



The AdMIRable Review

MIRR PHYSICIAN SPOTLIGHT Bruce W. Randolph, M.D., M.P.H.

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Bruce W. Randolph, MD, MPH, has served with distinction on the Medical Impairment Rating Registry since its start in 2005. With competencies in virtually all the chapters of the *AMA Guides to the Evaluation of Permanent Impairment* in the 5th and 6th Edition, he is one of the most versatile physicians on the registry.

Specializing in disability and impairment evaluation, Dr. Randolph established Randolph Occupational Medicine Services (www.roms-memphis.com) in 2002. He received his Doctor of Medicine Degree from the University of Florida's College of Medicine in 1984 and his Master of Public Health Degree



Bruce W. Randolph, MD, MPH

from Johns Hopkins University School of Public Health in 1989. He received residency training in Family Medicine at the University of Arkansas, General Preventive Medicine at Johns Hopkins University, and Occupational Medi-

MIRR PHYSICIAN SPOTLIGHT Bruce W. Randolph, M.D., M.P.H.

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“In 2007, he founded Issa Ministries, Inc. (www.issaministries.com), a nonprofit religious corporation which promotes holistic health and wellness through education, counseling, mentoring, and evangelism.”

cine at the University of Oklahoma. He became board certified in Occupational Medicine in 1999 and was recertified in 2009. He is currently licensed to practice medicine in Mississippi, Tennessee, Arkansas, and Oklahoma. He has been practicing medicine for 28 years.

Dr. Randolph is a native of Live Oak, Florida. He was born August 24, 1958, to Lucille Randolph and Perman Randolph, Jr. Upon graduating from Suwannee High School (Live Oak, Florida) in 1976, he attended Tuskegee Institute (now Tuskegee University) on a football scholarship. He graduated *summa cum laude* from Tuskegee University in 1980 with a Bachelor of Science Degree in Biology.

Dr. Randolph is also an ordained Gospel Minister. In 2007, he founded

Issa Ministries, Incorporated, (www.issaministries.com), a nonprofit religious corporation which promotes holistic health and wellness through education, counseling, mentoring, and evangelism. He is currently serving as Associate Pastor at Rufus K. Young Christian Church in Little Rock, Arkansas.

Dr. Randolph has been married to his wife, Mildred, for 34 years. They have three children: Khari, Kobie, and Trinity.

Medical Impairment Rating Registry

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PAIN IMPAIRMENT GUIDELINES

Robert B. Snyder, MD

James B. Talmage, MD

Jay Blaisdell, CEDIR



The new workers' compensation legislation that becomes effective for injuries occurring on or after July 1, 2014 directly affects how physicians will issue medical impairment ratings. Of particular note is Tennessee Code Annotated 50-6-204 (k) (2), which is as follows: ***"The treating physician or chiropractor shall assign impairment ratings as a percentage of the body as a whole and shall not consider complaints of pain in calculating the degree of impairment, notwithstanding allowances for pain provided by the applicable edition of the AMA guides as established by this chapter."***

MIR physicians have always converted MIR ratings to a percentage of a body as a whole

(BAW), so this aspect of the new legislation will not require you to make changes in your MIR Reports other than being aware that this practice derives from state law rather than the MIR Report template. The provision of the law regarding pain, however, requires you to make more significant changes in your derivation of medical impairment ratings.

Since the *AMA Guides* sometimes requires you to consider pain when assessing impairment, and Tennessee law, as of July 1, 2014, precludes it, physicians might be in a quandary as to how to proceed. Ultimately an administrative judge will decide precisely how this law is interpreted.

For now, the Medical Director of the Tennessee Division of Workers' Compensation is making the following suggestions that might help you. These recommendations apply to the *AMA Guides*, 6th Edition, and are for injuries that occur on or after July 1, 2014. Injuries before this

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time are regulated by state law that was in effect on the date of injury.

I) Do not use Chapter 3. This is the pain chapter and is rarely used even under current law.

