



The AdMIRable Review

MIRR PHYSICIAN SPOTLIGHT H. JAMES WIESMAN, MD

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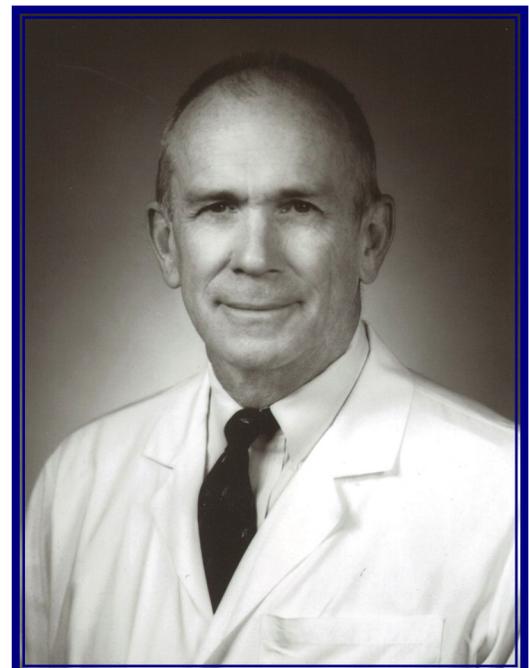
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H. James Wiesman, M.D., has been an active and steadfast member of the Medical Impairment Rating Registry since 2005. His attendance at multiple AMA *Guides* training events helps him produce MIR reports that routinely exceed expectations. His work is methodical, comprehensive, and well supported, making it resilient to even the highest levels of judicial scrutiny.

Dr. Wiesman practices orthopaedic surgery at the Columbia Orthopedic Clinic in Columbia, TN, and Maury Regional Hospital, where he currently serves as the Director of Physical Medicine. His practice interests include arthroscopic surgery of the knees and shoulders, total joint replacement, hand surgery, and the noninvasive treatment of axial and radicular spine problems. Other areas of interest are independ-



H. JAMES WIESMAN, MD

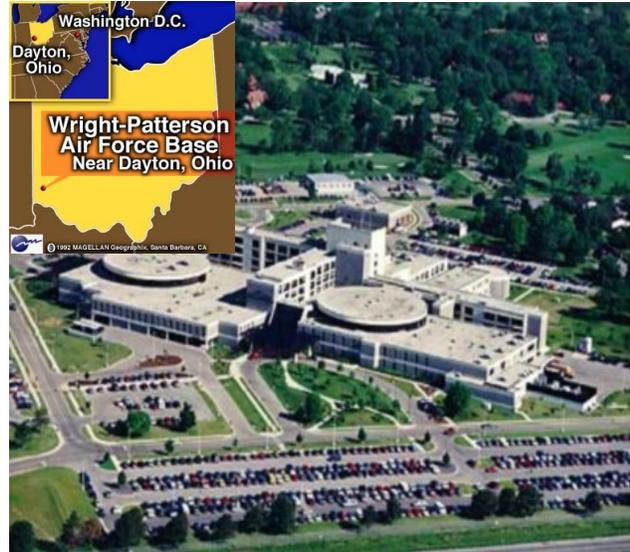
ent medical exams, disability exams, and medical legal problems. Through physical rehabilitation, therapeutic, and preventive programs, Dr. Wiesman attempts to influence the lifestyle of patients toward a more functionally sound existence. He is board certified in orthopedic surgery, a fellow of the American Acade-

