The Medical Impairment Rating Registry

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The AdMIRable Review

MIRR PHYSICIAN SPOTLIGHT
CLAIBORNE A. CHRISTIAN, MD

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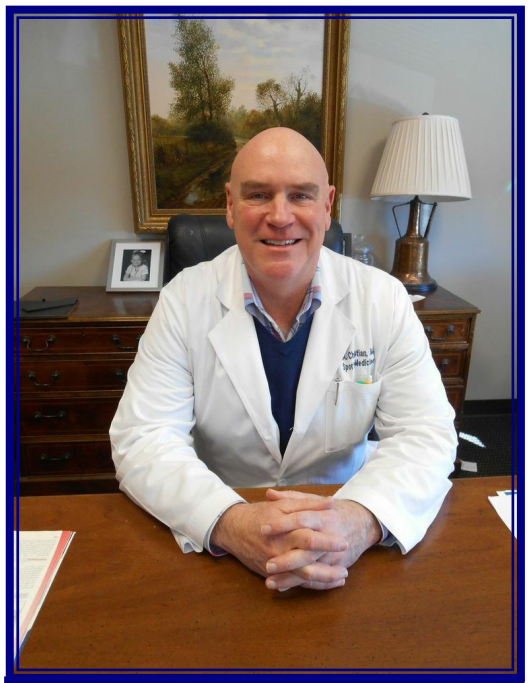
Dr. Claiborne "Chip" Christian is an orthopaedic surgeon practicing in Southaven, Mississippi. "I actually enjoy doing an MIR evaluation," he says. "I learn something applicable to my own practice every time." Considering that Dr. Christian has treated thousands of workers' compensation patients over a span of twenty-three years and performed hundreds of Independent Medical Evaluations, his ability to learn from the MIR process is quite a compliment to the Medical Impairment Rating Registry. Indeed, Dr. Christian's "growth mindset" has contributed in large part to the high quality of work found within the Medical Impairment Rating Registry. His MIR Reports are among the most laudable, and his personable nature makes doing business with his office both easy and a pleasure. It is no wonder why DeSoto



CLAIBORNE A. CHRISTIAN, MD

County residents voted him as the best orthopaedic surgeon in the county, awarding him the *DeSoto Times Tribune's* "Best of the Best" superlative two years in row.

In 2006, Dr. Christian founded Mississippi Orthopaedic and Sports Medicine,

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MIRR PHYSICIAN SPOTLIGHT
CLAIBORNE A. CHRISTIAN, MD

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"DeSoto County residents voted him as the best orthopaedic surgeon in the county, awarding him the *Desoto Times Tribune's* "Best of the Best" superlative two years in row."

PLLC, where he and his two partners, Dr. Tom Morris and Dr. James Varner, worked until April 1, 2015, when the practice merged with OrthoMemphis at their new Southaven location on Clarington Cove. He is Board Certified by the American Board of Orthopaedic Surgeons, a member of the AOSSM, AANA, Southern Orthopaedic Society, and the Medical Director of the DeSoto Surgery Center.

A native Virginian, Dr. Christian graduated from Davidson College in Davidson, North Carolina in 1982 and then received his M.D. degree from the Medical College of Virginia, Virginia Commonwealth University in Richmond. He completed his orthopaedic residency at The Campbell Clinic in Memphis in 1991 and completed a fellowship in Sports Medicine and Arthroscopy at the University of Florida in Gainesville in 1992. He was a staff physician at Campbell Clinic until 1995 when he left to pursue his own practice in Huntingdon, Tennessee, where he met former Commissioner of the Tennessee Department of Labor and Workforce Development, James Neely, and began to develop an interest in Occupational Orthopaedics.