II) When rating nerve injuries, rely on sensory deficit as opposed to pain assessment. For example, on page 532 in section 16.4 “Peripheral Nerve Impairment” under the subsection “Sensory Deficits,” it says,

Sensory deficits are evaluated according to the following criteria:

1. How does the sensory deficit or pain interfere with the individual’s performance of daily activities?

2. To what extent does the sensory deficit or pain follow the defined anatomic pathways of the peripheral nerve?

3. To what extent is the description of the sensory deficit or pain consistent with characteristics of peripheral nerve disorders?

4. To what extent does the sensory deficit or pain correspond to other disturbances (motor, trophic, vasomotor, etc) of the involved nerve structure?

Under the new law, the evaluator will consider only sensory deficit (loss of sensation) within these criteria, not complaints of pain.

III) Do not consider complaints of pain in determining the functional history grade modifier. Instead, rely on concepts such as how limited motion and motor weakness limit function. Thus, in the musculoskeletal chapters, if function is limited by pain and not by other factors, there would be no use of the Grade Modifier Functional History (GMFH). If walking tolerance or lifting and carrying tolerance were limited by pain, that would not be a basis to use the GMFH; however, if due to loss of median nerve sensation a person had verifiable difficulty buttoning buttons when dressing, the GMFH could be used to reflect the Activities of Daily Living (ADL) difficulties.

IV) Use the default value when using one of the non-specific chronic spinal pain diagnoses. By definition, these diagnoses have no applicable

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physical examination or clinical studies modifiers and rely exclusively on the Grade Modifier Functional History (p.563). Since pain is no longer a consideration in choosing a rating, the most straightforward approach to issuing an impairment with these diagnoses is to use the default value within impairment class 1. This new workers' compensation law section is not a law about causation or diagnosis, but rather is a law about impairment rating. Thus this may lead to the seemingly paradoxical situation of the rating physician feeling the back or neck pain is likely to be real and to be function limiting, choosing the non-specific chronic spinal pain diagnosis row (the first row in Tables 17-2, 17-3, and 17-4), and then not being able to use pain severity to choose a Grade within the Class.

V) Do not use the Pain Disability Questionnaire (PDQ). Thirteen of the 15 questions are exclusively about pain.

VI) Do not use the QuickDASH in rating upper limb impairments, either in Table 15-7 or in Table 15-23. Questions #9 and # 11 are

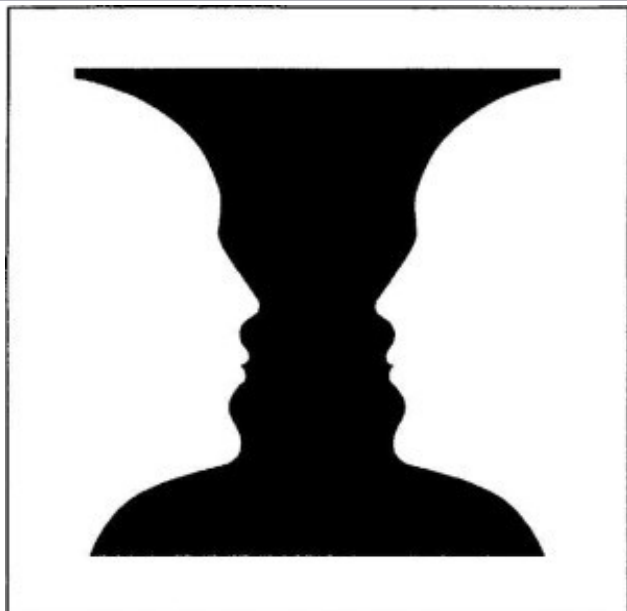
exclusively about pain and therefore cannot be used. Since the QuickDASH states that it can only be meaningfully scored and used if at least 10 of the 11 questions are answered by the individual, the whole QuickDASH cannot be used. In peripheral nerve entrapments, Table 15-23 requires use of the QuickDASH at the final step to choose one of the three potential numbers in each Class. In peripheral nerve entrapments, omit the final step of using the QuickDASH to select a rating from the Class and instead pick the middle integer from the list of 3 potential ratings in the appropriate Class. This is equivalent to picking the "default impairment."

If you have any questions regarding these guidelines, please feel free to call Robert B. Snyder, MD, Division Medical Director, at 615-532-8700, or James B. Talmage, MD, Division Assistant Medical Director 931-526-1604.

