AdMIRable REVIEW

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2017

PHYSICIAN SPOTLIGHT
T. SCOTT BAKER, MD

3rd ANNUAL
Workers' Compensation Physicians' Conference

20th ANNUAL
Workers' Compensation Education Conference

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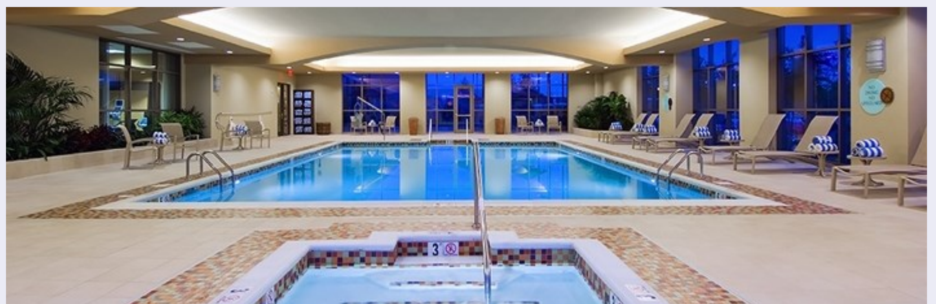

Medical Impairment Rating Registry
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MIR PHYSICIAN SPOTLIGHT
T. SCOTT BAKER, MD

"Serving on the MIR is an honor," says physiatrist T. Scott Baker, M.D., of Lebanon, Tennessee. "I take seriously my responsibility to investigate the facts, perform a thorough evaluation, and follow the *Guides* to formulate the correct impairment rating."

As one of the first physicians to be appointed to the MIRR, Dr. Baker has been perfecting the "art and science" of the MIR Report since 2005. His work is always accurate, timely, and well-supported. Dr. Baker's colleagues at Tennessee Physical Medicine and Pain Management (TPMPM), like Dr. Baker himself, are accessible, genuine, and extremely helpful.

"Lebanon has turned out to be the perfect fit for my family and practice. We want to give back to this community that has given us so much. Participating in the MIRR is just another way for us to help."

Dr. Baker is triple board-certified in Physical Medicine and Rehabilitation, Neuromuscular and Electrodiagnostic Medicine, and in Pain Medicine. He has served as Medical Director for In-Patient Rehabilitation Centers at McFarland Specialty Hospital in Lebanon and at Sumner Regional Medical Center in Gallatin as well as a Trustee and Chief of Staff at Tennova Healthcare – Lebanon (formerly University Medical Center). He currently serves on the Board of Directors for Friendship Christian School.

As a physiatrist, Dr. Baker provides "consultation and management services to patients suffering from acute or chronic pain." Work and sports-related injuries, genetic diseases, cancer and even depression, are all possible causes for this pain. Treatment plans include physical therapy, medications, injections, radio frequency lesioning and spinal cord stimulation.

"Each person has a unique pain response," says Dr. Baker. "We develop a plan tailored to each person's specific needs. Our goal with each patient is to restore their prior activity level and focus on improving their quality of life. Most musculoskeletal pain conditions do not require surgery. A herniated disc is an excellent example of a condition that responds well to

T. Scott Baker, MD

conservative management. If surgery is needed, we can make the appropriate referral."

As the current president of the Tennessee Academy of Physical Medicine and Rehabilitation and a member of the Tennessee Department of Health's Chronic Opioid Guideline Committee, Dr. Baker believes that "opioid risks are complex. We are worried about not only the risk of addiction but also the risk of accidental overdose. We have made gains toward safer prescribing practices and the reduction of Tennesseans on high dose opioids. We strive to find a balance for people suffering from chronic pain. The key is good education. My job is to find the best approach for each patient so that they can return to work as soon as possible."

During his college years in his parents' hometown of Louisville, Kentucky, Dr. Baker worked for his family's septic tank business, and also as a nurse's aid and an ER technician. He graduated Cum Laude with a B.A. in biology from the University of Louisville, his father's alma mater, and from the University of Louisville School of Medicine in 1995.

"By far the best decision I've ever made is asking Jean Ellen to marry me," Dr. Baker says of his wife of twenty-two years. "She's accomplished in her own right. She holds a Doctor of Pharmacy and plays an integral part in my current practice."

Within days of meeting each other through mutual friends, they realized that they had each met their perfect match. They married and moved to Columbus, Ohio, where Mrs. Baker worked as a pharmacist for Walgreens while Dr. Baker completed his residency in Physical Medicine and Rehabilitation at The Ohio State University Medical Center. There he served as Chief Resident of the OSU Medical Center's rehabilitation program. By the time he completed his residency, the Bakers had two children and were ready to put down roots.

