



# AdMIRable

## REVIEW

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MEDICAL IMPAIRMENT RATING REGISTRY

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physician  
spotlight  
Michael D. Calfee

IMPAIRMENTS  
OF THE  
PELVIS

CAUSATION AND  
MENTAL HEALTH INJURIES  
APPEALS BOARD DECISIONS

July 1  
E-BILLING  
BEGINS

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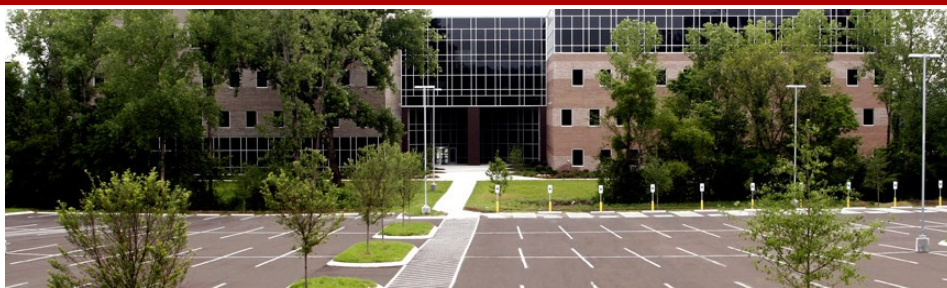
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Tennessee Bureau of Workers' Compensation

## BUREAU ANNOUNCEMENTS

### TN WORKERS' COMPENSATION E-BILLING

Starting July 1, 2018, Tennessee Workers' Compensation E-Billing program goes into effect. The program was created with legislation (T.C.A. § 50-6-202) and Tennessee Rule 0800-2-26. The purpose is to benefit both medical providers and bill payers. For insurance carriers and their agents, e-billing is designed to decrease the administrative costs of processing a claim and reduce the likelihood of complaints, reconsiderations, appeals, and lost or mishandled claims. Providers should realize a faster revenue cycle and a decrease in overhead costs associated with misidentification, duplications, postage, and the manual processing of records and bills. A clear electronic audit trail will benefit both payers and providers.

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### RECEIVE BWC UPDATES VIA EMAIL

Want to stay up-to-date on all things workers' compensation for Tennessee? Interested in upcoming Bureau events, legislative changes, and rule revisions? If so, [subscribe to our external newsletter today](#). You will find a trove of informational gems with each edition. Highlighting breaking news, updates, and event notices, the BWC newsletter makes it easier than ever to stay in the loop with what's happening at the Tennessee Bureau of Workers' Compensation.

### 2018 LEGISLATIVE UPDATE

[This](#) is a general overview of workers' compensation legislation passed by the 2018 session of the 110th General Assembly. For a complete, detailed review of this information and all workers' compensation bills introduced in this legislative session, please go to [www.capitol.tn.gov](http://www.capitol.tn.gov).

### NEW CLAIMS HANDLING STANDARDS (EFFECTIVE AUGUST 2, 2018)

Revisions to the [Claims Handling Standards](#) include requirements for adjusting entities to designate a liaison to the Bureau as a primary point of contact, clarification on the steps to file claims if the SSN is missing or unknown, deletion of the requirement to have a claims office in the state, and new requirements for making contact with the injured employee.

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## MIR PHYSICIAN SPOTLIGHT MICHAEL D. CALFEE, MD

**I** have enjoyed my experience as an MIR Physician,” says orthopedic surgeon Michael Calfee.” I think it has made me a better at doing impairment ratings in my practice. I have always enjoyed puzzles. I tend to view each case as a puzzle, and try to come up with the single best answer. The MIRR has really made me dig through and understand the *Guides* better.”

As the sole proprietor of Advanced Orthopedics in Union City and Dyersburg, Dr. Calfee is board-certified in in Orthopedic Surgery and Sports Medicine. He is a foot and ankle specialist but also practices general orthopedic surgery with an emphasis on total joint replacement, industrial injuries, carpal tunnel and hand surgery. He has served on the MIRR since its start in 2005 and regularly attends training events and conferences sponsored by the Bureau. Withstanding the highest levels of scrutiny, his MIR Reports are meticulous and well reasoned. He and his office staff are accessible, friendly, and of the highest professional deportment.



