At minimum, though, to follow the fundamental principles of the *Guides*, the physician is required to divide her report into three distinct sections: (1) Clinical Evaluation, (2) Analysis of Findings, and (3) Discussion of How the Impairment Rating Was Calculated (p.28). A report without one or more of these sections shows conclusively that the evaluator’s report is not in keeping with basic *Guides* methodology. The structure of the report form is not a minor detail, nor does it fall into the realm of physician discretion. The *Guides* explicitly states that the “3-step process is *required* [emphasis added] by the examiner to estimate impairment according to the *Guides*” (p.28).



The “Medical Impairment Rating (MIR) Report, AMA *Guides*, 6th Edition” template created by the Bureau of Workers’ Compensation’s Medical Unit is a model form in that it rigorously follows the 3-step process, as delineated in section 2.7 on page 28. The report is divided into three distinct sections, starting with “STEP-ONE CLINICAL EVALUATION.” This section is subdivided into three subsections: “PATIENT HISTORY: INTRODUCTION AND OVERVIEW,” “PHYSICAL EXAMINATION,” and “CLAIMANT’S CHRONOLOGICAL MEDICAL HISTORY FOR THIS INJURY.” This organizational structure parallels that found in section 2.7a Clinical Evaluation, which requires “a relevant history [. . .] obtained by a review of the medical records reflecting past medical history and the patient’s presentation of the current history” (p. 28) and a physician examination “performed in a manner and setting that facilitates the effective communication between the patient and the examiner, thereby decreasing anxiety and increasing concentration and effort” (p.28). To help create such an environment, Tennessee Rules and Regulations 0800-2-20-.05(f)(3) states that a physician shall “not conduct a physician examination on a claimant of

the opposite sex without a witness of the same sex as the claimant present.” This should be an employed medical professional, and not a family member or friend of the claimant. An individual certified by the court system as competent to translate a second language into English, who is employed to translate for the impairment exam, may serve in this capacity if the examiner so chooses.

The introduction and overview section should contain a contextual history of the injury as derived from the examinee. This means the physician will ask the injured worker to explain what happened. The injured worker should be asked to share information regarding her treatment for the injury in question, treatment outcomes, periods of unemployment, current symptoms (as described by the injured worker, not the physician), current medications, and current limitations on activities of daily living.

Finally, the last part of section 2.7a emphasizes the importance of reviewing “all available diagnostic studies and laboratory data” (p.28). This should be done before the evaluation to help resolve apparent discrepancies between the record review, the interview, and the examination (p.28).

The physical examination subsection should include the injured worker’s height, weight, and relevant clinical information (exam findings). The record review, including the dates and results of diagnostic tests and imaging, is a separate section of the report. The review should also make clear whether the physician reviewed the actual images or imaging reports (or both). Surgical procedures should be listed. Operation reports should be included in the body of the impairment report. Several operations are “diagnoses” in the *Guides* tables, and if the examiner does not have the actual operation report, she may miss factors for which impairment should be rated. If radiculopathy is suspected, the results of a sensory test (including sharp/dull discrimination) should be provided, as well as atrophy measurements for both injured and contralateral limbs. Range of Motion measurements, if limitations are suspected, should be given for all planes of the joint in question and for both the injured limb and the uninjured contralateral limb, so that anyone with a copy of the *Guides*, whether physician or judge, can check to see if anything was omitted and the arithmetic is correct.



Appropriately enough, the second main section of the MIR Report form template shares its name with the second step in the *Guides*’s report process: “ANALYSIS OF THE FINDINGS.” In this section, the physician answers very directly, for the record, questions such as, “Does the claimant have a permanent impairment?” and, “Has the claimant reached maximum medical improvement?” The physician should then list all the diagnoses for which there is “a ratable permanent impairment causally related to the work injury or exposure in question.” The form cover letter to the MIR physician lists which conditions the MIR physician is to rate. Other injuries with other impairments may have resulted from the same work incident, but if the other

issues have already been agreed to by both the injured worker and the insurer, the MIR physician will not be asked for a rating for those “settled” concerns.

MIR Physicians should be mindful that they are called upon to give impairment ratings, not causation opinions. That said, if the injured worker has comorbidities, especially in the same body-part or organ system, then the MIR Physician, pursuant to the *Guides* and MIRR Program Rules, should choose the causally-related diagnosis that will yield the highest impairment rating. The only other instance when an MIR Physician might be forced to opine on causation is when one of the two disputing physicians has given a 0% with the sole rationale that the pathology found was not causally-related. If both physicians have opined that the injury is causally related, then the MIR Physician should not “unsettle” that portion of the discussion by freely offering a contrary (and unsolicited) causation assessment. For the record, then the physician should list all the diagnoses for which there is a ratable impairment causally related to the work injury or exposure in question.