Tennessee Governors Don Sundquist and Phil Bredesen appointed Dr. Christian as a physician representative to the formerly named "Advisory Council on Workers' Compensation." He was instrumental in helping to establish the Work-

Dr. Christian and colleagues at OrthoMemphis, Southaven, Mississippi

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LUMBAR SPINAL STENOSIS

James B. Talmage, MD

Jay Blaisdell, CEDIR

Acquired lumbar spinal stenosis is anatomic size reduction (narrowing) of the lumbar central spinal canal, lateral recess, and/or neural foramen that results in symptomatic nerve root compression. Each of these 3 anatomic regions of potential stenosis has consensus agreement[1] on the anatomic definitions of the region (e.g. definition of what is the foramen). The central canal is bordered on each side by the lateral recess, which anatomically extends from the medial edge of the articular facet to the medial most aspect of the pedicle. The foramen corresponds to the segment from the medial pedicles to the lateral pedicles.

Aging brings inevitable changes in spinal anatomy that are many times totally asymptomatic. Enlargement of the disc (bulging, protrusion, or extrusion), the facet joints, synovial cysts, osteophytes, and/or the ligamentum flavum (posterior) may occur and cause neurologic symptoms and signs of nerve root compression. However, these aging changes may occur and **not** cause symptoms. Thus the presence of "stenosis" on an imaging report is **not** equivalent to a clinical (treatment related) diagnosis of stenosis, which is **not** equivalent to a diagnosis of stenosis for AMA *Guides, 6th Edition* impairment rating purposes.

A 2015 systematic review[2] of all previously published 33 studies of lumbar MRI in 3,110 **asymptomatic** adults clearly showed that aging changes (*like gray hair*) become more common with age in people **without** back complaints. [*From Brinjikji 2015 – Table 2*]

Imaging Finding	20s	30s	40s	50s	60s	70s	80s
Disc degeneration	37%	52%	68%	80%	88%	93%	96%
Disc signal loss	17%	33%	54%	73%	86%	94%	97%
Disc height loss	24%	34%	45%	56%	67%	76%	84%
Disc bulge	30%	40%	50%	60%	69%	77%	84%
Disc protrusion	29%	31%	33%	36%	38%	40%	43%
Annular fissure	19%	20%	22%	23%	25%	27%	29%
Facet degeneration	4%	9%	18%	32%	50%	69%	83%
Spondylolisthesis	3%	5%	8%	14%	23%	35%	50%

The above studies were done on 1.5 Tesla units with 4-5 mm slice thickness. Three Tesla MRI is becoming more common in the imaging community, and per-

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LUMBAR SPINAL STENOSIS

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mits higher resolution imaging of thinner slices (*equivalent of more pixels in a digital camera image*). Kim et al[3] studied 102 asymptomatic adults equally distributed by decade from age 14 to age 82 and found on 3T imaging disc herniation in 81%, annular fissures in 76%, and disc degeneration in 76%, with the expected increase in incidence of each finding with age. Thus a greater percentage of asymptomatic adults may appear to have pathology on 3T imaging, and "stenosis" may be a more frequent radiologic diagnosis as 3T imaging comes to more communities.

Lumbar spinal stenosis is at times a fairly easy clinical diagnosis, and at times a difficult diagnosis to establish. A systematic review of 46 studies on making the clinical diagnosis of stenosis[4] stated:

> The challenge to the anatomically based definition is that while necessary for the diagnosis of LSS, it is not sufficient to determine the severity of symptoms that leads a patient to seek treatment. The extent of narrowing of the spinal canal correlates poorly with symptom severity and radiologically significant lumbar stenosis can be found in asymptomatic individuals. Furthermore, lower extremity pain, numbness, or weakness is frequently seen in the setting of low back pain and other causes abound. As a consequence, correlating symptoms and physical examination findings with imaging results is necessary to establish a definitive diagnosis.

For the IME physician, the problem of diagnosing lumbar spinal stenosis for impairment rating purposes is compounded. In some jurisdictions rules on "*lighting up asymptomatic pre-existing*" disease permit lumbar stenosis to be treated and rated in the workers' compensation system. In other jurisdictions, like Tennessee, that now use a "primarily,"[5] or ">50% of causation" standard, the individual with no injury incident, or with symptom onset during normal activity (*no violent incident expected to injure most people*), the rules should logically exclude this diagnosis from the workers' compensation system.