**MICHAEL D. CALFEE, MD**

Dr. Calfee grew up in Cleveland, Tennessee, the middle of five children. He has three brothers and a sister. They grew up working on a dairy farm where they had long hours in the hayfield and helped their parents manage twenty-six rental units that the family owned. Church and God were always very important to them. Dr. Calfee was also active in sports growing up. He was quarterback of his high school football team and enjoyed playing baseball as well.

He attended the University of Tennessee, Knoxville, where he was awarded the Torchbearer award, the highest honor that the university can give to a student. He went on to attend medical school at the University of Tennessee, Memphis, on a four-year full scholarship. He completed his orthopedic residency at The Campbell Clinic, also in Memphis.

Dr. Calfee spends most of his free time with his family. He has been married

for twenty-five years and has three children. His oldest daughter is a senior at Lee University and plans to attend law school. His middle daughter will be a freshman at the University of Tennessee, Knoxville, and would like to pursue a career in medicine. His son, his youngest child, loves all sports and enjoys playing baseball and basketball for his high school.

Dr. Calfee's favorite hobby is flying airplanes. "I started flying three years ago and absolutely fell in love with it," he says. "I got my private pilot license after about eight weeks, and my instrument rating in about six months. I currently fly a Beech Baron. It's a six-place airplane that has two engines. I love the fact that I can take my family of five and go anywhere in a hurry.



I started flying because my family live in Cleveland, Tennessee. I wanted to be able to get there in a hurry if I needed to. The cockpit is the one place I feel I can get away from my practice as a solo orthopedic surgeon.”

Taking two to three trips a year to Honduras, Dr. Calfee performs joint replacements and leads building projects in very impoverished communities. He has served on the boards of FCA (Fellowship of Christian Athletes), the Boy and Girls Club, and Union City Schools Foundation. He is currently on the executive committee for the Board of Alumni of University of Tennessee Medical School.



Dr. Calfee and Family in Montana

## APPEALS BOARD ADDRESSES MENTAL INJURY DEFINITION Jane Salem, Esquire



**T**he Reform Act of 2013 altered the definition of compensable mental injuries. The Appeals Board has now weighed in on the extent of the change. Within the last year, the release of two appellate opinions have offered guidance on mental injuries. This article summarizes those decisions and attempts to highlight their lessons for attorneys and physicians.

### A “SUDDEN OR UNSUAL MENTAL STIMULUS”

First, in *Edwards v. Fred's Pharmacy*, the Appeals Board affirmed the trial court's order favoring a store manager who alleged post-traumatic stress disorder resulting from a physical assault while

confronting a shoplifter. Before the assault, employee Genda Edwards was receiving psychiatric treatment for depression, anxiety and panic attacks. She saw her psychiatrist, who took her off work after the encounter with the shoplifter. The doctor also wrote, in response to a letter from the employee's lawyer, that Edwards suffered an aggravation of her pre-existing psychiatric condition that arose primarily out of the work incident. Fred's accepted the claim regarding her physical injuries but denied the mental injury claim. In an order awarding benefits, Judge Joshua Davis Baker relied heavily on that psychiatrist's opinion. The Board affirmed in a Feb. 14 opinion penned by Presiding Judge Marshall Davidson.

The Board explained that a mental injury is “a loss of mental faculties or a mental or behavioral disorder” under Tennessee Code Annotated § 50-6-102(17). This part of the defini-

(Continued on page 6)



**F**ractures of the pelvis are relatively uncommon, comprising about 3% of all adult fractures. Most pelvic fractures in workers' compensation are the result of an acute, high-impact event such as a fall from a roof or an automobile collision. Since major parts of the bladder, bowel, reproductive organs, nerves and blood vessels all pass through the pelvic ring, traumatic pelvis fractures often coincide with damaged organs, significant bleeding, and sensory and motor dysfunction. Treatment for high-impact pelvic fractures usually requires surgery, with the goal of restoring stability so the injured worker can resume activities of daily living.

**DEFINITIONS:**

**Hip:** For impairment rating purposes, the hip is defined as the "region from the articular cartilage of the acetabulum to the mid shaft of the femur" (Rondinelli, 2009, p.500).

**Instability:** Per the left column note in Table 17-11, pelvic instability is defined as a "position shift that occurs when comparing supine and weight-bearing x-rays" (Rondinelli, 2009, p.593). Thus, prior to beginning an impairment rating evaluation for pelvic fractures/dislocations, it may be necessary to call the MIR coordinator to obtain permission to order supine and standing (weight bearing) pelvic x-rays. If these are ordered, the examinee must be instructed to fully bear weight on the most painful lower limb during the x-ray so that instability, if present, is detected by the films. If supine x-rays on the day of injury show no displacement through the pubic symphysis or either Sacroiliac joint, and if the final healed x-rays show that all fractures have healed (no pseudarthrosis), there is no need for weight bearing x-rays, as there will be no motion in solidly healed fractures. This should be stated in the report as part of the rationale for the examiner's choice of Class.

