STATE OF TENNESSEE
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Workers' Compensation Division
Medical Impairment Rating Program
220 French Landing Drive
Nashville, TN 37243-1002
(615) 253-1613; (615) 253-5263 fax

Medical Impairment Rating (MIR) Report

AMA Guides, 6th Edition

[For Dates of injury on or after January 1, 2008]

PATIENT INFORMATION (please type all responses)

Claimant Name _____

Address _____

City _____ **State** _____ **ZIP** _____

Phone # _____

State File # _____ **MIR case #** _____

Social security # _____ **Date of Birth** _____

Date of Injury _____ **Date of MIR Evaluation** _____

MIR PHYSICIAN INFORMATION

MIR Physician Name _____

Address _____

City _____ **State** _____ **ZIP** _____

Phone #_____ **Fax** _____

Location of evaluation if different than above) _____

_____

LIST THE FINAL WHOLE PERSON IMPAIRMENT:
In NUMBERS _____ % WPI

AND

In WORDS _____ whole person impairment.

[This is the FINAL rating legally presumed to be the correct impairment rating.]

PHYSICIAN CERTIFICATION AND QUALIFICATIONS

"It is my opinion, both within and to a reasonable degree of medical certainty that, based upon all information available to me at the time of the MIR impairment evaluation and by utilizing the *AMA Guides 6th Edition* with its Errata, or other appropriate method as noted that the claimant has the permanent impairment so described in this report. I certify that the opinion furnished is my own, that this document accurately reflects my opinion, and that I am aware that my signature attests to its truthfulness. I further certify that my statement of qualifications to serve on the MIR Registry is both current and completely accurate."

Signature: _____ Dated: _____

Printed full name of physician _____

STEP ONE—Clinical Evaluation

PATIENT HISTORY

INTRODUCTION AND OVERVIEW (brief description of the injury/illness, prior treatment received, and any periods the claimant was unable to work)

PHYSICAL EXAMINATION

CLAIMANT'S CHRONOLOGICAL MEDICAL HISTORY FOR THIS INJURY

Name & Address of All treatment Providers	Date Treatment Received	Nature of the injury or illness? Part of the body affected?

Make additional copies if necessary.

MEDICAL RECORD REVIEW (Use additional pages as required)

In the space below, check the applicable blocks next to any test results which you reviewed and relied upon to base your medical assessments or conclusions. Be sure to indicate whether you review imaging reports, OR, both the imaging reports and the actual images. Be sure to show the date of each test and summarize results. Please attach copy(ies) of the report(s) .

DATE(S) PERFORMED SUMMARY OF RESULTS

Please note whether it was the actual images reviewed or if the paper report was reviewed.

[_____] **X-RAY**
 # Reviewed

[_____] **X-RAY Reports**
 # Reviewed

[_____] **EMG/NCS**
 # Reviewed

[_____] **If radiculopathy exists, state abnormal findings that are consistent with radiculopathy:**

[_____] **If a peripheral nerve entrapment exists, state any abnormal findings, and state whether they meet *Guides* criteria for conduction delay, conduction block, or axon loss:**

[_____] **If an acute traumatic peripheral nerve injury occurred, state findings that are consistent with permanent nerve dysfunction:**

[_____] **CT SCAN**
 # Reviewed

[_____] **MYELOGRAM**
 # Reviewed

[_____] **MRI**_____
 # Reviewed

[_____] **OTHERS (Describe)**_____
 # Reviewed

SURGICAL PROCEDURES

Please list all operative procedures performed in chronological order with the operation title noted. Attach copy(ies) of report(s) if surgery was performed. List operative findings:

STEP TWO—Analysis of the Findings

1. **Does the claimant have a permanent impairment? YES _____ NO _____**

2. **Has the claimant reached maximum medical improvement (MMI)? YES _____ NO _____**
   If YES, date MMI was reached _____ If NO, state why the examinee is NOT at MMI, and what will be needed for the examinee to be at MMI. Do NOT rate the impairment. [Note: If you feel the patient is not at MMI because an additional treatment is required, you MUST document that the patient wants the additional treatment performed.]