Step 3 of the report process is also, conveniently, the third main section of the MIR Report form template: “Discussion.” This is the section where the physician shows clearly, in terms both medical and legal professionals can understand, how the rating was derived. The physician should explicitly state which impairment rating method is most appropriate and why. If applicable, the physician should list which diagnosis line was used and which table and page number it came from. The impairment class and grade modifiers should also be provided, along with the rationale for choosing them. If the net adjustment formula was used, the physician should write it out and show how individual adjustments add up to form the Net Adjustment. The MIR Report form template already provides the basic structure of the net adjustment formula, so providing the formula is merely an exercise of fill-in-the-blank.

To be a case in the Medical Impairment Rating Registry system, there must be a dispute as to the correct rating. The MIR physician should detail what ratings were assigned by other physicians, why the MIR physician’s rating is correct, and why either one or both of the previously assigned ratings are incorrect. Examples would be “Dr. X deviated from the *Guides’s* methodology for no stated reason.” And “Dr. Y rated range of motion immediately after physical therapy, and since then the examinee has stopped doing the painful exercises and has lost motion.”

If there are multiple ratable impairments, then the physician should follow the above process for each of them and combine them using the appropriate methodology from the “Combined Values Chart” found as Appendix A on pages 604-606.

Tennessee Caveats

Principle 5 of Table 2-1 states that the injured worker must be certified at Maximum Medical Improvement before being evaluated for impairment rating purposes; yet, this is not true for impairment evaluations commissioned through the Medical Impairment Rating Registry. Pursuant to Tennessee Rules and



Regulations 0800-20-20-.11(3):

If, after reviewing the records, taking a history from the claimant and performing the evaluation, the MIR physician does not concur with the attending doctor's determination of MMI, a report shall be completed similar to the one outlined above which documents and certifies to, in sufficient detail, the rationale for disagreeing. The MIR physician must state what test or treatment is needed to determine if the examinee is at MMI.

The physician is still entitled to collect/retain the appropriate MIR fee. Even if the claimant is determined not to be at MMI by the MIR physician, the MIR physician must still issue a completed MIR report with a permanent medical impairment rating based upon the findings at the time of evaluation.

Prior to the adoption of this rule, if the MIR Physician opined that the injured worker was not at MMI, the parties seldom knew how to move forward to resolve their impairment dispute, especially if both the injured worker and employer agreed that the injured worker was, in fact, at MMI. This rule allows the parties the option to settle the claim or to seek additional treatment.

Pain is also no longer a consideration under Tennessee law when determining the degree of permanent impairment. Even if it were, in most instances, the *Guides* already incorporates functional losses due to pain within each methodological approach—whether it be the Diagnosis-based Impairment (DBI) method, the Range of Motion (ROM) method, or those unique methods particular to entrapment syndromes, Complex Regional Pain Syndrome, etc. The bottom line is that the evaluator should, under no circumstances, give an additional or “add on” rating expressly for pain. Additionally, Chapter 3 (Pain Related Impairments) should likely not be used to rate Tennessee claims with injury dates on or after July 1, 2014, and pain disability questionnaires should not be relied on to determine the functional history modifier (GMFH). Rather, the physician should focus on how the injury affects the injured worker's ability to function—whether the injured worker, for example, says she can perform activities of daily living such as bathing, dressing, and feeding herself.



Again, for MIR purposes, the MIR Physician must read the MIR Request that the Program Coordinator emailed when formally confirming the evaluation. The top of the first page of the MIR Request lists all the body parts and organ systems that are officially disputed, as agreed upon by the disputing parties. This is important since not all regional or organ system impairments may be disputed. In some cases, for instance, the parties may agree on the rating given for a wrist fracture but may dispute the rating given for the shoulder, or vice versa, resulting from the same injury event. Not only does the MIR Physician do unnecessary work when she rates a part of the body that is not disputed, she must go back and revise her report after the peer-review process and delete the aspects of the ratings that were not

requested. This can be avoided by simply reading the MIR Request made by the parties.

Finally, all MIR Reports have a concluding section where the MIR Physician has the opportunity (and obligation) to discuss why this final “rating is correct and why the other ratings, if different, are not correct.” This section allows the MIR Physician to get at the heart of the matter by drawing contrasts in methodology and leaving a lasting impression. If this concluding section is clear and well supported, the MIR Report will likely not be challenged.

Conclusion

In addition to reading chapters relevant to the physician’s specialty, the rating physician should also read Chapters 1 and 2 of the *AMA Guides*, Sixth Edition, being particularly mindful of the overarching principles presented in Table 2-1 on page 20. Being familiar with these principles will potentially go a long way in supporting and defending the chosen methodology for any given medical impairment rating report. Even treating and IME physicians who do not perform MIR evaluations would do well to mimic the basic structure of the MIR Report template on her own letterhead, as the MIR Report template is nearly perfectly in-sync with report requirements, as stipulated in Chapter 2 of the *Guides*. All reports are divided into three main sections: clinical evaluation, analysis of the findings, and discussion. These three main sections, in turn, are required to have specific subsections, such as patient history and a records-review, that cannot be omitted if the report is to be in keeping with *Guides* methodology. Finally, to obtain the highest level of competency, the rating physician should be familiar with Tennessee jurisdictional requirements that effectively supplant *Guides* methodology in certain matters such as the consideration of pain.