(Continued on page 8)

Dr. Baker and colleagues at TN Physical Medicine and Pain Management

HEARING IMPAIRMENTS, AMA *Guides,* 6th Edition

Jay Blaisdell, CEDIR VI, and James B. Talmage, MD

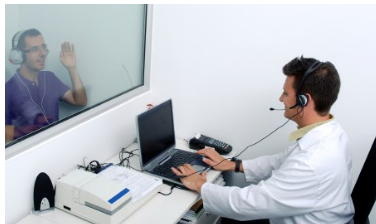
Occupations that routinely expose workers to loud noises have the highest risk of Noise Induced Hearing Loss (NIHL). These occupations include flight crews, ambulance drivers, factory workers, athletes, bartenders, construction workers, physical education teachers, and dentists. Singular events, such as explosions and gunshots, can also cause permanent hearing loss. Standards for evaluating hearing impairments are established by means of hearing threshold testing, the most reproducible gauge of hearing.[1(249)] While otolaryngologists are the preferred arbiters of hearing impairment disputes brought before the Medical Impairment Rating Registry, occupational medicine and family physicians may also opine, provided they have access to appropriate audiometry equipment or valid hearing threshold test results for the injured worker in question.

DEFINITIONS:

ASHA: (American Speech-Language-Hearing Association) a professional association for speech-language pathologists, audiologists, and speech, language, and hearing scientists in the United States.[2]

Audiogram: a graph that shows the audible threshold for standardized frequencies as measured by an audiometer where the vertical axis represents sound intensity measured in decibels and the horizontal axis represents frequency measured in Hertz.

Audiometer: "an instrument used in measuring the acuity of hearing."[3]



Audiometry: "the testing and measurement of hearing acuity for variations in sound intensity, pitch, and tonal purity."[4]

ANSI: (American National Standards Institute) a private, non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.[5]

Central Hearing Loss: is generally caused by disorders of the brainstem or brain. It involves the inability to process auditory signals. "It is different from peripheral (inner ear or eighth nerve) hearing loss in that it is a form of brain dysfunction, cannot be quantified easily; and is excluded for impairment rating in [Chapter 11 of the AMA *Guides*, 6th Edition]."[1 (248)]

Conductive Hearing Loss: dysfunction in which sound is not conducted efficiently through the outer ear canal to the eardrum and through the tiny bones of the middle ear due to a variety causes, including ear infection (otitis media), allergies (serous otitis media), poor Eustachian tube function, perforated eardrums, benign tumors, impacted earwax (cerumen), infection in the ear canal (external otitis), swimmer's ear (otitis externa), and the presence of a foreign body.[6]

Hertz(Hz): the unit of frequency in the International System of Units (SI) defined as one cycle per second and named for Heinrich Rudolf Hertz, the first person to provide conclusive proof of the existence of electromagnetic waves.[7]

HEARING IMPAIRMENT RATING PROCESS

STEP 1: Obtain valid hearing threshold testing results for each ear.

STEP 2: Add the decibel hearing threshold levels at 500, 1000, 2000, and 3000 Hz for each ear.

STEP 3: Apply the sums obtained in step 2 to Table 11-2 to obtain BI (binaural hearing impairment).

STEP 4: Convert BI to WPI using table 11-3.

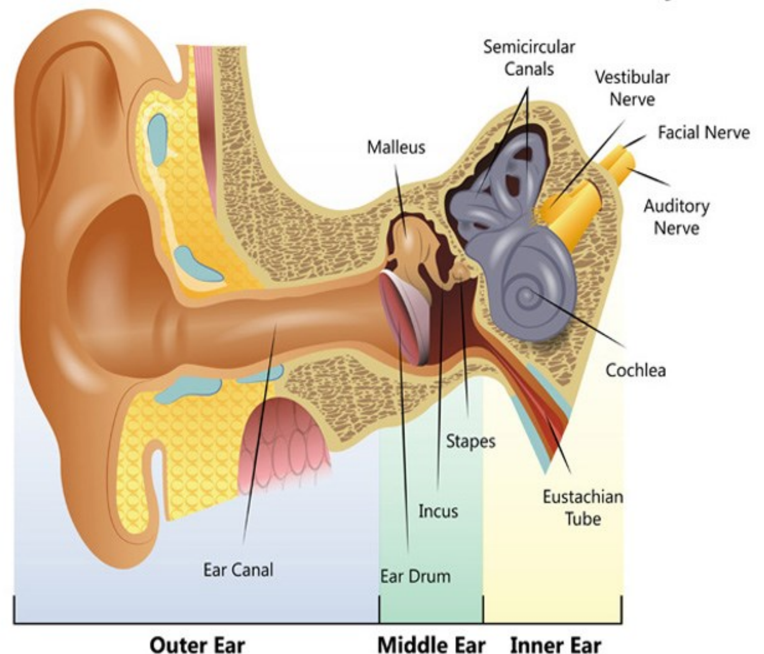
Decibel (dB): a unit for expressing the relative intensity of sounds on a scale from zero for the average least perceptible sound to about 130 for the average sound intensity at which pain occurs.[8]