_____

_____

_____

_____

3. **Do the *AMA Guides, 6TH EDITION* with its ERRATA adequately assess the medical impairment rating of the claimant? Yes _____ NO _____ If NO, state why they do not.**

_____

_____

_____

_____

4. **List ALL diagnoses for which there is a ratable permanent impairment causally related to the work injury or exposure in question:**

   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
   6. _____

5. **Are there diagnoses which the *AMA Guides, 6th Edition* does not include in impairment tables or for which the *Guides* does not provide a methodology, so that rating "by analogy" to a condition that is covered in the *Guides* must be used for impairment rating? (Pages 385, 495, 559, etc.) YES _____ NO _____**
   If YES, please list the diagnosis in question and express an impairment percentage that you think is appropriate, explain the analogy utilized to determine it, and explain in detail how you arrived at the percentage of impairment chosen. Calculated total whole person impairment: _____%.

_____

_____

_____

_____

STEP THREE—Discussion

1. **Using the *AMA's Physicians Guide to the Evaluation of Permanent Impairment*, 6th Edition, please translate each of the claimant's diagnoses as documented above to a percentage of impairment. If there are more than 6 ratable diagnoses, photocopy this page and submit this table for each additional diagnosis.**

	Diagnosis # 1	Diagnosis # 2	Diagnosis # 3
Diagnosis			
Body part/system			
Chapter #			
Table #/page #			
Key factor			
Diagnosis line used			
Class			
Grade Modifier FH			
Grade Modifier PE			
Grade Modifier CS			
BOTC (if applicable)			
Final Class and Grade Used			
Regional impairment			
Whole person impairment			

	Diagnosis # 4	Diagnosis # 5	Diagnosis # 6
Diagnosis	_____ _____	_____ _____	_____ _____
Body part/system	_____ _____	_____ _____	_____ _____
Chapter #	_____ _____	_____ _____	_____ _____
Table #/page #	_____ _____	_____ _____	_____ _____
Key factor	_____ _____	_____ _____	_____ _____
Diagnosis line used	_____ _____	_____ _____	_____ _____
Class	_____ _____	_____ _____	_____ _____
Grade Modifier FH	_____ _____	_____ _____	_____ _____
Grade Modifier PE	_____ _____	_____ _____	_____ _____
Grade Modifier CS	_____ _____	_____ _____	_____ _____
BOTC (if applicable)	_____ _____	_____ _____	_____ _____
Final Class and Grade Used	_____ _____	_____ _____	_____ _____
Regional impairment	_____ _____	_____ _____	_____ _____
Whole person impairment	_____ _____	_____ _____	_____ _____

Submit this page for each ratable diagnosis.

Diagnosis # 1. Please restate diagnosis: _____

_____

Criteria that support this diagnosis as present:

_____

_____

Class _____. Criteria that support choice of Class for this diagnosis:

_____

_____

Functional History, Grade modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Physical Exam, Grade Modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Clinical Studies, Grade Modifier_____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Burden of Treatment Compliance Grade Modifier (if Chapter 9 or 10 was used) _____. Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

Submit this page for each ratable diagnosis.

Diagnosis # 2. Please restate diagnosis: _____

_____

Criteria that support this diagnosis as present:

_____

_____

Class _____. Criteria that support choice of Class for this diagnosis:

_____

_____

Functional History, Grade modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Physical Exam, Grade Modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used.

_____

_____

_____

Clinical Studies, Grade Modifier_____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used.

_____

_____

_____

Burden of Treatment Compliance Grade Modifier (if Chapter 9 or 10 was used) _____. Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

Submit this page for each ratable diagnosis (photocopy for additional diagnoses)

Diagnosis # ____ Please restate diagnosis: _____

_____

Criteria that support this diagnosis as present:

_____

_____

Class _____. Criteria that support choice of Class for this diagnosis:

_____

_____

Functional History, Grade modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Physical Exam, Grade Modifier _____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

_____

Clinical Studies, Grade Modifier_____

Criteria that support choice of this Grade Modifier, or reason this Modifier is not used.

_____

_____

_____

Burden of Treatment Compliance Grade Modifier (if Chapter 9 or 10 was used) _____. Criteria that support choice of this Grade Modifier, or reason this Modifier is not used:

_____

_____

Use this table for any Central Nervous System injury, condition, or diagnosis to be rated:

Chapter 13 Central Nervous System Diagnosis or Condition	Table Number/ Page Number	Rationale for Impairment % Chosen	% Impairment of the Scheduled Member	% Impairment of the Whole Person If appropriate
a.				
b.				
c.				