The Next Step Program

Progress and Opportunity

Brian Holmes, MA



Since beginning nine months ago, the Next Step Program has maximized the BWC's "access points" to increase applications, collaborated with other agencies to enhance its services, and helped diverse injured workers return to work.

Sometimes our assistance has involved education; other times we've connected them with appropriate resources or provided necessary advice. Still, the program needs referrals from stakeholders who can encourage injured workers to utilize this program.

Assistance

Of twenty-nine applicants, seven returned to work, and five enrolled in school. Two more are preparing to start school in January. Others are still looking for work.

We help anyone with a work injury return to work, which sometimes involves education. But a common misunderstanding is that the program serves only those who qualify for the annual \$5,000 scholarship. Most applicants have not qualified for the scholarship. But they've received help with finding job openings, writing better resumes, and improving their interviewing skills. We've also connected those wanting education with programs that have helped them afford that dream.

One program participant wanted to become a truck dispatcher. We found a school a program for her that would help achieve that goal. Unfortunately, we then discovered her ineligibility for the Next Step Scholarship. Discouraged, she stopped trying until she received personal coaching from our program. We advised her to complete a Free Application for Federal Student Aid and access TnReconnect. After doing so, she received a Pell Grant to cover all program costs and assist with living expenses.

We impart hope that resources are plentiful and that using them yields success. We inform them about the American Job Centers and the value of www.jobs4tn.gov. We meet with them at the job centers, introduce them to the staff, and ensure the initial contact is a positive encounter. We look for jobs together and set objectives to be accomplished before we meet again. We discuss their hopes and dreams. We encourage and provide an extra boost when they get discouraged.

The Next Step Program's applicants have been diverse. They are young and old, some with high school educations and some with bachelors' degrees. We started with mostly men but had a recent surge of women applicants. Their impairments and work restrictions are just as varied. The common thread between all is that they need to do something to provide for their family or simply to obtain independence.

Recruiting Applicants

The program has utilized BWC's access points to influence injured workers to apply to the program. The BWC accesses injured workers through multiple fronts. The three most prominent are the ombudsman program, mediation program, and the Court of Workers' Compensation Claims (CWCC).

CWCC judges received training on the program in December and individual follow-ups in March and April. Several judges have modified their approval hearings to include information about the program to injured workers who are seeking approval of their workers' compensation settlement agreements. Workers' compensation mediators are advocating for the program during mediation sessions for permanent disability benefit disputes. We produced brochures and distributed them to all eight BWC offices. The brochures are located in lobbies, mediation rooms, conference rooms, and approval locations. Posters for the programs are in the lobbies where injured workers wait before their mediation and in the mediation rooms.



The ombudsmen are the most influential advocates for the program, as most participants come from ombudsman-referrals. In April, they competed in a contest to spread the word about the program. They have spoken to over 100 injured workers who are not employed and handed out as many program brochures.

Sixty-one workers qualified for the Next Step Program Scholarship, meaning they were injured after July 1, 2018, reached maximum medical improvement, and received their resulting award. Unfortunately, not one of them applied to the program immediately after settlement. We sent them letters to notify them about the program. The letters resulted in three injured workers filing scholarship applications.

We have also asked for recruitment help from stakeholders, such as insurance adjusters, attorneys, and medical providers. We have reached out to medical providers through this publication and through speaking engagements at conferences. Adjusters have learned of the program through adjuster certification training and conferences. Several publications for attorneys published stories about the program, and the program has been publicized at attorneys' conferences as well. Several applicants have indicated an attorney or adjuster had them apply to the program.

Going Forward

Our program collaborates with other agencies to improve outreach, and recommendations for collaboration with other agencies are appreciated. We developed a strong relationship with American Job Centers and hope to dedicate more staff hours to relationship-building with other agencies with similar missions.

In August, the program held a meeting with the Fund Allocation Committee to discuss progress. This group will review applications and make scholarship recommendations when necessary. They offered valuable feedback and suggestions, like contacting participants through text messaging and identifying participants' preferred methods of contact. They recommended prioritizing an injured worker's functionality over impairment to better identify potential occupations. Additionally, they suggested ways to be more intentional with our initial contacts.

In September, we added a full-time staff member who can focus on serving participants full-time and recruiting more applicants.

For questions about the program, to receive a poster, or for Next Step Program applications, please contact Brian Holmes at 615-253-1206.

What is Maximum Medical Improvement? And Why is it Important?