DSHL: (Decibel Sum of Hearing threshold Levels) the sum of hearing thresholds at 500, 1000, 2000, and 3000 Hz used for impairment rating purposes under the AMA *Guides*, 6th Edition.

Hearing Threshold: the lowest level sound that can be heard 50% of the time.[9]

MMI (Maximum Medical Improvement): "a status where patients are as good as they are going to be from the medical and surgical treatment available."[1(26)] For hearing loss injuries, this means impairment causative exposures have been controlled, and therefore hearing loss is hopefully no longer accelerating beyond an age-appropriate rate. [1(248)]

Mixed Hearing Loss: dysfunction in which conductive hearing loss occurs in combination with a sensorineural hearing loss



https://www.hearinglink.org/your-hearing/how-the-ear-works/

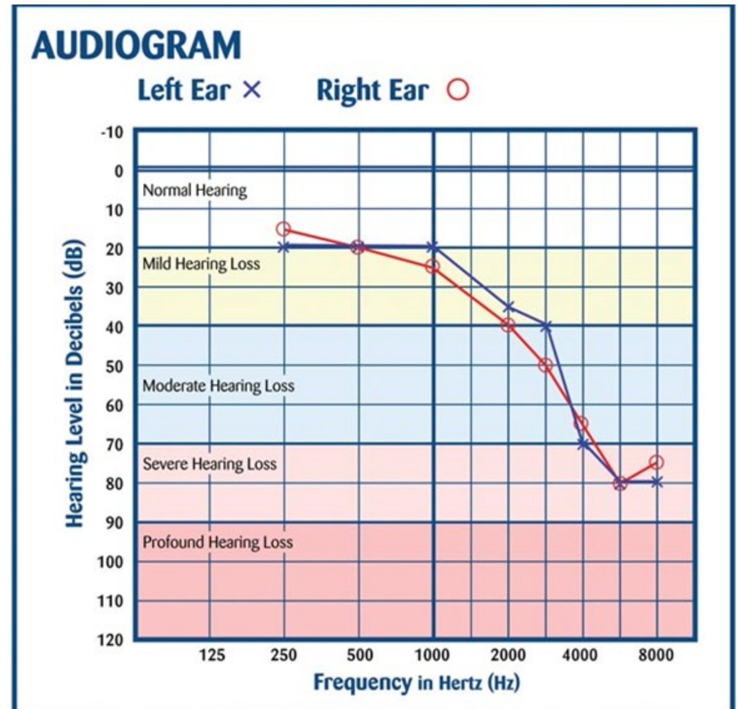
(Continued from page 4)

(SNHL) due to irregularities in the outer and middle ear as well as the inner ear.[10]

Frequency: "the number of repetitions of a periodic process in a unit of time."[11]

Pure Tone Audiometry (PTA): "the key hearing test used to identify hearing threshold levels of an individual, enabling determination of the degree, type and configuration of a hearing loss."[12]

Sensorineural Hearing Loss (SNHL): dysfunction of the cochlea or cochlear nerve due to a variety of causes, including illnesses, drugs that are toxic to hearing, genetic predispositions, aging, head trauma and exposure to loud noise. It is the most common type of hearing loss and usually cannot be medically or surgically corrected, unlike conductive hearing loss.[13]



SCOPE
Chapter 11, Section 11.2a, starting on page 248 of the AMA *Guides*, 6th Edition, covers sensorineural, conductive hearing loss, and mixed hearing loss, but not central hearing loss, which might be addressed in section13.3e of Chapter 13, The Central and Peripheral Nervous System, provided that evidence of brain dysfunction is clearly distinguishable from symptoms of dysfunction of the inner ear or eighth nerve.