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THE AMA GUIDES: A MATTER OF INTERPRETATION?

Jay Blaisdell, CEDIR



The title of the book that we all know and love, the *Guides to the Evaluation of Permanent Impairment*, 6th Edition, suggests to many physicians that the *AMA Guides* is just that: a guide that serves as a starting point. Independent medical evaluators of this persuasion might, for instance, place an L4-5 disk herniation in impairment class 2 because they are of the opinion that severely-impaired Activities of Daily Living justify a higher class, even though the patient does not exhibit radiculopathy at the clinically appropriate level as the regional grid on page 570 stipulates. These same evaluators might be of the opin-

ion that the ultimate authority in any given impairment rating is an experienced physician's professional discretion, not a book.

On the other side of the spectrum, we have physicians who are of the opinion that the authors of the *AMA Guides* delivered wisely on a methodology that, while imperfect, is the best approach the medical community has to date. Independent medical evaluators of this persuasion believe that the *AMA Guides* should be followed strictly, precisely, not more, less, generally, or implicitly. In a clinical setting, given the same L4-5 disk herniation, these physicians might expound for a few paragraphs on the steps implemented to keep the sensory test as objective as possible, and only then, when sensation is clinically proven to be only minimally abnormal within a reasonable degree of medical certainty, place the patient in impairment class 1 because radiculopathy is not present, only nonverifiable radicular complaints per page 576.

Both points of view offer a valuable contribution to the discussion because, on one hand,

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we must acknowledge that impairment ratings require physicians to make subjective judgment calls that rely exclusively on individual experience and expertise. On the other hand, impairment ratings also require adherence to state law as well as deference to agreements made by the wider medical community (as represented here by the American Medical Association) and a comprehensive methodology established through decades of research and revisions. The question before us, then, is a question of degree, not whether to accept one point of view over the other. The purpose of the *AMA Guides* is to promote a system, which if followed, results in multiple physicians having the same rating for a single person, which translates into patients with very similar clinical presentations receiving the same rating in Memphis as they do in Bristol, TN.

When issuing impairment ratings, MIR Physicians should use judgment for those questions requiring judgment and methodology for those issues requiring methodology (when

methodology is explicitly stated in the *Guides*). Knowing whether a question falls into the sphere of judgment or methodology requires thorough and practiced knowledge of the *AMA Guides*.

The very purpose of the Medical Impairment Rating Registry is to rely less on unpredictable experienced-based decisions—that is, judgments—and more on the standardized, evidenced-based methods of physicians who faithfully apply the *AMA Guides*. Your opinion as an MIR Physician has a presumption of legal accuracy, in part, because 1) you have had specialized training in the *AMA Guides*, 2) you are required to disclose the exact methodology used, 3) you are impartial to the employer and employee, and 4) your opinion is subject to peer review. All of these factors combine to create more predictable and objective results in accordance with the *AMA Guides*.

With this in mind, an MIR Physician should rely on methodology, as prescribed by the *AMA*

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Guides, whenever possible. If the diagnosis is not covered in the *AMA Guides*, the physician should use professional experience to rate by analogy. In no circumstances should an MIR Physician override the methodology found in *AMA Guides* with one's own rationale. To do so is to step out of your role as an MIR Physician. Unless indicated otherwise by state law, the *AMA Guides* should be followed exactly.

In a treatment setting, for example, a physician may aptly diagnose radiculopathy without having performed a sensory test. In an impairment rating setting, however, the *AMA Guides*, 6th Edition, requires the evaluator to perform a sensory test to distinguish radiculopathy from nonverifiable radicular complaints (p.576). The reliability and results of the sensory test require solid clinical judgment and experience; however, if the MIR physician chooses not to perform the sensory test, the MIR Report might be rebutted by clear and convincing evidence to the contrary, as the *Guides* methodology was not followed.

Similarly, in a treatment setting, a physician may aptly diagnose carpal tunnel syndrome without consulting an EMG; however, when evaluating for impairment, the MIR physician must consult Appendix 15-B, Electrodiagnostic Evaluation of Entrapment Syndromes, on page 487 to make the diagnosis. If the diagnosis is used without meeting the criteria in Appendix 15-B, the MIR Report might be overcome by clear and convincing evidence to the contrary, as the *Guides* methodology was not followed.