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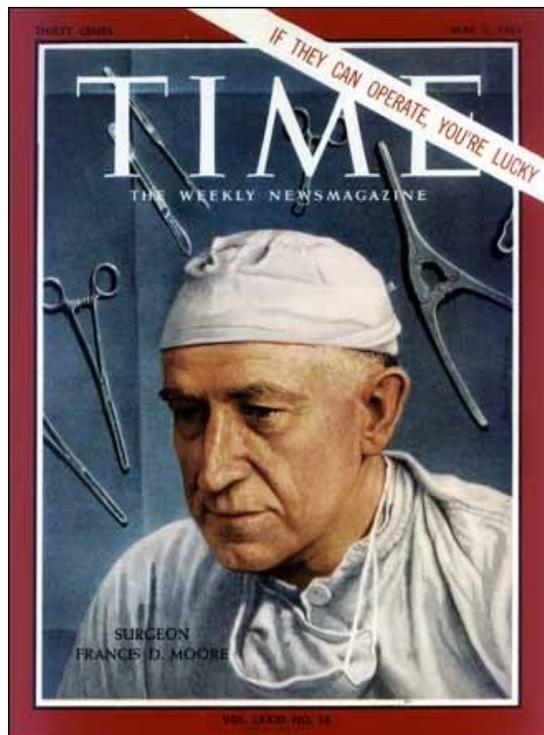
my of Orthopaedic Surgeons, a member of the American Association of Disability Examining Physicians, and certified by the American Board of Independent Medical Examiners.

Dr. Wiesman was born and raised in Evansville, IN, in the “southern Midwest.” He received a Bachelor of Arts from Vanderbilt University and a medical degree (MD) from Vanderbilt University School of Medicine. After medical school, Dr. Wiesman spent two years in a general surgery internship in residency under Dr. Francis D. Moore at the



Peter Bent Brigham Hospital in Boston, MA. He then completed the Harvard Orthopedic Surgery residency under Henry Mankin, MD, Clement Sledge, M.D. and John Hall, M.D., working in the Massachusetts General Hospital, the Brigham Hospitals, and was chief resident at Boston Children’s Hospital. At the completion of his residency he won the Harvard Orthopaedic Residency Thesis prize and was awarded the Boston Orthopedic Club Resident medal. He then served two years as a Major and orthopaedic surgeon in the United States Air Force at Wright-Patterson Air Force Base near Dayton, OH.

“Dr. Wiesman spent two years in a general surgery internship in residency under Dr. Francis D. Moore at the Peter Bent Brigham Hospital in Boston, MA.”



Dr. Wiesman’s interests outside of his practice include fly fishing, landscape painting, classical

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CARDIOVASCULAR IMPAIRMENTS

James B. Talmage, MD
Jay Blaisdell, CEDIR



The overwhelming majority of MIR referrals utilize the musculoskeletal chapters of the *AMA Guides*, 6th Edition. Consequently, MIR Physicians may not be as familiar with the rating scheme presented in the internal medicine chapters. A closer look at Chapter 4, “The Cardiovascular System,” can help illustrate differences between the two schemes and provide an illustration of the internal medicine chapters as a whole. Every internal medicine chapter is different, but many elements are consistent. Cardiovascular problems are uncommonly caused by work, so this chapter is not commonly used in workers’ compensation cases.

While grids in the musculoskeletal chapters are named by regions of the back and extremities, cardiovascular grids are named by diagnosis. A diag-

nosis is listed at the top of the each grid rather than having multiple diagnoses listed down the left column, as they are in the regional musculoskeletal grids. For the purpose of assessing medical impairments, the *AMA Guides* divides cardiovascular diseases into eight groups, or umbrella diagnoses, each with its own grid: Valvular Heart Disease, Coronary Artery Disease, Cardiomyopathies, Pericardial Heart Disease, Dysrhythmias, Hypertensive Cardiovascular Disease, Vascular Diseases Affecting the Extremities, and Diseases of the Pulmonary Artery.

Within these grids, the rows are divided into three main impairment variables: History, Physical Findings, and Objective Test Results. These variables serve the same purposes of the Functional History, Physical Examination, and Clinical Studies Grade Modifiers of the musculoskeletal chapters respectively, but with a few important differences. In the musculoskeletal chapters, the Clinical Studies grade modifier (GMCS) is not applicable if objective test results are used to place the injury in its impairment class. Otherwise the same information would be incorporated into the impairment twice. In cardiovascular impairments, however, objective test results

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are always used to place the injury in its impairment class; therefore, objective tests are never used to modify the rating once the evaluator chooses the impairment class. Consequently, there are only two variables to modify the default value, History and Physical Findings, not the customary three grade modifiers found in the musculoskeletal chapters. This is determined by following the footnote for “Objective Test Results” in each of the eight grids in this chapter, that labels the Test Results as the “key factor.” In the Internal Medicine chapters (except for the Central Nervous System and the Mental Disorders chapters) the key factor is identified in each Table or Grid, and the Key Factor determines the Class.