METHODOLOGY OVERVIEW
Using valid hearing threshold test results, the MIR Physician adds the decibel threshold hearing levels at 500, 1000, 2000, and 3000 Hz for each ear. These sums are applied to Table 11-2 to obtain the injured worker's binaural hearing impairment (BI), which is then converted to whole person impairment (WPI) using table 11-3.

STEP 1: OBTAIN VALID HEARING THRESHOLD TEST RESULTS FOR EACH EAR
While an otolaryngologist is the preferred MIR Physician for hearing loss impairment disputes, an occupational or family physician may also receive referrals. Regardless, the MIR Physician should base the impairment rating only on valid, recent hearing threshold testing results. Results must include the decibel hearing threshold levels at 500, 1000, 2000, and 3000 Hz for each ear. As with all injuries, hearing should be evaluated only after MMI has been achieved. If the MIR Physician finds that test results are not valid or recent, additional testing should be performed. If the MIR Physician does not have the equipment or training to perform hearing threshold tests, additional testing may be arranged by contacting the MIRR Program Coordinator before the evaluation pursuant to TN Rules and Regulations 0800-2-20-.07(2).

Threshold audiometry should conform to the current "Guidelines for Manual Pure-Tone Threshold Audiometry" published by the ASHA, except when specified by the AMA *Guides*, 6th Edition. The following summary highlights salient points:

Audiometric equipment should be calibrated to meet the reference levels of ANSI Standard S3.6-1996, pursuant to the AMA *Guides*, 6th Edition, not ANSI Standard 3.6-2004b as currently directed by the ASHA (250). Use of a sound-isolated room is viewed as standard practice provided it meets specifications in ANSI Standard 3.1-1999, Maximum Permissible Ambient Noise Levels for Audiometric Test Rooms. Any hearing aids should be removed after examinee has received instructions on how to respond to stimuli during the test. Instructions should underscore that the purpose of the test is to determine the faintest sounds that the examinee can hear. The MIR Physician should emphasize that the examinee should (1) expect to have each ear tested separately with tones of different pitches, (2) not talk, eat, drink, smoke, or chew during the test, and (3) respond immediately and overtly with an "on" response as soon as the tone is heard, no matter how faintly, and with an "off" response when the tone ceases. The MIR Physician should use an otoscope to conduct a visual inspection of the examinee's ear canal to make sure it is free of impacted ear wax (cerumen) before actual threshold testing begins. Seating should enable the MIR Physician to easily observe visual or verbal responses to stimuli yet shield the MIR Physician from revealing inadvertent clues. If the examinee is known to have worse hearing in one ear, testing should begin with the better ear.

Commonly used responses are (1) pressing signal switches, (2) verbalizing, and (3) raising and lowering an arm, hand, or finger. The primary parameters used to determine thresholds are (1) the presence or absence of "on" and "off" responses, (2) the number of false responses, and (3) the delay of responses.

To determine threshold during pure-tone audiometry, the ASHA recommends "an ascending technique beginning with an inaudible signal." The tone should last between 1 and 2 seconds, and the interval between successive tones should be varied. The decibel level of the first test tone should be well below what the MIR Physician expects that the examinee can hear. If the examinee fails to respond to the tone, the MIR Physician should increase the level of the tone in 5-dB

(Continued from page 5)

steps until the examinee responds. Since the examinee's hearing threshold is the lowest level at which the examinee responds 50% of the time, the minimum number of responses for a given threshold is 2 out of 3. After the examinee initially responds to a tone, the MIR Physician should decrease it by 10dB and begin the ascension again. To ascertain acceptable test-retest viability for the examinee, the MIR Physician should establish limits in consultation with Annex B of Methods for Manual Pure-Tone Threshold Audiometry (ANSI Standard S3.21-2004, ANSI 2004a).[14]

For impairment rating purposes according to the *Guides*, 6th Ed., if the examinee's hearing level for a given frequency is greater than 100 dB, it should be interpreted as 100 dB. If the hearing level for a frequency is lower than 0, it should be interpreted as 0. [1(250)]

STEP 2: ADD THE DECIBEL HEARING THRESHOLD LEVELS AT 500, 1000, 2000, and 3000 Hz FOR EACH EAR.

This is a relatively straight-forward step in that the MIR Physician merely adds the dB threshold levels obtained for 4 different frequencies—500, 1000, 2000, and 3000 Hz—to obtain the DSHL.

STEP 3: APPLY THE SUMS OBTAINED IN STEP 2 TO TABLE 11-2 TO OBTAIN BI (BINAURAL HEARING IMPAIRMENT).