James B. Talmage, MD, and Robert B. Snyder, MD



Both the Tennessee Workers' Compensation Law and the *AMA Guides to the Evaluation of Permanent Impairment*, Sixth Edition, use the term "Maximum Medical Improvement" (MMI).

The *Guides*, Sixth Edition defines this term:

Maximum Medical Improvement refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change.

(p. 26)

The *Guides* goes on to explain that:

MMI represents a point in time in the recovery process after an injury when further formal medical or surgical intervention cannot be expected to improve the underlying impairment. Therefore, MMI is not predicated on the elimination of symptoms and/or subjective complaints. Also, MMI can be determined if recovery has reached the stage where symptoms can be expected to remain stable with the passage of time, or can be managed with palliative measures that do not alter the underlying impairment substantially, within medical probability. Maximum Medical Improvement does not preclude the deterioration of a condition that is expected to occur with the passage of time or as a result of the normal aging process; nor does it preclude allowance for ongoing follow-up for optimal maintenance of the medical condition in question.

(p. 26)

The statutory definition in Tennessee workers' compensation law is similar:

T.C.A. § 50-6-207(1)(E): An employee claiming an injury as defined in § 50-6-102, when the date of injury is on or after July 1, 2014, shall be conclusively presumed to be at maximum medical improvement when the treating physician ends all active medical treatment and the only care provided is for the treatment of pain or for a mental injury that arose primarily out of a compensable physical injury.

The term "treatment that is available to them" has practical significance. The *Guides* explains that individuals may decline the treatment offered, and yet still be at MMI, even though the treating physician believes additional treatment would be helpful. The surgeon may state that a devastating injury to a lower limb has resulted in a

residual limb that functions worse than the typical result from a lower limb amputation, but the individual may choose to live with the limb “as is” and not undergo elective limb amputation surgery. This individual then is “at MMI” (p. 24).

In addition, in workers’ compensation, if Utilization Review has determined that the authorized treating physician’s treatment recommendation is incongruent with the BWC-adopted, evidence-based guidelines, then the recommended treatment is not “available to them,” and thus the individual is at MMI.

After a UR denial, either the injured worker or the physician can appeal the denial to the BWC Medical Director, and ultimately to the Court of Workers’ Compensation Claims. Denial of a procedure by the insurer should not be a reason that the physician holds up the determination of MMI. Doing that places the injured worker and the entire claim in limbo. The case cannot be resolved where the patient might be able to get the treatment outside of workers’ compensation; temporary benefits continue and further permanent impairment could result.



Once MMI has been established, it is the duty of the authorized treating physician to issue a permanent impairment rating using the *AMA Guides*. The MMI date becomes the date at which the worker receiving Temporary Total Disability payments stops receiving the temporary wage replacement but becomes eligible for a permanent disability payment, as explained in T.C.A. § 50-6-207. Note that this section of the law [quoted above] states that if the authorized treating physician ends active treatment and the remaining treatment is for residual pain, or residual mental injury resulting from a physical injury, that the referral date for “pain management” becomes the date of MMI, meaning the authorized treating physician, and not the future pain management physician, is responsible for the permanent impairment rating.

The *AMA Guides* indicates permanent impairment cannot be assigned unless the individual is already at MMI:

Only permanent impairment may be rated according to the Guides, and only after the status of “Maximum Medical Improvement” (MMI) is determined, as explained in Section 2.5e. Impairment should not be considered permanent until a reasonable time has passed for the healing or recovery to occur. This will depend on the nature of underlying pathology, as the optimal duration for recovery may vary considerably from days to months.

(p. 24)

Another potential event triggered by the authorized treating physician opining that MMI has been reached is, if the employee is still not working for the original employer, the employer has to consider the Americans with Disabilities Act

requirement for the process to determine if the employer can accommodate the worker's restrictions (risk-based work guidelines) and limitations (capacity based work abilities). It helps the insurer and employer if the authorized treating physician clearly states in the office note that the "date of MMI is..." and that subsequently the now "Permanent work guidelines" (a.k.a. "restrictions") are"

Thus, the phrase "at MMI" has considerable practical significance for the injured worker, insurer, and employer, and physicians should carefully consider the concept and opine on MMI correctly.

Role of Referral Physicians

Recent Case Law

Jane Salem, Esquire



The Tennessee Workers' Compensation Appeals Board recently released two opinions of interest to medical and legal practitioners regarding the selection and role of referral physicians.

Employer Designated a “Preferred Physician”

In *Rhodes v. Amazon*, Jason Rhodes injured his foot at the Amazon warehouse. Amazon offered a panel, and Rhodes chose AFC Urgent Care. Dr. Natasha Ballard, a primary care physician, treated him until referring him to Dr. Ricky Hutcheson, an orthopedic surgeon. Instead, Rhodes treated with his own specialist, Dr. Jesse Doty, because Dr. Hutcheson's office was too far to drive.