While the Division of Workers' Compensation cannot assist you with judgment calls, we are one of many resources for questions on *AMA Guides* methodology. General questions regarding the *AMA Guides* may be directed to James B. Talmage, MD, Assistant Medical Director: James.Talmage@tn.gov or 931-526-1604. Other resources include the *AMA Guides Newsletter*, the American Academy of Disability Evaluating Physicians, and the American Board of Independent Evaluators.

AMA GUIDES, 6th EDITION TRAINING SEMINAR



The Medical Impairment Rating Registry (MIRR) and the American Academy of Independent Medical Evaluators (AADEP) are co-sponsoring a summer training seminar in the *AMA Guides*, 6th Edition on Friday and Saturday, August 22-23, 2014, in Memphis. This training will meet requirements for physicians wishing to apply for appointment to the MIRR and for existing MIR Physicians who wish to reinforce their knowledge. Participants will receive 9.0 AMA PRA Category 1 Credits.

Friday evening, August 22, 2014, at 6:30 PM, Robert B. Snyder, MD, Medical Director of the Division of Workers' Compensation, will be presenting on the 2013 Tennessee Workers' Compensation Reform Act that goes into effect July 1, 2014. This new legislation makes

several changes in workers' compensation law, including matters of causation, MMI, pain management, permanent impairment ratings, administrative procedure, and panel rules. Treatment guidelines that go into effect January 1, 2016, will also be discussed. Saturday, Division Assistant Medical Directors James B. Talmage, MD, and Jeffrey E. Hazlewood, MD, will teach the musculoskeletal, nervous system, and mental disorder chapters. As the MIRR Peer Review Physician, Dr. Talmage will also offer instruction on how to complete an MIR Report and point out common errors that he sees. A question and answer session will follow.

The seminar will take place at the Marriott Memphis East, 5795 Poplar Avenue, Memphis, TN 38119. You will be able to receive the room rate of \$99 through August 15, 2014 as long as you mention AADEP. Please call 800-228-9290 or 901-682-0080 to make your hotel reservations. To register for the seminar, please click [HERE](#). If you have colleagues who might be interested in the MIRR, CME credit, or learning about the new legislation, please bring them along.

AMA GUIDES, 6th EDITION, IMPAIRMENT RATING COURSE

MIRR/AADEP
SATURDAY, AUGUST 23, 2014

MARRIOTT MEMPHIS EAST, 5795 Poplar Avenue, Memphis, TN 38119

9.0 AMA PRA Category 1 Credits™

- 7:30 am PRE-TEST
- 8:00 am **Welcome/Introduction**
TN Medical Impairment Rating Registry
Jay Blaisdell, MA, CEDIR, MIRR Program Coordinator
- 8:30 am **Introduction to the AMA Guides, 6th Edition**
Chapters 1 & 2: Definitions and Philosophies
James Talmage, MD, FAADEP
- 9:00 am **Chapter 17: The Spine and Pelvis**
Jeffrey Hazlewood, MD
- 10:00 am **BREAK**
- 10:15 am **Chapter 15: The Upper Extremity**
James Talmage, MD, FAADEP
- 11:30 am **LUNCH (ON YOUR OWN)**
- 12:30 pm **Chapter 16: The Lower Extremity**
Jeffrey Hazlewood, MD
- 1:30 pm **Chapter 13: Central and Peripheral Nervous System**
Jeffrey Hazlewood, MD
- 2:30 pm **Chapter 14: Mental Disorders and Pain**
James Talmage, MD, FAADEP
- 3:00 pm **BREAK**
- 3:15 pm **How to Complete the MIR Report Form/Common Errors Seen in MIR Reports**
James B. Talmage MD, FAADEP
- 4:30 pm **Questions and Answers**
James Talmage, MD, Jeffrey Hazlewood, MD, Jay Blaisdell
- 4:45 pm **POST-TEST**
- 5:00 pm **RECESS**



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 *

* East and West TN Only



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