The resulting DSHL for each ear is then applied to Table 11-2 (pg.252) to obtain binaural hearing impairment. The sum of the better ear (lowest sum) is read at the bottom of the table. The sum of the worse ear (highest sum) is read at the side of the table. The intersection of the two sums in the table is the examinee's binaural impairment.

STEP 4: CONVERT BI TO WPI USING TABLE 11-3.

As with all impairment ratings provided for Tennessee workers' compensation injuries on or after July 1, 2014, impairment ratings must be converted to Whole Person Impairment. Binaural hearing impairment is converted to whole person impairment using Table 11-3 on page 254.

REFERENCES

[1]Rondinelli R, Genovese E, Katz R, et al. *Guides to the Evaluation of Permanent Impairment*. 6th ed. Chicago, IL: AMA, 2008.

[2]Wikipedia. American Speech-Language-Hearing Association. https://en.wikipedia.org/wiki/American_Speech%E2%80%93Language%E2%80%93Hearing_Association. Accessed May 9, 2017.

[3]Merriam-Webster. Audiometer. https://www.merriam-webster.com/dictionary/audiometer#medicalDictionary. Accessed May 9, 2017.

[4]Merriam-Webster. Audiometry. https://www.merriam-webster.com/medical/audiometry. Accessed May 9, 2017.

[5]Wikipedia. ANSI. https://en.wikipedia.org/wiki/American_National_Standards_Institute. Accessed May 9, 2017

[6]ASHA. Conductive Hearing Loss. http://www.asha.org/public/hearing/Conductive-Hearing-Loss/. Accessed May 9, 2017.

[7]Wikipedia. Hertz. https://en.wikipedia.org/wiki/Hertz. Accessed May 9, 2017.

[8]Meriam-Webster. Decibel. https://www.merriam-webster.com/dictionary/decibel. Accessed May 9, 2017.

[9]The National Hearing Test. How to Read an Audiogram and Determine Degrees of Hearing Loss. http://www.nationalhearingtest.org/wordpress/?p=786. Accessed May 9, 2017.

[10]ASHA. Mixed Hearing Loss. http://www.asha.org/public/hearing/Mixed-Hearing-Loss. Accessed May 9, 2017.

[11]Merriam-Webster. Frequency. https://www.merriam-webster.com/dictionary/frequency. Accessed May 9, 2017.

[12]Wikipedia. Pure Tone Audiometry. https://en.wikipedia.org/wiki/Pure_tone_audiometry. Accessed May 9, 2017.

[13]ASHA. Sensorineural Hearing Loss. http://www.asha.org/public/hearing/Sensorineural-Hearing-Loss. Accessed May 9, 2017.

[14]ASHA. Guidelines for Manual Pure-Tone Threshold Audiometry. http://www.asha.org/policy/GL2005-00014.htm. Accessed May 9, 2017.

2016 TN Workers' Compensation Case Law in Review

JANE SALEM, ESQUIRE

Last year, the Tennessee Workers' Compensation Appeals Board hit its stride, conducting its first oral arguments and releasing dozens of weighty opinions, a few of which are recapped below. (The Board also issued a few not-so-weighty opinions; it was the year that the Board began writing "memorandum opinions" in cases that present no novel factual or legal issues.)

But first, a few disclaimers: This article isn't legal advice or citable; it's merely meant to help stakeholders understand new developments in workers' compensation law since the Reform Act took effect.

Many cases present multiple issues, but for purposes of this article, the focus is only on one issue per case. Moreover, for the sake of brevity, complex cases are broken down into a mere one or two sentences per matter. It's meant to whet the reader's appetite for more; all of these opinions, full-text and searchable, are available for free online at the University of Tennessee College of Law Library website, TRACE.

COMPENSATION HEARING APPEALS

Starting with compensation hearing appeals, remember that since the Court of Workers' Compensation Claims handles cases arising on and after July 1, 2014, there simply haven't been many litigated cases that proceeded all the way to a final compensation hearing. Even fewer were appealed.

Of them, the Board heard oral argument in four cases. First, in *Lightfoot v. Xerox Business Services,* the Board held the trial judge did not abuse its discretion in dismissing a case with prejudice for failure to prosecute. The case sat dormant on the judge's docket for over four months after continuing the expedited hearing. Meanwhile, the employee's attorney missed court appearances or appeared but provided a series of excuses for his inaction, including computer mishaps and personal health problems.