When asked why she referred Rhodes to Dr. Hutcheson, Dr. Ballard said, “[W]e were told [by Amazon] that, you know, for orthopedic we prefer Dr. Hutcheson.” She explained that using a “preferred physician” can speed up the process but acknowledged she had no medical reason to choose him.

Dr. Doty also explained the decision-making regarding referrals. He said, “I think these relationships occur all the time where employers have a relationship with a physician and generally the injured employee starts out with that physician for their overall history, physical and evaluation. But I don't think that has anything to do with whether it's in the patient's best interest.” Dr. Doty further said that case managers sometimes suggest providers with whom they have relationships, making the referral process easier because they know physicians who accept workers' comp.

After an expedited hearing, the trial court held that Amazon failed to comply with “the spirit” of the referral statute and ordered it to provide a panel of orthopedic specialists.

The Appeals Board majority reversed, reasoning that no case law extended an employee's right to select the initial treating physician from a panel to a choice of referral physician. Presiding Judge Marshall Davidson wrote that this comports with “an important public policy underlying the workers' compensation system in general, namely, the employer's right to control medical treatment.” He further wrote, “[W]e are not unmindful of Employer's purported influence on Dr. Ballard's referral decision-making. However, directing employers' actions in a manner not currently mandated by statute is best left to the legislature, not the courts. Similarly, Employee's argument that employers exercise too much control over medical treatment is a policy argument best addressed to the legislature[.]”

Judge David Hensley penned a spirited dissent, tracing the history of the panel provision within the statute from 1943 to the present. He characterized an injured worker's statutory right to select the ultimate treating physician from a panel as “an

important and valuable benefit.” He continued, “[T]he majority’s interpretation clears the way for an employer or insurer to unilaterally select the treating physician in any claim where a referral to a specialist physician or surgeon becomes necessary. While this allows employers and insurers significantly greater control over the medical care, it effectively returns the medical provider selection process to the pre-1943 procedure in any case requiring treatment by a specialty physician.”

No Presumption on Medical Causation

In *Gilbert v. United Parcel Service, Inc.*, Thomas Gilbert delivered packages for UPS. He suffered a work injury in 2011 to his left knee, which needed surgery to repair a medial meniscal tear. The case settled with open future medical benefits. In 2015, Gilbert returned to the authorized treating physician complaining of knee pain. The doctor ultimately recommended a total knee arthroplasty and referred him to Dr. Gregory Raab, who performed the surgery.

Gilbert alleged “continuous trauma” to his knee when he “climbed into a UPS truck 150 to 200 times a day.” In contrast, UPS contended this wasn’t a new injury but a continuation of the 2011 injury. The compensation hearing essentially pitted two expert medical opinions against each other. Gilbert hired Dr. Stephen Neely, who said the force of repeatedly climbing in and out of the work truck accelerated the degeneration of the knee. UPS relied on Dr. Raab, who said that since the right knee showed no evidence of “wear and tear,” it was reasonable to conclude that the need for the arthroplasty wasn’t related to wear and tear but rather the natural progression of arthritic changes due to the previous meniscal repair. The trial court found that Dr. Neely’s opinion overcame the presumption of correctness afforded to Dr. Raab’s opinion on causation and awarded permanent partial disability benefits.



UPS appealed, and the Board affirmed. UPS argued Dr. Raab’s causation opinion was entitled to a presumption of correctness and that the lower court erred by concluding Dr. Neely’s opinion rebutted the presumption. The Board disagreed.

Judge Tim Connor wrote: “Dr. Raab was not selected from a panel of physicians, but became an authorized treating physician as the result of a referral[.] Tennessee Code Annotated section 50-6-102(14)(E) makes clear that the rebuttable presumption of correctness attributable to a causation opinion applies only to such opinions expressed by a treating physician ‘selected by the employee from the employer’s designated panel of physicians[.]’”

The Board concluded, “Employee testified without contradiction that he entered his work vehicle up to 200 times per day bearing weight on his left leg. The fact that he may have exited the vehicle using his right leg is not determinative of the causation issue. Moreover, while the pre-existing left knee condition may have contributed to the need for surgery, the totality of Dr. Neely’s testimony supported the trial court’s conclusion that the need for the knee replacement was more than fifty percent attributable to the cumulative trauma injury aggravating or accelerating the arthritic changes in that knee.”

Relevant Medical Literature Abstracts

Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

Orthopedics. 2009 Oct; 32(10).

Surgeon bias in the medical record.

Calfee R, Fynn-Thompson E, Stern P.