**PDQ:** Pain Disability Questionnaire. It is commonly used to help assign the functional history grade modifier. For Tennessee injuries that occur on or after July 1, 2014, the PDQ should not be used in most circumstances. Please see this [link](#) for more information.

**SCOPE**

Fractures of the ilium, ischium, coccyx, and sacrum are rated in Chapter 17 using the Pelvis Regional Grid, Table 17-11, on page 593. Fractures, and fracture-dislocations, of the pelvis are assessed for impairment when the individual is at Maximum Medical Improvement. The amount of displacement that exists on the final healed x-ray is the amount of fracture displacement used to determine the Class, and not the amount of displacement on the day of injury films (usually taken before surgery to reduce and stabilize the fracture).

Depending on their severity, fractures of the acetabulum may be rated either in section 17.4 (pg. 592) or 16.7 (pg. 543). Table 17-11 instructs the user to rate acetabular fractures by hip range of motion, using Table 16-24. If this method is used the report should document measurements of hip motion in 6 directions plus the presence or absence of an abduction contracture.

For acetabular fractures there is an alternate methodology that can be used. Table 16-4 (page 514) lists acetabular fractures, and the Class is determined by the amount of fracture displacement. Both the rating by just range of motion (Table 17-11 directing the user to Table 16-24) and the rating by Table 16-4 should be determined, and the higher rating accepted. Early after fracture there may be little or no loss of hip motion, but the displaced intra-articular fracture will result in hip osteoarthritis, and the higher rating from Table 16-4 is the appropriate rating.

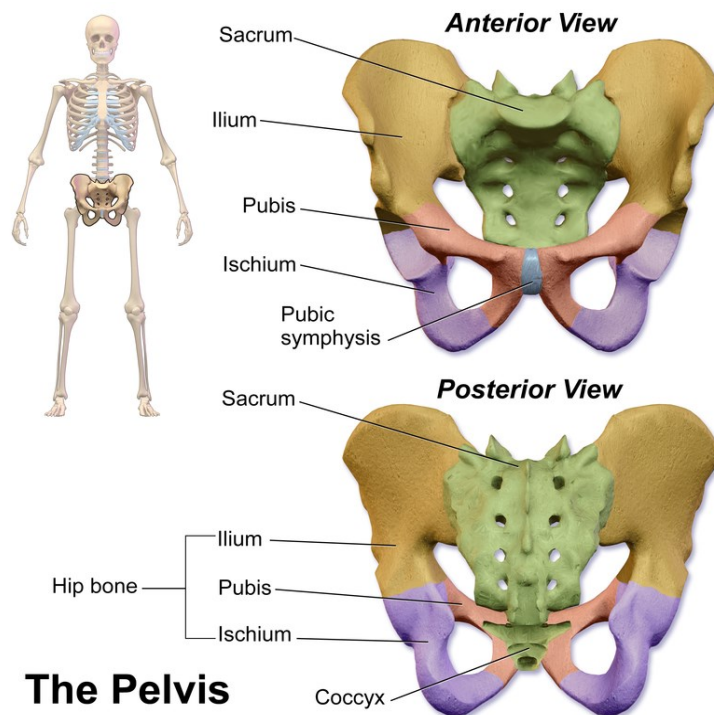
Sacroiliac (SI) joint dysfunction unrelated to pelvic fracture is rated using the lumbar spine regional grid, Table 17-4, on page 570, using the first diagnostic row for "Non-specific pain", as the definitions in this row include SI joint dysfunction. Sacroiliac joint dislocations or fracture dislocations with rupture of SI ligaments are rated in 17.4. Impairments of the hip, including acetabular labral tears, are rated in Chapter 16 using the Hip Regional Grid (LEI), Table 16-4, on page 512. Impairments of the sciatic nerve are rated using Table 16-12, Peripheral Nerve Impairment (LEI) on page 534. Finally, sexual and urogenital dysfunction is rated in Chapter 7 starting on page 129, and digestive system impairment is rated from Chapter 6 starting on page 101.