Second, the Appeals Board made a rather forceful pronouncement disfavoring the bifurcation of compensation hearings – essentially dividing the hearing into two parts to hear a set of issues without looking at all aspects – in *Cotton v. HUMACare, Inc., et al.*

Then, in *Garassino v. Western Express*, the Board held a trial court erred when it awarded an independent medical examiner's examination fee as a discretionary cost to a party that prevailed at a compensation hearing. The employee has appealed to the Tennessee Supreme Court; stay tuned.

The final case where the Board heard argument was *Pope v. Nebco of Cleveland, Inc., d/b/a Toyota of Cleveland. In Pope,* the Appeals Board reversed a trial judge's determination that an employee's injury, sustained during participation in a charity "mud run" alongside co-workers, was compensable. The Board held the employee wasn't "impliedly required" to race, nor was it part of his work duties.

In another noteworthy compensation hearing appeal last year, the Board took a fairly detailed look at the definition of "wages" in *Marshall v. Mueller Company.* Specifically, the Board examined how to calculate the average weekly wage for the purpose of permanent total disability benefits where the employee received a "summer hours bonus" temporary higher rate of pay.

EXPEDITED HEARING APPEALS

Turning now to the expedited hearing appeals—the majority of the Board's opinions—several cases dealt with the appellate rules/procedures themselves. Perhaps the most significant (and complicated) was *Syph v. Choice Food Group, Inc.,* where the Board held that the Tennessee Rules of Evidence and Rules of Civil Procedure apply at all proceedings in the Court of Workers' Compensation Claims. The question arose within the context of an employer's motion to dismiss prior to a trial on the merits, which the trial court granted but the Appeals Board affirmed on other grounds, including the employee's failure to respond to the motion or appear at the motion hearing.

Moving on to more rules-oriented rulings, in *Barrett v. Lithko Contracting, Inc.,* the Board held that an expedited hearing order is interlocutory and a party may appeal as a right; it's not a "permissive" appeal. Further, once a matter is before the Board, under *Boutros v. Amazon,* evidence not considered by the trial court cannot be submitted for consideration on appeal. In addition, in *Gilbert v. United Parcel Service,* the Board held that the failure to submit a transcript on appeal rendered appellate review difficult, so that the Board had little choice but to affirm the trial court's ruling. (For the budget-conscious, remember, the rules do allow a joint "statement of the evidence" instead of a transcript, which must be approved by the trial judge.) Additionally, *Love v. Delta Faucet Co.* is noteworthy mostly for the Board's comments regarding approximately 800 pages of medical records. The take-away is obvious: The Appeals Board does not want to read about the employee's decades-old bunions or kidney stones when the issues revolve around a recent back injury.

The Board additionally offered guidance on areas that can stymie a case before considering the injury itself, namely, notice and statute of limitations. Respectively, in *Buckner v. Eaton Corp.,* the Board examined the notice requirement and in particular the prejudice suffered by the employer, while in *Kelso v. Five Star Food Service,* the Board considered the statute of limitations and "last-day worked" rule.

Causation and issues ancillary to it continue to be prime topics for the Appeals Board. In *Lewis v. Molly Maid, et al.,* the Board affirmed the trial court's conclusion that, while an employee's evidence was insufficient to establish compensability by a preponderance of the evidence, it was sufficient to support an order compelling the employer to provide a panel.

Then in *Navyac v. Universal Health Services,* the Appeals Board clarified causation under the Reform Act in two ways. First, the Board held that the general assembly did not alter the traditional two-prong analysis of "arising out of" and "in the course of" employment when it added the verbiage "scope of" employment to the definition of "injury." Second, the Appeals Board explained that the critical causation question is not whether a third party's fault or negligence "caused" the injury as that term is applied in tort law, but whether the employment more likely than not caused the accident in that the accident had its origin in hazards to which the employee was exposed through the employment.

Causation within the context of alleged idiopathic injuries was discussed in *Frye v. Vincent Printing Co.* and *Osborne v. Beacon*

2016 TN WORKERS' COMPENSATION CASE LAW IN REVIEW

(Continued from page 7)

Transport. As an aside, in *Osborne,* the Board clarified that a workers' compensation judge can't order payment of past medical expenses if evidence of those expenses isn't admitted into evidence.

In *Lee v. Western Plastics,* the Board took another look at the "direct and natural consequences" rule. Similarly, in *Richards v. Kiewit Power Constructors Company,* the Board examined alleged intervening causative factors in conjunction with an employee's recurrent hernias. Further, in *Partilla v. Velocity Ventures, Inc*. and *Poellnitz v. Resolute Forest Products,* the Board considered causation where there are competing medical experts.

In sum, it was a productive year for the Appeals Board. As the appellate judges continue to interpret the Reform Act, they are rapidly building a body of case law that covers a wide variety of issues.