Author information

The medical chart is presumed to be an impartial record of a patient's history, examination, and treatment. This study was designed to determine if hand surgeons introduce selective bias into the medical record. Fifty consecutive new patients were referred to a hand surgery practice for presumed carpal tunnel syndrome. Forty-four patients were diagnosed with carpal tunnel syndrome and were eligible for study inclusion. Prior to evaluation, all patients wrote in free-response fashion and diagrammed their symptom quality and location. Surgeon dictations from these visits were then evaluated against the patients' self-reported symptomatology. Statistical analysis was performed to determine if specific symptom types and locations were preferentially omitted from medical records. The surgeons' records most closely replicated patients' self-reported diminished sensibility in the thumb, index, and middle fingers (100% inclusion rate). When patients described presenting with pain, it was recorded significantly less frequently ($P < .001$) in the surgeon's note (16 of 27; 59%). Surgeon documentation of patient symptoms in the median nerve distribution (98% inclusion) was more likely than documentation of symptoms in the small finger (50% inclusion; $P < .001$), forearm (45% inclusion; $P < .001$), and arm (50% inclusion; $P < .001$). Because symptoms less readily attributed to median nerve compression at the wrist were more likely to be omitted, it is possible that surgeons introduce bias into the medical record. Although the cause of this discrepancy is likely multifactorial, the medical records often failed to document patients' pain as well as symptoms outside of the median nerve distribution.

PMID: 19824608 DOI: [10.3928/01477447-20090818-07](https://doi.org/10.3928/01477447-20090818-07)

Relevant Medical Literature Abstracts

Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

Acta Orthop Scand. 1998 Aug; 69(4):408-11.

Pain drawing evaluation--the problem with the clinically biased surgeon. Intra- and interobserver agreement in 50 cases related to clinical bias.

Reigo T, Tropp H, Timpka T.

Author information

Abstract

To assess whether the clinical knowledge of the treating surgeon had any effect on the reliability of the pain-drawing evaluation, drawings from 50 low-back pain patients were evaluated by the treating surgeon and by three colleagues who had no clinical knowledge of the patient. The evaluation was repeated after 10 days. The treating surgeons were also blinded to clinical data. The kappa value in the evaluation when the surgeon had clinical knowledge of the patient was lower (0.29 (95% CI 0.13-0.45)) than the kappa value in the evaluations made without clinical knowledge (0.60 (CI 0.45-0.75)). The differences observed in interobserver reliability between open and blind evaluations suggest that clinical knowledge of a patient influences the evaluation of the pain drawings.

PMID: 9798452 DOI: [10.3109/17453679808999057](https://doi.org/10.3109/17453679808999057)

Relevant Medical Literature Abstracts

Selected by James B. Talmage, MD

Published verbatim from [PubMed.gov](http://pubmed.gov), in the public domain.

[BMC Musculoskelet Disord.](#) 2010 Nov 30;11:275.

Bias in the physical examination of patients with lumbar radiculopathy.

Suri P, Hunter DJ, Katz JN, Li L, Rainville J.

Author information

Background

No prior studies have examined systematic bias in the musculoskeletal physical examination. The objective of this study was to assess the effects of bias due to prior knowledge of lumbar spine magnetic resonance imaging findings (MRI) on perceived diagnostic accuracy of the physical examination for lumbar radiculopathy.

Methods

This was a cross-sectional comparison of the performance characteristics of the physical examination with blinding to MRI results (the 'independent group') with performance in the situation where the physical examination was not blinded to MRI results (the 'non-independent group'). The reference standard was the final diagnostic impression of nerve root impingement by the examining physician. Subjects were recruited from a hospital-based outpatient specialty spine clinic. All adults age 18 and older presenting with lower extremity radiating pain of duration ≤ 12 weeks were evaluated for participation. 154 consecutively recruited subjects with lumbar disk herniation confirmed by lumbar spine MRI were included in this study. Sensitivities and specificities with 95% confidence intervals were calculated in the independent and non-independent groups for the four components of the radiculopathy examination: 1) provocative testing, 2) motor strength testing, 3) pinprick sensory testing, and 4) deep tendon reflex testing.

Results

The perceived sensitivity of sensory testing was higher with prior knowledge of MRI results (20% vs. 36%; $p = 0.05$). Sensitivities and specificities for exam components otherwise showed no statistically significant differences between groups.

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Conclusions

Prior knowledge of lumbar MRI results may introduce bias into the pinprick sensory testing component of the physical examination for lumbar radiculopathy. No statistically significant effect of bias was seen for other components of the physical examination. The effect of bias due to prior knowledge of lumbar MRI results should be considered when an isolated sensory deficit on examination is used in medical decision-making. Further studies of bias should include surgical clinic populations and other common diagnoses including shoulder, knee and hip pathology.

PMID: 21118558 PMCID: [PMC3009628](https://pubmed.ncbi.nlm.nih.gov/PMC3009628/) DOI: [10.1186/1471-2474-11-275](https://doi.org/10.1186/1471-2474-11-275)

Relevant Medical Literature Abstracts

Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

Clin Spine Surg. 2018 Dec; 31(10):E481-E487.

Do Cervical Spine Surgery Patients Recall Their Preoperative Status?: A Cohort Study of Recall Bias in Patient-reported Outcomes.