The IME physician many times has medical treatment records and imaging reports, but many times the rating physician has no actual images to review, and no knowledge of the imaging criteria used by a particular radiologist. The previously cited consensus document[1] has standardized nomenclature for disc bulges, disc protrusions, disc herni-

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ations, and annular fissures. Unfortunately, there are no standardized consensus criteria for lumbar stenosis in the central canal, lateral recess, or foramen. A 2013 systematic review[6] found 14 semiquantitative or qualitative criteria on imaging that have been used in published studies of lumbar stenosis. For 10 of these the inter-rater reliability was between 0.01 and 1.0. These reliability data are in research studies in which the interpreting radiologists agreed before the study on criteria definitions. The few studies on reliability of the MRI interpretations of community radiologists do not permit conclusions.

The best reliability appears to be the determination of the presence or absence of fat about the nerve root on T1 sagittal images of the nerve root as it exits the foramen (*far from the mid-sagittal image*). The published studies are on stenosis patients before a first operation, and thus don't address whether

Criterion	Intra-rater reliability	Inter-rater reliability
Central Stenosis		
Compression of central canal	0.82	0.41-0.73
Reduced or absent fluid around cauda equina	0.65 -0.90	0.44 – 0.95
Nerve root sedimentation sign	1.0	0.93
Hypertrophy of ligamentum flavum	No data	No data
Redundant nerve roots of cauda equina	No data	No data
Reduced posterior epidural fat	No data	No data
Lateral Recess Stenosis		
Decreased size of lateral recess	0.75-0.77	0.49
Nerve root compression in lateral recess	No data	No data
Foraminal Stenosis		
Perineural fat on sagittal T1 at foramen	0.62-1.0	0.91-1.0
Hypertrophic facet	0.16-0.89	0.07- 0.89
Decreased foramen size	0.75-0.77	0.58
Foraminal nerve root impingement	0.72 – 0.77	0.51 – 0.67
Size and shape of foramen	No data	0.47

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absence of fat about a nerve root on T1 sagittal images, or absence of spinal fluid about a nerve root on T2 sagittal images, in a patient who has had **surgery at that level** and thus has post-operative scar at that level, has "surgical significance" or potentially explains persisting symptoms after surgery.

A study looking for consensus[7] among 27 "expert" neuroradiologists from Europe and the United States found a wide range of suggestions for diagnosing stenosis, but relative consensus on the following "cut off" measurements of dimensions on MR images:

Parameter	"Cut off"
A-P Canal diameter	< 11 mm (< 11 – 14 mm)
Midsagittal dural sac diameter	< 12 mm (<10 – 12 mm)
Diameter of foramen	< 3 mm (<2 – 4 mm)
Lateral recess height (A-P)	< 3 mm (<2 – 4 mm)
Axial view area of dural sac	< 100 mm^2 (< 69 – 100 mm^2)

The conclusion from this literature review is that the diagnosis of spinal stenosis requires clinical correlation of symptoms and signs with imaging.

An interesting anecdote is probably familiar to IME physicians. Many patients with a pre-operative diagnosis of lumbar spinal stenosis in the workers' compensation system have suboptimal surgical outcomes, and thus get a repeat MRI study in the early post-operative period. The pre-operative MRI report describes "severe" foraminal and/or lateral recess stenosis based on osteophyte(s) and facet hypertrophy. The Operation Report describes a very adequate decompression by removal of bone at the lateral recess and foramen. The Operation Report states that, after the bony decompression, a ball tipped probe could be easily passed on all sides of the nerve root through the foramen. The early post-operative MRI radiologist report reads that "severe" foraminal stenosis and/or lateral recess stenosis is still present at the level just operated. The surgeon who ordered the post-operative MRI views these same films and records "very adequate decompression of the involved nerve root." The lesson from this anecdote is that the nerve root is much smaller than the foramen, and that very adequate decompression of a nerve root may leave behind a foramen that still meets some radiologist's criteria for "severe" stenosis. This emphasizes that "mild" (perhaps < 1/3 reduction in size) or "moderate" (perhaps > 1/3 but < 2/3 reduction in size[8]) foraminal stenosis is aging change that is