MIR PHYSICIAN SPOTLIGHT, T. SCOTT BAKER, MD

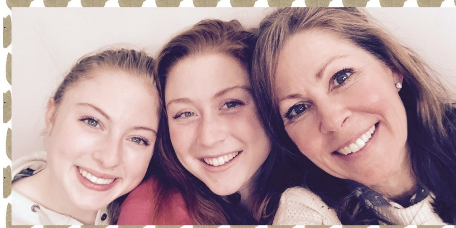
(Continued from page 3)

"We were looking for a place close to our families in Kentucky," says Mrs. Baker. "We definitely wanted to return to the warmer south. Lebanon turned out to be the perfect choice. It was close to Kentucky, had small-town country values and yet was close to a large metropolitan area."

In August 1999, Dr. Baker "gratefully accepted a position" with Dr. Jeffrey Hazlewood in Lebanon, with whom he was "greatly impressed." Dr. Baker started his own practice in Lebanon in 2006, with a satellite office at Riverview Hospital in Carthage.

Tennessee Physical Medicine and Pain Management (TPMPM) has seen so much growth that the building itself was recently expanded from 4,000 to 6,000 square feet. The remodeled office is stunning, thanks in large part to Mrs. Baker who helped with the interior design. A twenty-one member staff assists Dr. Baker in caring for the needs of his patients. "One of our greatest priorities is taking care of injured workers."

When not treating patients, Dr. Baker can be found at home with his wife and three children. Jolin, age 20, just finished her sophomore year at UT Knoxville in Neurosciences. Noah, age 18, is off to King University in Bristol, Tennessee, accepting tennis and academic scholarships. And Emmy (age 15) is going into high school at Friendship Christian School. In March, Dr. Baker and Noah went to Kenya and Uganda on a ten-day Christian mission trip, where they helped repair thirteen hand pump wells, build three chicken coops, and provide foot protection to three Leper Colonies.



Dr. and Mrs. Baker enjoy skiing, traveling and staying active in the community. They play tennis a couple times per week and are members of Providence United Methodist Church in Mt. Juliet, where Dr. Baker serves on the Staff Relations Committee.

TN WORKERS' COMPENSATION PHYSICIANS' CONFERENCE, June 10-11, 2017

The Tennessee Bureau of Workers' Compensation and the International Workers' Compensation Foundation are sponsoring a special Educational Conference for Physicians and Attorneys focusing on medical topics of particular importance to physicians, attorneys, nurse practitioners, physician assistants, and medical and administrative staff.

WHO SHOULD ATTEND?

The Saturday session is directed to physicians, attorneys, medical staff and other professionals who are interested in the proper application of the AMA *Guides*. This session meets the training requirements for physicians seeking appointment to the MIR Registry.

The Sunday session will provide valuable and current information for physicians, nurse practitioners, physician assistants, medical and administrative staff, attorneys, and other individuals involved in workers' compensation in Tennessee. Topics covered include causation and return-to-work, Utilization Review, ODG, Treatment Guidelines, Drug Formulary, and the WC Administrative Courts.

LOCATION

The Guest House at Graceland
3600 Elvis Presley Blvd.
Memphis, TN 38116
(800) 238-2000

A block of rooms has been reserved at the conference hotel at the rate of $129, available 3 days prior and post based on availability. Rooms will be held through May 10, 2017, unless this block becomes fully reserved prior to this date. Call (800) 238-2000. Indicate you are attending the Tennessee Workers' Compensation Physicians Conference and give the code 170609INTE when making your reservations or book online.

CONTINUING EDUCATION

Up to 12 general credit hours of continuing medical education (CME) may be earned for physicians and 11.42 continuing legal education (CLE) credit hours for attorneys.

The AMA *Guides*, 6th Edition Training Course (Saturday) and the Physician Education Program (Sunday), are jointly sponsored by the International Academy of Independent Medical Evaluators (IAIME) and the Tennessee Bureau of Workers' Compensation (BWC). The IAIME is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The International Academy of Independent Medical Evaluators™ (IAIME) designated this Tennessee Bureau of Workers' Compensation educational activity for a maximum of 12 hours of AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activi-

AGENDA for SATURDAY, June 10, 2017
AMA *Guides*, 6th, Edition, IMPAIRMENT RATING COURSE

THIS PROGRAM MEETS TRAINING REQUIREMENTS FOR PHYSICIANS SEEKING APPOINTMENT TO THE TN MEDICAL IMPAIRMENT RATING REGISTRY.