**OVERVIEW**

Fractures of the pelvis are rated using the diagnosis-based impairment method (DBI). For musculoskeletal injuries, including those that occur to the pelvis region, the rater selects the applicable diagnosis within the left column of the appropriate regional grid, then the impairment class based symptoms and severity, and finally modifies the rating from a default value by applying modifiers to a simple mathematical formula known as the "net adjustment formula" (Rondinelli, 2009, p.560).

**STEP 1: ASSIGN THE DIAGNOSIS AND IMPAIRMENT CLASS FOR THE PELVIS FRACTURE.**

Using Table 17-11 on 593, the rater selects one of two possible diagnoses, as applicable: (1) "Fractures of the pubic rami: fractures of the ilium, ischium, and/or sacrum," and (2) "Fracture of the acetabulum." The former diagnosis is divided into five potential impairment classes with the grid ranging from Class 0 to Class 4, and a potential impairment ranging



# PELVIS IMPAIRMENTS, AMA Guides, 6th Edition

## PELVIS IMPAIRMENT DBI RATING PROCESS

**STEP 1: Assign the diagnosis and impairment class for the pelvis.**

**STEP 2: Assign the Functional History, Physical Examination, and Clinical Studies grade modifiers.**

**STEP 3. Apply the net adjustment formula.**

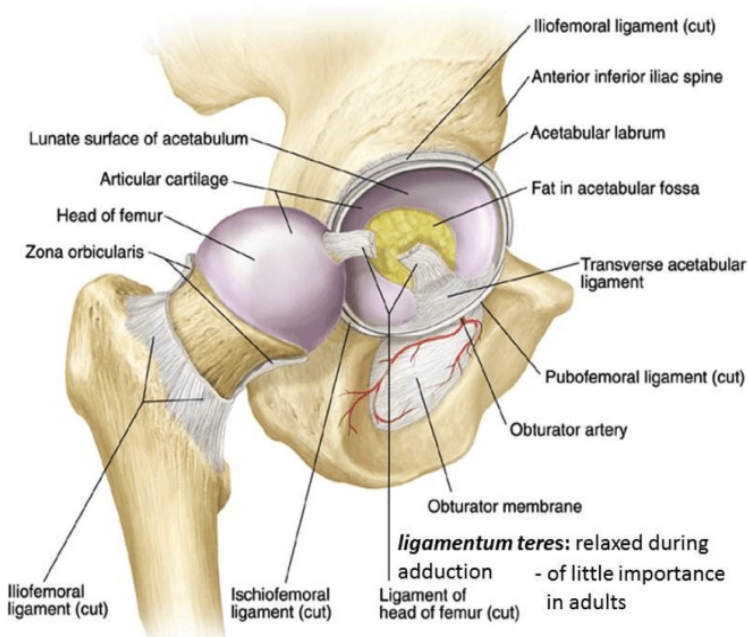
from 0% to 16% whole body impairment. The latter diagnosis provides only one option, Class 0 for a rating of 0%, and may be used only if the acetabulum is healed and nondisplaced, with no residual or structural deformity, and/or there are no residual symptoms related to the fracture.

Once the diagnosis is selected, the impairment class is assigned according to severity. Factors considered include displacement, deformity, instability, SI joint dislocation, ruptured SI joint ligament, and residual symptoms. Acetabulum fractures not meeting Class 0 criteria should be evaluated using range of motion (ROM) methodology for the hip joint as provided in section 16.7 of Chapter 16, The Lower Extremities, starting on page 542, and utilizing Table 16-24, Hip Motion Impairments, on page 549.

### STEP 2: ASSIGN THE FUNCTIONAL HISTORY, PHYSICAL EXAMINATION, AND CLINICAL STUDIES GRADE MODIFIERS.

Using Tables 17-12 through 17-14 (pgs. 394-95), the rater assigns the grade modifiers, which have the potential to modify the default impairment rating within each impairment class.

Table 17-13 on page 595 is used to assign the physical examination grade modifier (GMPE), whose value is expressed as integer ranging from 0 to 4. Results are obtained during the physical examination of the injured worker. More severe symptoms result in a greater value for the modifier. Deformity, tenderness, and gait are the primary considerations used to assign the physical examination modifier.