The *Guides* names the “Objective Test Results” variable as the “key factor” to underscore its role in assigning the impairment class in the cardiovascular chapter. The *Guides* names the remaining History and Physical Findings variables as “non-key” factors, rather than grade modifiers, though they still modify the grade. In other internal medicine chapters, the key factor could be a variable other than Objective Test Results. In the digestive system chapter, for example, the key factor for liver disease is History while Physical Findings and Objective Test Results are considered

non-key factors. In all internal medicine chapters, however, the key factor is always used to place the impairment in its class, and the non-key factors are used to modify the grade.

There is no explicit “Net Adjustment Formula” in the cardiovascular system chapter, but the basic principles of the formula still apply. The “impairment class” integer is subtracted from each “grade modifier” or “non-key factor” integer and the differences are added for a net adjustment. The default grade is “C,” which is in the middle of the five possible grades in this chapter. A positive adjustment moves the final grade to the right of the default grade. A negative adjustment moves the final grade to the left of the default grade. Even if the net adjustment is more than the number two, it may never move the impairment rating into another impairment class. If the impairment class is “Class 4,” the evaluator adds +1 to each non-key factor integer before subtracting the impairment class integer and summing the differences for the net adjustment (pages 50-51). When the grid uses “and” both conditions must be met to choose the impairment class or non-key factor in question. When the grid uses “or” either condition must be met. When the grid uses

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neither “and” or “or,” all the conditions must be met unless otherwise noted.

Objective Test Results are essential in assigning cardiovascular impairment ratings. Pursuant to Tennessee Rules and Regulations 0800-2-20-.07 (2), “All non-routine test(s) for an impairment rating essential under the applicable edition of the *AMA Guides to the Evaluation of Permanent Impairment* shall have been performed prior to the evaluation.” If, for some reason, you are missing test results, please contact the Medical Impairment Rating Registry at (615)253-5616 or Jay.Blaisdell@tn.gov. If necessary, the claimant may be required to undergo such testing before the MIR evaluation.

While MIR Physicians are not required to administer cardiovascular clinical tests, they must be familiar with the many types of tests to appropriately apply the grids in the cardiovascular chapter. Many of the grids utilize functional capacity and left ventricular function test results in assessing cardiovascular medical impairments. Functional capacity is objec-

tively determined using standard treadmill protocols (Bruce, Ellestad, Balke, Naughton) or bicycle ergometry. Bruce protocol, as measured in the number of minutes until fatigue failure, is used to determine impairment class in the Valvular Heart Disease grid. Other stress test protocols objectively measure metabolic expenditure (METs) and cardiopulmonary exercise testing can measure maximal oxygen uptake (VO₂ max). Left ventricle ejection fraction (LVEF) is measured by the percentage of blood that the left ventricle expels relative to what it holds immediately before systole. Any percentage over 50 is considered normal. Ejection fraction may be measured by, and hence the MIR Physician must be literate in, “echocardiography, radionuclide angiography (multiple gated acquisition, or MUGA), left ventriculography during diagnostic left-side hearth catheterization, computer tomography (CT), and cardiac magnetic resonance imaging” (p.48).

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

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For the purposes of imaging the heart, which is in continual motion, electron beam computer tomography (EBCT) is superior to conventional CT machines for objectively measuring calcium deposits in coronary arteries. Using an algorithm, EBCT software converts these deposits into a coronary calcium score. The evaluator uses this EBCT score (if this test was performed) to help select the impairment class in the Coronary Artery Disease grid. This test, however, is not commonly obtained, and most coronary artery disease cases can be rated without this information.