Time	Session
7:30 - 8:00 am	**REGISTRATION & Continental Breakfast**
8:00 - 8:10 am	**Opening Introductions** Robert Snyder, M.D.
8:10 - 8:30 am	**Pre-Test**
8:30 - 9:00 am	**Welcome/Introduction to the Tennessee Medical Impairment Rating (MIR) Registry** Jay Blaisdell, CEDIR VI, MIRR Program Coordinator
9:00 - 10:00 am	**Introduction, Chapters 1 & 2, Definitions and Philosophies** James Talmage, M.D., Fellow IAIME
10:00- 10:15 am	**Break**
10:15- 12:15 pm	**Breakout Session A: Chapter 17, Spine & Pelvis** Jeffrey Hazlewood, M.D. **Breakout Session B** (as needed): **Chapter 5, Pulmonary** **Chapter 11, Ear Nose and Throat** **Chapter 14, Mental and Behavioral** **Chapter 12, Visual** James Talmage, M.D.
12:15 -12:45 pm	**Lunch (provided)**
12:45 - 2:00 pm	**Chapter 15, Upper Extremity** James Talmage, M.D.
2:00 - 3:00 pm	**Chapter 16, Lower Extremity** Jeffrey Hazlewood, M.D.
3:00 - 3:15 pm	**Break**
3:15 - 4:15 pm	**Chapter 13, Central & Peripheral Nervous System** **Chapter 3, Pain** James Talmage, M.D.
4:15 - 5:00 pm	**How to Complete the MIR Registry Report Form/Common Errors Seen in MIR Reports** **Q & A** James Talmage, M.D. Jeffrey Hazlewood, M.D. Jay Blaisdell
5:00 - 5:55 pm	**Post Test/Case Examples & Discussion**

REGISTRATION FORM

TENNESSEE WORKERS' COMPENSATION PHYSICIANS CONFERENCE
SPECIAL SATURDAY AND SUNDAY PROGRAMS FOR PHYSICIANS AND ATTORNEYS
JUNE 10-11, 2017

Registration fee includes conference admission (Sat and/or Sun), materials, break & lunch and CME or CLE credits.

(Copy of AMA *Guides* not included.)

Registration Fee Before May 1st:

________ **$300** per day ☐ Saturday, June 10 or ☐ Sunday, June 11 (Please check which day you will attend)
________ **$475** both sessions Saturday & Sunday, June 11 & 12
________ **$250** for Saturday 8:00 a.m.-12:15 p.m. only with Breakout B

Registration Fee On or After May 1st:

________ **$325** per day ☐ Saturday, June 10 or ☐ Sunday, June 11 (Please check which day you will attend)
________ **$525** both sessions Saturday & Sunday, June 11 & 12
________ **$300** for Saturday 8:00 a.m. - 12:15 p.m. only with Breakout B

Please Specify
☐ Payment by credit card. Fax this form to (386) 677-0155.
☐ Check enclosed. Make payable to IWCF and mail to IWCF, 570 Memorial Circle, Suite 320, Ormond Beach, FL 32174

Name:____
Business Name:____
Title:____
Address:____
Email:____
Amount:____
Name on Credit Card:___________________________________
Credit Card Billing Address (must match billing address at issuing bank):________________
____
Credit Card Number:____________________________________
Expiration Date:____
Credit Card CVV2: (3-digit number on back of Visa/MC, 4 digits on front of AMEX)__________
Date:____

LODGING: The Guest House at Graceland is located at 3600 Elvis Presley Blvd., Memphis, TN 38116. A block of rooms has been reserved at the rate of $129.00 plus applicable taxes. This rate will be available through May 10, 2017, unless this block becomes fully reserved prior to this date. Call the hotel's direct number, (800) 238-2000 and give group code 170609INTE or book online at https://tinyurl.com/TNPHYS17. Hotel reservations alone do not guarantee admission to the conference.

CANCELLATION REFUND POLICY: Cancellation of pre-registration must be made before 5:00 pm on May 31,2017. Substitution of personnel is recommended in lieu of cancellation after that date. The full registration fee will be forfeited if you fail to attend or cancel timely.

SPECIAL NEEDS: Individuals attending the conference who may need auxiliary aids or special services are requested to provide notice of their needs in writing no later than 10 working days before the conference so that appropriate arrangements can be made.

DRESS CODE: Casual clothing is appropriate for all events.

For additional information contact the IWCF at (386) 677-0041, Fax (386) 677-0155, or email IWCF@bellsouth.net.