Aleem IS, Currier BL, Yaszemski MJ, Poppendeck H, Huddleston P, Eck J, Rhee J, Bydon M, Freedman B, Nassr A.

Author information

Study Design

This is a prospective cohort study.

Objective

To characterize the accuracy of patient recollection of preoperative symptoms after cervical spine surgery.

Summary of Background Data

Recall bias is a well-known source of systematic error. The accuracy of patient recall after cervical spine surgery remains unknown.

Methods

Consecutive patients undergoing cervical spine surgery for myelopathy or radiculopathy were enrolled. Neck and arm numeric pain scores and Neck Disability Indices were recorded preoperatively. Patients were asked to recall their preoperative status at either short (<1 y) or long-term (≥1 y) follow-up. Actual and recalled scores were compared using paired t tests and relations were quantified using the Pearson correlation coefficients. Multivariable linear regression was used to identify factors impacting recollection.

Results

In total, 73 patients with a mean age of 58.2 years were included. Compared with their preoperative scores, patients showed significant improvement in neck pain [mean difference (MD)=-2.9; 95% confidence

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intervals (CIs), -3.5 to -2.3], arm pain (MD, -3.4; 95% CI, -4.0 to -2.8), and disability (MD, -12.4%; 95% CI, -16.9 to -7.9). Patient recollection of preoperative status was significantly more severe than actual for neck pain (MD, +1.5; 95% CI, 0.8-2.2), arm pain (MD, +2.3; 95% CI, 1.6-3.0), and disability (MD, +5.8%; 95% CI, 2.4-9.2). Moderate correlation between actual and recalled scores with regard to neck ($r=0.41$), arm ($r=0.50$) pain, and disability ($r=0.67$) was seen. This was maintained across age, sex, and time between date of surgery and recollection. Over 30% of patients switched their predominant symptom from neck-to-arm pain or vice versa on recall of their preoperative symptoms.

Conclusions

Relying on patient recollection does not provide an accurate measure of preoperative status after cervical spine surgery. Prospective and not retrospective collection of patient-reported outcomes remain the gold standard to measure and interpret outcomes after cervical spine surgery. Recall bias has the potential to affect patient satisfaction and requires further study.

PMID: 30299282 DOI: [10.1097/BSD.0000000000000726](https://doi.org/10.1097/BSD.0000000000000726)

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Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

Arch Intern Med. 2002 May 13;162(9):981-4.

Forgetting, fabricating, and telescoping: the instability of the medical history.

Barsky AJ

Author information

Patients' recollections of their past symptoms, illnesses, and episodes of care are often inconsistent from one inquiry to the next. Patients frequently fail to recall (and therefore underreport) the incidence of previous symptoms and events; tend to combine separate, similar occurrences into a single, generic memory; and falsely recall medical events and symptoms that did not in fact occur. This unreliability of recall is affected by personality characteristics and by the patient's current state at the time of recall. Thus, current anxiety or depression and pain or bodily distress foster the recall of symptoms and events that are not recalled when the patient is more comfortable. Finally, current beliefs about one's health and the nature and causes of one's illness also affect the recall of past symptoms and illness. Physicians can maximize the reliability of the clinical history by (1) noting and taking into account the patient's current physical and emotional state; (2) first establishing historical "anchor points" or memorable milestones; (3) decomposing generic memories by finding features that distinguish them from each other; and (4) recalling the clinical history in retrograde fashion, beginning with the most recent event and working backward.

PMID: 11996606 DOI: [10.1001/archinte.162.9.981](https://doi.org/10.1001/archinte.162.9.981)

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Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

[Spine J.](#) 2009 Jan-Feb; 9(1):4-12.

Is the self-reported history accurate in patients with persistent axial pain after a motor vehicle accident?

[Don AS](#), [Carragee EJ](#).

Author information

Background Context

A patient's self-reported history has, in general, assumed to be accurate. Clinical management of individuals with persistent axial pain after a motor vehicle accident (MVA) and measures to prevent future MVA, spinal cord injury, and traffic deaths often depend on a presumed accurate report of preexisting axial pain, drug, alcohol, and psychological to initiate intervention. In addition, research efforts to determine the effects of MVA on subsequent health are often predicated on a presumed accurate history from the patient of past medical and psychosocial problems. Despite so many clinical, public health, and research efforts being dependent on an accurate assessment of pre-injury health, the validity of the self-reported history after MVA has not been systematically investigated.

Purpose

To determine the validity of self-reported history in subjects with axial neck or back pain attributed to a recent MVA.

Study Design

A prospective, multiclinic validation study examining the critical elements of a patient's self-reported history after an MVA judged against an audit of his or her medical records.

Patient Sample

A cohort of consecutive patients with persistent axial pain after an MVA was prospectively identified from five spine-specialist's outpatient clinics. Of 702 patients, 335 subjects were randomly selected for auditing of their medical records.