The grid used to assign the functional history (GMFH) modifier for pelvis ratings is Table 17-12 on page 594. Like the physical examination modifier, the GMFH's value is expressed as an integer ranging from 0 to 4, yet it is assigned based on the extent to which symptoms interfere with activities of daily living such as walking, dressing, bathing, driving, and climbing stairs. Tennessee claims with dates of injury on or after July 1, 2014, should not incorporate PDQ results or complaints of pain when assigning the functional history modifier. Rather, the rater should limit consideration to symptoms other than pain. Since pelvic fractures are often accompanied by injuries of other body parts and organ systems, the rater should be mindful to apply the functional history modifier to the single highest diagnosis based impairment (594). Otherwise, this part of the rating would be duplicative. If the rater finds that the claimant's self-reported symptom history is inconsistent or otherwise unreliable, the functional history grade modifier should be excluded from the grading process entirely, particularly if it differs by two or more grades from either the physical examination or clinical studies modifiers, which are both considered more objective in nature (Rondinelli, 2009, p.594).

Finally, the clinical studies grade modifier (GMCS) is assigned using Table 17-14 on page 595 and any available imaging studies, bone scans, and MRIs. Please note that if x-rays were used to determine stability and subsequently assign the patient's impairment class in Table 17-11, then the GMCS should be totally excluded from the grading process. Otherwise, results would be duplicative and therefore inaccurate.

### STEP 3: APPLY THE NET ADJUSTMENT FORMULA.

With the impairment class and grade modifiers assigned, the rater uses the net adjustment formula to determine the final whole person impairment rating. Essentially, the rater subtracts the impairment class integer from each the grade modifiers integers and then adds the differences resulting in the net adjustment. The impairment rating starts at the default value, Grade C, at the center of each impairment class range. A net adjustment of +1 or +2 increases the final impairment rating to the whole person percentage values associated Grade D and Grade E, respectively. A net adjustment of -1 or -2 decreases the impairment rating to the percentage values associated with Grades B and A, respectively. Please note that a net adjustment of more than +2 or less than -2 may never move an impairment rating out of its impairment class; rather, the rating remains Grade E and Grade A, respectively. The rater should also note that any time impairment class 4 is selected, +1 should be added to each grade modifier before applying the net adjustment formula. Otherwise it would be mathematically impossible to achieve a whole person impairment rating greater than the default value within impairment class 4. After the net adjustment formula is applied, the result is the final whole person impairment rating.

### CONCLUSION:

The diagnosis based methodology for rating pelvis fractures may serve as a simple archetype for the diagnosis based methodology as a whole, and certainly as it applies to musculoskeletal grids within the *Guides*, 6<sup>th</sup> Edition. Raters and medical professionals new to the *Guides*, 6<sup>th</sup> Edition, and who seek to understand its diagnosis based method better, may find it helpful to start with the concepts found in section 17.4, "Pelvis Impairment," beginning on page 592.

### REFERENCES

Rondinelli, R.D. (Ed.). (2009). *Guides to the Evaluation of Permanent Impairment* (6th ed). Chicago, IL: American Medical Association.

## APPEALS BOARD ADDRESSES MENTAL INJURY DEFINITION

(Continued from page 3)

tion is consistent with pre-Reform Act law. However, the statute now reads that a mental injury must arise “primarily” out of a compensable physical injury or an identifiable work-related event resulting in a “sudden or unusual mental stimulus.”

The Board cited a recent authority, *Ireton v. Horizon Mental Health Management, LLC*. In the 2016 *Ireton* opinion, the Tennessee Supreme Court’s Special Workers’ Compensation Appeals Panel held that, to be compensable, a mental injury (1) “must stem from an identifiable stressful, work-related event producing a sudden mental stimulus, and (2) the event must be unusual compared to the ordinary stress of the worker’s job.”

Fred’s argued that the altercation with the shoplifter didn’t qualify as a “sudden or unusual stimulus” because retail managers commonly encounter shoplifters and, while unpleasant, “such encounters are a normal part of a manager’s duties.” Further, per the employer, the event was a “minor interaction.”

The Appeals Board disagreed, reasoning that the psychiatrist didn’t see the interaction in that way. Additionally, Fred’s didn’t introduce evidence about how often, if ever, Edwards encountered shoplifters.

The Board also cited the statute to hold that the aggravation of a pre-existing mental condition isn’t compensable “unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment.”

Important to the Appeals Board, Edwards’ psychiatrist gave the only expert medical opinion in the record. Further, he gave that opinion quoting the statutory definition, more or less.