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rarely clinically significant. Even "severe" lateral recess or foraminal stenosis on a MRI report may be just asymptomatic age-related imaging change, and not significant.

"When all else fails, examine the patient."

Lumbar spinal stenosis is occasionally seen at multiple levels in younger individuals (40s) who lack major degenerative changes (*aging on imaging*). These individuals typically have congenital spinal stenosis, most commonly due to unusually short pedicles[9]. In jurisdictions with rules on "*lighting up asymptomatic pre-existing*" disease may permit this type of lumbar stenosis to be treated and rated in the workers' compensation system. In other jurisdictions, like Tennessee, that now use a "primarily"[5] or ">50% of causation" standard, the individual with no injury incident, or with symptom onset during normal activity (*no violent incident expected to injure most people*) the rules should logically exclude this diagnosis from the workers' compensation system.

Much more commonly, lumbar spinal stenosis is seen in older individuals, in their 60s, 70s, or 80s. As Americans stay in the workforce at older ages, this will become more common in individuals who still work. In these individuals, lumbar flexion opens up the neural foramina, and lumbar extension closes up the foramina. Thus the already somewhat ischemic ("stretched") nerve root is less symptomatic during flexion. Over time the individual adopts a posture to minimize symptoms, and the posture of lumbar flexion (*loss of lumbar lordosis*) may become fixed. Activities that maintain lumbar flexion are more comfortable, like walking uphill, bicycling, leaning over a shopping cart, etc. In more severe cases the leg pain becomes more severe, and leg muscle weakness may develop as level ground walking continues. This progressively increasing leg pain as walking continues is termed "*neurogenic claudication.*" Vascular claudication from peripheral arterial disease is a similar symptom.

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Medical Impairment Rating Registry

Tennessee Department of
Labor and Workforce Development

Division of Workers' Compensation

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If the symptom of claudication is present, the examiner must rule out vascular claudication with some combination of physical exam[10] findings (*limb bruits, pedal pulses, foot color with elevation and dependency, hair pattern, infra-red foot skin temperature, ankle-brachial index, or vascular surgery consult*). If there is no clear basis for vascular claudication, the claudication symptom can be assumed to be either neurogenic or psychosomatic.

If the IME physician has excluded vascular claudication, and the choice of "diagnosis" to be used for AMA *Guides, 6th Edition* impairment rating includes from Table 17-4 both "Non-specific chronic or chronic recurrent low back pain" (page 570) and "Spinal Stenosis" (page 571), the examiner needs to look for current or prior medical record evidence of objective neurologic deficit. Note that the diagnosis of spinal stenosis in Table 17-4 has the footnote "a" referring the reader to the bottom of page 571. Here it is stated that there should be consistent objective findings of radiculopathy at the appropriate level when most symptomatic. This is consistent with the current literature on diagnosing stenosis.If there is objective evidence of radiculopathy on physical exam, then "most symptomatic" can be now, and the impairment can be rated using the "stenosis" diagnosis.

If there is no current objective evidence of radiculopathy on physical exam, but prior medical records (*for example before decompressive surgery*) consistently document neurologic deficit on the side and at the level of the stenosis, then the impairment can be rated using the "stenosis" diagnosis.

If medical records do not consistently document objective physical exam or needle EMG evidence of radiculopathy, then usually the impairment rating would default to using the "non-specific chronic low back pain" row on page 570 of Table 17-4, and the imaging findings that lack clinical correlation would be considered unrelated aging change.