Use this section and table for any mental or behavioral disorder or diagnosis to be rated:

Are you a Psychiatrist? YES _____ NO _____ If YES, continue. If NO, do not complete this section.

Diagnosis:

Axis I: [Please remember—this is the only diagnosis that potentially could be ratable]

_____

_____

Axis II:

_____

_____

Axis III:

_____

_____

Axis IV:

_____

_____

Axis V: (GAF)

_____

_____

BPRS impairment score	
GAF impairment score	
PIRS impairment score	
Median or middle value of these 3 – Impairment (WPI)	
Subtract impairment for pre-existing mental disorder or borderline intellectual function	
FINAL IMPAIRMENT RATING FROM CHAPTER 14	

Submit photocopy of Table 14-8 of the *Guides* with score for each BPRS item circled. Narrative report must contain documentation for each BPRS Symptom Construct. Your narrative report must also contain documentation for choice of GAF Scale and must contain documentation for choice of each score from Tables 14-12 through 14-16.

Use this section for any ratable Pain Related Impairment [Chapter 3]

Diagnosis that is ratable from Chapter 3:

_____

_____

Explain why this condition/injury was not ratable by Chapters 4-17: [Note: The *Guides* Errata specifies that "zero is a rating."]

_____

_____

_____

_____

PDQ score _____ [Submit a copy of the PDQ attached to this report that is signed by the examinee.]

Final pain related impairment: _____ % whole person impairment.

_____

Use this table if there are multiple ratable impairments.

List the mathematically highest impairment first, then in order of decreasing numerical impairment.

Diagnoses	Whole Person Impairment
#1	
#2	
#3	
#4	
#5	
#6	
Final Whole Person Impairment from Combined Values	

Is there a prior, work-related medical impairment rating that should be considered for subtraction from the impairment(s) described above? YES ____ NO _____ If YES, state the prior medical impairment rating and in the following section, "COMMENTS ON IMPAIRMENT RATING," calculate the final rating both WITH AND WITHOUT subtraction of this pre-existing, work-related impairment rating.

<u>COMMENTS ON IMPAIRMENT RATING</u> (including a discussion on subtracting prior, work-related, impairment ratings, if applicable).

If a QuickDASH Form, AAOS Lower Limb Outcome Form, a Pain Disability Questionnaire Form or any other questionnaire was completed by the examinee, please include a copy with your report.

Complete and return with all required attachments <u>via overnight delivery</u> to:

Tennessee Department of Labor and Workforce Development
Workers' Compensation Division
ATTN: J. Edward Blaisdell, MIR Program Coordinator
220 French Landing Drive
Nashville, Tennessee 37243-0661

QuickDASH—Disabilities of the Arm, Shoulder and Hand

Instructions: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer *every question*, based on your condition in the last week, by circling the appropriate number. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate.

(1 is not difficult, not limited, or none; 2 is mild difficulty, slightly limited, or mild; 3 is moderate difficulty, moderately limited, or moderate; 4 is severe difficulty, very limited, or severe; and 5 is unable, extremely, or extreme.)

1. Open a tight or new jar.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
2. Do heavy household chores (e.g., wash walls, floors).	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
3. Carry a shopping bag or briefcase.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
4. Wash your back.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
5. Use a knife to cut food.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or group?	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
9. Arm, shoulder or hand pain.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
10. Tingling (pins and needles) in your arm, shoulder or hand.	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?	**1** ☐	**2** ☐	**3** ☐	**4** ☐	**5** ☐

Pain Disability Questionnaire

Instructions: These questions ask your view about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally — Unable to work at all

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely — Need help with all my personal care

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

3. Does your pain interfere with your traveling?

Travel anywhere I like — Only travel to see doctors

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

4. Does your pain affect your ability to sit or stand?

No problems — Cannot sit/stand at all

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems — Cannot do at all

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems — Cannot do at all

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

7. Does your pain affect your ability to walk or run?

No problems — Cannot walk/run at all

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

8. Has your income declined since your pain began?

No decline — Lost all income

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors regularly

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem — Never see them

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help — Need help all the time

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

14. Do you now feel more depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems — Severe problems

0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