The B-Type Natriuretic Peptide (BNP) blood test is an objective means of measuring the severity of heart failure. It should be used to help assign impairment class for valvular heart disease, cardiomyopathies, and pericardial heart disease. The erythrocyte sedimentation rate (ESR or sed rate) is used to objectively measure inflammation of the pericardium and may be used to help assign the impairment class in the Pericardial grid in conjunction with other tests results. Since many other diseases elevate the sedimentation rate, attrib-

uting an elevated sed rate to pericarditis requires clinical judgment and comment in a report.

If a Holter monitor has been used to record the heart's electrical activity over a twenty-four hour or longer period, this documentation may be used to assign impairment class in the Dysrhythmias grid. An ankle-brachial index test (ABI), which compares blood pressures of the ankle and arm, is standard for assigning impairment class in the Lower Extremity Peripheral Vascular Disease grid while arterial calcification, finger-brachial index test, and arterial or venous Doppler studies are used to assign impairment class for the



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Upper Extremity Peripheral Vascular Disease grid. Unfortunately, in the 6th Edition, upper limb and lower limb vascular disorders are covered in the cardiovascular chapter assuming they are due to peripheral atherosclerosis. Thus this section and the tables are difficult to use for acute trauma cases with arterial or venous insufficiency. If tasked with rating such a case, the MIR physician may wish to call Jim Talmage, one of the Division's Assistant Medical Directors for guidance.

In regard to non-key factors, the New York Heart Association (NYHA) functional classification for cardiac disease, found in Table 4-1 on page 48, may be used to assign the "Class" (non-key factor modifier) for "History" in all the cardiovascular grids except peripheral vascular disease. The documented severity of pain and swelling correlating with extremity usage (claudication) determines History in the vascular grids. Physical Findings in the non-peripheral vascular grids may be assigned depending on the results of auscultation, blood pressure, and the severity of heart failure (HF). Auscultation with a stethoscope can detect pericardial friction rub and stenotic or regurgitant murmurs; however, echocardiography, which has been shown to have a

greater sensitivity in the detection of stenotic or regurgitant valves than a stethoscope, may be a part of your physical exam record. In the vascular disease grids, amputations and ulcers, if present, are also used to assign Physical Findings.

While not all internal medicine chapters designate Objective Test Results as the key factor, they all use one key-factor and one or two other non-key factors. The key factor is always clearly marked in the grid by a footnote, and the other one or two rating variables are the non-key factors. This rating scheme emphasizes Objective Test Results, History, or Physical Findings and avoids incorporating variables twice. If you have questions regarding the methodology employed in the cardiovascular chapter (or any other chapter in the *AMA Guides*) please feel free to write James.Talmage@tn.gov or call (931) 526-1604.

**Medical Impairment Rating Registry
Tennessee Department of
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Division of Workers' Compensation**

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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.



MIRR PHYSICIAN SPOTLIGHT H. JAMES WIESMAN, M.D.

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music and reading non-fiction. He has always been of an athletic nature, participating in sports throughout his youth and, more recently, riding three-day event horses, doing sprint triathlons, Masters and Senior Olympic track and field, and regular workouts on the track road and at the gym.

Dr. Wiesman has three daughters, Evelyn Lawrence, Linden Hume, and Stratton Jameson, and three grandchildren. Linden, his second daughter, was a member of the bronze medal winning three-day equestrian team at the 2000 Sydney Olympic Games. That experience, as Dr. Wiesman reflects, “was one of the high points of my life.”



2000 Sydney Olympic Games
United States Equestrian Three-Day Event Team.

Left to Right:

Linden Wiesman, David O'Conner, Karen O'Conner, and Nina Fout
Photo Credit: Associate Press/Susan Walsh



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IN THE FOLLOWING AREAS
OF EXPERTISE:

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- 6) Ophthalmology
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- 8) Cardiology
- 9) Pulmonology
- 10) Psychiatry *

Click [HERE](#) for an application.

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