In the difficult situation in which neither medical records nor current physical exam document any objective findings to potentially correlate with imaging, but the individual has had a spinal stenosis decompression surgery, the examiner must use judgment and

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make a "best guess" as to whether or not significant stenosis was actually present pre-operatively. If dramatic improvement occurred from surgery, this would suggest stenosis was in fact present pre-operatively[11]. If no improvement occurred, the examiner should consider whether this reflects that the pre-operative diagnosis of stenosis was not correct, and whether the "non-specific chronic low back" diagnosis should be used for impairment rating.

If the diagnosis of spinal stenosis is selected as the most appropriate causally related diagnosis for impairment rating, the next step is to assess Grade Modifiers.

The Grade Modifier Functional History is selected as usual, with no modification.

The Class Selection and Grade Modifier Physical Exam selection requires some comment. The objective evidence of radiculopathy versus non-verifiable radicular complaints definitions of page 576 require the examiner to document the results of Sharp versus Dull perception. This is not "It feels odd when you poke with the pin" but rather this means with eyes closed the examinee cannot tell whether the sharp stimulus or the dull stimulus is applied to a dermatome-like area. This would be Grade 3 physical exam sensory deficit in Table 17-7 (page 576). If the examinee did not even know when he or she was being "poked with the pin" (*sharp stimulus applied*), this would be Grade 4 sensory loss, or loss of protective sensation.

On physical exam, the individual with stenosis should be asked to walk in the hallway of the examiner's office. The distinction between classes in Table 17-4 may depend on the results of watching the individual walk. Having the individual walk while a pulse oximeter is attached to a finger allows the examiner to assess time walked, distance covered, pulse rate increase with this degree of exercise, and

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the presence or absence of oxygen desaturation during walking. Individuals who can walk > 10 minutes are consistent with Class 2 criteria in Table 17-4 (page 571). Individuals who walk < 10 minutes because of leg pain (***not*** *chest pain,* ***not*** *fatigue,* ***not*** *dyspnea,* ***not*** *arthritic knee pain, etc.*) are consistent with Class 3. Class 4 may suggest that a wheel chair or electric "scooter" is required for ambulation. In Tennessee the criteria for a handicapped license plate on a motor vehicle is physician attestation that the individual cannot walk 200 feet. If < 200 feet of ambulation ability is documented on the impairment rating exam, that could be accepted as the equivalent of Class 4, with documentation in the impairment rating report of this rationale.

Note that many abnormal gait patterns are not physiologic, but are either consciously feigned or are unconsciously produced by somatization disorders. These gaits tend to normalize during 10 minute observed walks, while gaits due to objectively documented pathology tend to worsen with sustained walking.

If apparent neurogenic claudication develops during this 10 minute observed gait, the individual should be immediately examined for motor weakness and sensory loss, as walking to the point of claudication means the nerve root becomes more ischemic, and objective neurologic deficit not present at rest may be documentable after this level of exercise.

The Grade Modifier Clinical Studies would not be used in lumbar spinal stenosis. The imaging must show at least some of the above literature review of imaging findings of stenosis, and thus imaging would have been used in diagnosis selection and Class placement, and would not be used as a Grade Modifier, unless it showed surgical complications.

In summary, use of the lumbar spinal stenosis diagnosis for AMA *Guides, 6th Edition* impairment rating requires considerable thought, careful and complete physical examination, and a thorough review of medical records. If possible, the actual MR images on CD should be obtained and reviewed, as there is a wide variation among radiologists in the criteria for the diagnosis of stenosis and for grading its severity.

LUMBAR SPINAL STENOSIS

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[1]Fardon DF, Williams, AL, Dohring EJ, et al. Lumbar disc nomenclature: version 2.0: Recommendations of the combined task forces of the North American Spine Society, the American Society of Spine Radiology and the American Society of Neuroradiology. The Spine Journal 14 (2014) 2525–2545

[2]Brinjikji W, Luetmer PH, Comstock B. et al. Systematic literature review of imaging features of spinal degeneration in asymptomatic populations. AJNR 2015 Apr;36(4):811-6. doi: 10.3174/ajnr.A4173.