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Outcome Measures

Self-reported demographic and clinical features were recorded by standardized questionnaires and clinical interviews. Audits compared these responses to an extensive medical record search.

Methods

The self-reported prevalence of preexisting axial pain, at-risk comorbidities (psychological distress, alcohol, and drug abuse), and control conditions (hypertension and diabetes) was recorded. The medical records of a random sample of 50% of the enrolled cohort underwent auditing of their medical records in a wide search of network paper and electronic and archived records, and compared with the self-reported history of pre-accident health.

Results

Overall, approximately 50% of the subjects were found to have previous axial pain problems at audit when none was reported to the spine-specialist after an MVA. Similarly, approximately 75% of the subjects were found to have one or more preexisting comorbid conditions at audit that were not reported during the evaluation after the MVA (alcohol abuse, illicit drug use, and psychological diagnosis). For those who perceived that the accident was the fault of another, as opposed to their own or no one's fault, the documented previous back and neck pain troubles in the medical records was more than twice the self-reported rate of these problems ($p < .01$). The rate of previously documented psychological problems was more than seven times that of the self-reported rate ($p = 0.001$). In those subjects who perceived that the accident was their own or no one's fault, a lesser degree of under-reporting of axial pain and comorbid conditions was found.

Conclusion

The validity of the patient's self-reported history when presenting with persistent axial pain after an MVA appears poor in this large multiclinic random sample. The self-reported rates of alcohol abuse, illicit drug use, and psychological diagnosis, as well as prior axial pain were significantly lower than that seen in the medical records, especially in those who perceive that the MVA was another's fault. The failure to recognize this under-reporting may seriously compromise clinical care, public health efforts at injury prevention, and research protocols dependent on accurate pre-accident morbidity assessments.

PMID: 19111258 DOI: [10.1016/j.spinee.2008.11.002](https://doi.org/10.1016/j.spinee.2008.11.002)

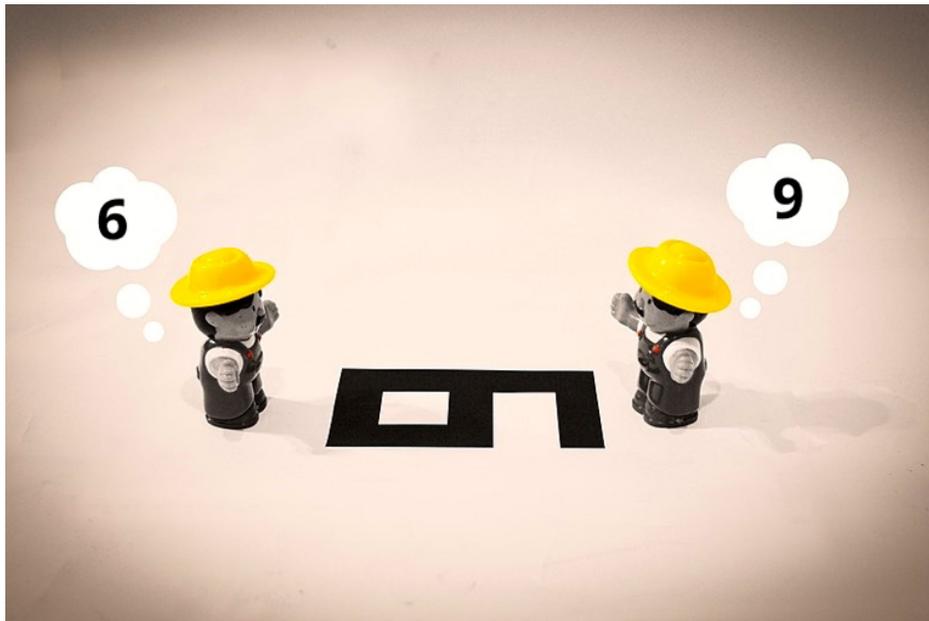
Comments on Selected Abstracts

James B. Talmage, MD



A bias in evidence-based medicine is any factor that leads to conclusions that are systematically different from the truth. Thirty-nine of the types of bias that can occur in published medical research studies are summarized well at: <https://first10em.com/bias/>. Bias explains why many published articles and research studies are potentially misleading.

The two legal case decisions summarized in this issue raise the issue of whether the selection of a treating physician is affected by the employer/insurer belief that a physician gets better treatment outcomes as opposed to the belief that a physician's opinion tends to favor the employer/insurer. Injured workers/plaintiff attorneys and insurers/defense attorneys may disagree as to which patients and which physicians are being honest and/or scientific.



The abstracts reprinted show that physicians are people, and their judgments are not always consistent with truth. The abstracts also show that patients are not always "truthful." The cases summarized, and the abstracts reprinted, highlight difficulty of the workers' compensation judges' job. They usually see the patient in settlement or trial, but their exposure to the physician's testimony is usually only by deposition or medical records. They are tasked with somehow finding the truth with conflicting evidence. I am glad I am not a judge.

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