[3]Kim SJ, Lee TH, Lim SM. Prevalence of Disc Degeneration in Asymptomatic Korean Subjects. Part 1: Lumbar Spine. JKNS 2013; 53: 31-8.

[4]de Schepper EIT, Overdevest GM, Suri P, et al. Diagnosis of Lumbar Spinal Stenosis: *An Updated Systematic Review of the Accuracy of Diagnostic Tests* Spine 2013 ;38:E469–E481

[5]TN Public Chapter 289 for date of injury on or after July 1, 2014

[6]Andreisek G, Imhof M, WErtli M, et al. A systematic review of semiquantitative and qualitative radiologic criteria for the diagnosis of lumbar spinal stenosis. AJNR 2013; 201: W735-46.

[7]Mamisch N, Brumann M, Hodler J, et al. Radiologic Criteria for the Diagnosis of Spinal Stenosis: Results of a Delphi Survey. Radiology 2012: 264: 174-9.

[8]Lurie JD, Tosteson AN, Tosteson TD, et al. Reliability of Readings of Magnetic Resonance Imaging Features of Lumbar Spinal Stenosis. Spine 2008; 33 (14): 1605-10.

[9]Singh K, Samartzis D, Vaccaro AR, et al. Congenital lumbar spinal stenosis: a prospective, control-matched cohort radiographic analysis. The Spine Journal 2005; 5: 615-22.

[10]Khan NA, Rahim SA, Anand SS, et al. Does the Clinical Examination Predict Lower Extremity Peripheral Artery Disease? JAMA 2006; 295 (5): 536-46

[11]Park DK, An HS, Lurie JD, et al. Does Multilevel Lumbar Stenosis Lead to Poorer Outcomes? A subananalysis of the Spine Patient Outcomes Research Trial (SPORT) Lumbar Stenosis Study. Spine 2010; 35 (4): 439-46.

THE 18TH ANNUAL TN WORKERS' COMPENSATION EDUCATION CONFERENCE: JUNE 6-10, 2015

AMA GUIDES, 6TH ED., IMPAIRMENT RATING COURSE: JUNE 6, 2015

The Nashville Airport Marriott
600 Marriott Drive, Nashville TN 37214
(615) 889-9300

The Tennessee Division of Workers' Compensation and the International Workers' Compensation Foundation are jointly sponsoring an Educational Conference, unique to Tennessee, at the Nashville Airport Marriott on June 6-10, 2015. The goal of this conference is to educate those who participate in the Tennessee workers' compensation system regarding current and pending rules, procedures, policies, and forms, and to provide an opportunity for dialogue among these participants.

This year's program includes additional sessions on the AMA *Guides*, 6th Edition, and on medical topics of particular importance for physicians, attorneys, and their accompanying medical staff.

- The Saturday, June 6, 2015, AMA *Guides* course meets the training requirements for physicians seeking appointment to the Medical Impairment Rating Registry.

- The Sunday, June 7, 2015, course meets Public Chapter 430, Title 63, requirements for physician continuing education in Controlled Substance Prescribing for re-licensure by 2016.

- The American Academy of Disability Evaluating Physicians (AADEP) designates a maximum of twelve AMA PRA Category 1 Credits™ for these weekend courses.

A block of rooms has been reserved at the Nashville Airport Marriott at the conference rate of $165, single or double. To reserve call (615) 889-9300. The rooms will be held through May 15, 2015, unless this block becomes fully reserved prior to this date. Individually, the Saturday or Sunday course is $250 if you register before May 1, 2015, and $275 if you register after May 1, 2015. Jointly, the Saturday and Sunday courses are $425 if you register before May 1, 2015, and $475 if you register after May 1, 2015. To register on-line click HERE. To register by mail click HERE.

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THE 18TH ANNUAL TN WORKERS' COMPENSATION EDUCATION CONFERENCE : JUNE 6-10, 2015

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WEEKEND AGENDA

SATURDAY, JUNE 6, 2015

10:00AM—10:20AM Registration

10:20AM—10:30AM Pre-test

10:30AM—11:00AM Welcome/ Introduction to the TN Medical Impairment Rating Registry (MIRR). Jay Blaisdell, CEDIR, MIRR Program Coordinator.

11:00AM—11:30AM Introduction to the AMA Guides, 6th Edition, Chapters 1—2: Definitions and Philosophies. James Talmage, MD, FAADEP, Assistant Medical Director.

11:30AM—12:30PM Chapter 17: The Spine and Pelvis. Jeffrey Hazlewood, MD, Assistant Medical Director.

12:30PM—1:00PM Lunch (provided)

1:00PM—2:00PM Chapter 15: The Upper Extremity. James Talmage, MD, FAADEP.

2:00PM—3:00PM Chapter 16: The Lower Extremity. Jeffrey Hazlewood, MD.

3:00PM—3:15PM Break

3:15PM—4:15PM Chapter 13: Central and Peripheral Nervous System. Chapter 14: Mental Disorders and Pain. James Talmage, MD, FAADEP.

4:15PM—5:00PM How to Complete the MIR Report Form/Common Errors Seen in MIR Reports. Q&A. James Talmage, MD, FAADEP. Jeffrey Hazlewood, MD.

5**:00PM—5:15PM** Post Test

5:15 PM Recess

SUNDAY, JUNE 7, 2015

7:30AM—8:00AM Continental Breakfast

7:50AM Introduction and Welcome. Robert Snyder, MD, Medical Director.

8:00AM—9:00AM Causation: One Year Later. Analysis of the Impact of the Most Recent Reforms. James Talmage, MD, FAADEP.

9:00AM—10:00AM All Things UR: The Utilization Review Appeals Process: The Hows and the Whys. Robert Snyder, MD.

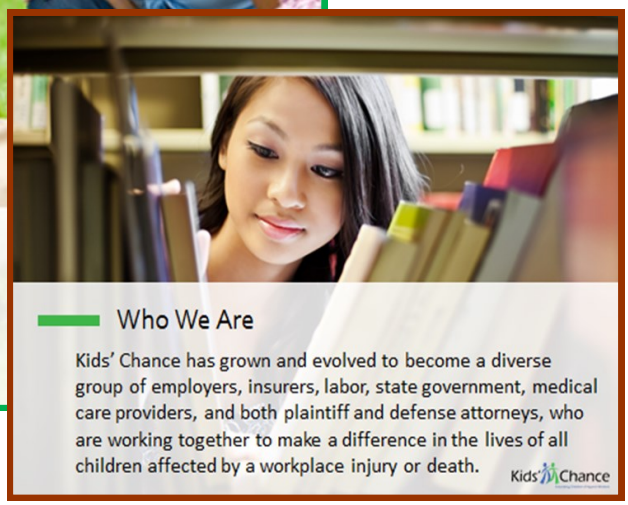
10:00AM—10:15AM Break

10:15AM—12:15PM Multi-Disciplinary Programs and New Approaches to the Management of Chronic Pain in Workers' Compensation. Jeffrey Hazlewood, MD. Sushil Mankani, MD. Mitchell Mutter, MD.

12:15PM—12:45PM Lunch (provided)

12:45PM—1:45PM Accurate Assessment of Return-to-Work, Restrictions and Limitations. James Talmage, MD, FAADEP.

1:45 PM—2:00PM Panel Discussions and Q&A. Robert Snyder, MD. James Talmage, MD, FAADEP.



Prior to the start of this year's Workers' Compensation Educational Conference, there will be a 5K Benefit Run and Fun Walk for Kids' Chance of Tennessee (TN). Kids' Chance of TN is a 501(c) organization dedicated to helping kids who need assistance for college because a parent or legal guardian has been fatally or catastrophically injured in a work-related accident.

The run/walk will be staged at the Nashville Airport Marriott and will begin at 8:00AM on June 6th. Race management and chip timing for this certified course will be provided by the Nashville Striders. Sponsorship opportunities include placement of company logos on the shirts provided to the participants and on the banner which will remain posted during the Educational Conference. Additional information for sponsoring this event is available by clicking HERE.

Walkers and joggers may register ON-LINE. Awards will be given to the top finishers in designated age groups including some for children. Volunteers are welcome.

Please consider taking this opportunity to show your support for Tennessee dependents of workers who have paid such a high price for doing their job.

Questions may be submitted to

kidschanceoftn5k@gmail.com .

Kids' Chance
Educating Children of Injured Workers

5K Benefit Run & Fun Walk

Hosted by TN Self Insurers' Assoc & TN Division of Workers' Compensation

When: Saturday, June 6th, 2015 @ 8:00 am
Where: Nashville Airport Marriott - 600 Marriott Drive Nashville

SPONSORSHIP LEVEL OPTIONS	
$2,500 Platinum Sponsor	➢ Company logo on race day shirts ➢ Vendor display table at race ➢ Signage on event day ➢ 10 FREE Race Registrations
$1,500 Gold Sponsor	➢ Company logo on race day shirts ➢ Signage on event day ➢ 6 FREE Race Registrations
$1,000 Silver Sponsor	➢ Company logo on race day shirts ➢ Signage on event day ➢ 4 FREE Race Registrations
$500 Bronze Sponsor	➢ Company logo on race day shirts ➢ 2 FREE Race Registrations
$350 H_2O Station Sponsor	➢ Company name on race day shirts ➢ Company logo on sign at water station ➢ 1 FREE Race Registration
$250 Shirt Sponsor	➢ Company name on race day shirts ➢ 1 FREE Race Registration

Return this form and payment to:

Kids' Chance of TN
Attn: Dawn Trojan
P.O. Box 1125
Brentwood TN 37024

Email Logo by May 17th to:

KidsChanceofTN5K@gmail.com

Each walker/runner needs to register online at:

http://www.active.com/nashville-tn/running/distance-running-races/kids-chance-5k-benefit-run-and-fun-walk-2015

Sponsor Name:	
Contact:	
Email:	
Cell Phone:	
Sponsorship Level:	

Check for $_____ payable to Kids' Chance of Tennessee (Tax ID#76-0744054) is enclosed.

Kids' Chance of Tennessee is a 501(c)3 non-profit organization dedicated to helping kids who need assistance for college because a parent or legal guardian has been fatally or catastrophically injured in a work-related accident.

MIRR PHYSICIAN SPOTLIGHT CLAIBORNE A. CHRISTIAN, M.D.

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ers Compensation Physician Fee Schedule. He has served on the MIRR since the program started in 2005.

Dr. Christian's wife, Rita, is a Registered Nurse and former Certified Case Manager. Her involvement in Workers' Compensation cases sparked Dr. Christian's interest in occupational medicine. Together they have established a thriving practice, whether serving the people of Huntingdon, Southaven, or the surrounding areas. Their personal interests include spending time at their lake home in Heber Springs, Arkansas, golfing, boating and reading.

ORTHOMEMPHIS
7085 Clarington Cove, Southaven MS 38671

THE MIRR IS NOW ACCEPTING PHYSICIAN APPLICATIONS IN THE FOLLOWING AREAS OF EXPERTISE:

1) Orthopaedics
2) Occupational Medicine
3) Physical Medicine and Rehabilitation
4) Neurology
5) Internal Medicine
6) Ophthalmology
7) Otolaryngology
8) Cardiology
9) Pulmonology
10)Psychiatry

Click HERE for an application.

The TDLWD is an equal opportunity employer/program; auxiliary aids and services are available upon request.