### A BATTLE OF THE EXPERTS

A couple of months later, in *Creasman v. Waves, Inc.* — also an aggravation case — the Appeals Board cited the same statutory definition and *Ireton* to uphold the trial court’s order of medical benefits. Employee Sherry Creasman managed a group home for developmentally disabled adults. She claimed physical and mental injuries after a resident hit her with a television remote.

Waves accepted the claim, and Creasman saw Dr. Subir Prasad, a neurologist. He wrote in response to a letter from Waves’ attorney that the employment didn’t contribute more than 50 percent to her need for ongoing medical treatment. Creasman later saw neuropsychologist James Walker, PhD, for authorized treatment. He, like Dr. Prasad, told Waves the work incident was less than 50 percent responsible for her “distress.”

In response, Creasman hired Dr. Greg Kyser, a psychiatrist, for an independent medical examination. Dr. Kyser wrote a lengthy report summarizing the other experts’ opinions and ultimately finding her mental condition work-related. Judge Dale Tipps held that Dr. Kyser’s opinion overcame the statutory presumption of correctness to those of the authorized providers.

Presiding Judge Davidson once again wrote for the Board in its April 16 opinion. The Board cited longstanding law, *Orman v. Williams Sonoma, Inc.*, listing the criteria courts must consider when a case presents contrary expert opinions. These criteria are: 1) the qualifications of the experts; 2) the circumstances of their examination; 3) the information available to them; and 4) the evaluation of the importance of that information by other experts.

The Board noted that Dr. Kyser is a psychiatrist, while Dr. Prasad is a neurologist. Judge Davidson wrote, “Given that Employee’s condition entails psychiatric issues, the trial court acted within its discretion in giving more weight to Dr. Kyser’s opinion on psychiatric matters.”

Further, Dr. Kyser considered Creasman’s psychiatric history in detail yet still concluded that her symptoms were more than fifty percent caused by the assault at work. Also, Dr. Kyser, unlike Dr. Prasad, “comprehensively documented his evaluative process and the information he considered.”

In addition, the lower court found credible the uncontroverted testimony of the employee and her sister, which supported Dr. Kyser’s characterization of Creasman’s pre- and post-accident mental conditions. Specifically, Dr. Kyser corroborated Creasman’s testimony that “at the time of her work injury, she was mentally stable and functioning well.” The Board, once again citing longstanding law, concluded, “An employee’s lay testimony along with corroborative expert testimony may constitute adequate evidence of medical causation.”

In a footnote, Judge Davidson observed that the trial court correctly found that, as a psychologist, Dr. Walker had no statutory authority to give a causation opinion, although psychologists may be treating providers under appropriate circumstances.

### A FEW TAKEAWAYS

Before proceeding, please keep in mind that the opinions below are mine alone. *Don’t read them as pronouncements from the Court of Workers’ Compensation Claims or the Appeals Board.*

That said, for starters, although the statute now requires that a mental injury arise “primarily” from work, that change hasn’t dramatically altered the Appeals Board’s medical causation analysis. Not yet, anyway.

Moreover, these opinions make it clear that, under the Reform Act, if a party plans to challenge an expert’s causation opinion, for both physical and mental injuries, that party probably needs to hire its own expert.

Further, *Creasman* serves as a roadmap for parties looking to overcome the presumption of correctness the statute gives to authorized treating physicians. Dr. Kyser’s report achieved this with its in-depth analysis of the employee’s mental history as well as its summaries of the other experts’ conclusions. Finally, parties (still) shouldn’t tap psychologists in cases where medical causation is contested.

# TENNESSEE WORKERS' COMPENSATION E-BILLING

(Continued from page 2).

Unless a provider is exempt, they are to begin submitting medical bills for workers' compensation treatment and services electronically. Additionally, insurance carriers, or their agents, or TPAs for self-insured employers, are to begin processing medical bills electronically.

Exemptions to this requirement are made automatically for **healthcare providers** that employ 10 or fewer employees or that have submitted fewer than 120 bills for Tennessee workers' compensation treatment or services in the previous calendar year. Exemptions are made for **insurance carriers** if they processed fewer than 250 bills for Tennessee workers' compensation treatment or services in the previous calendar year.

If either a health care **provider** or insurance **carrier** considers that compliance will result in an unreasonable financial burden, it may apply to the Bureau to be exempted from the mandate.

To qualify for an exemption based on unreasonable financial burden, the organization's authorized representative must submit its rationale, Tax ID, and supporting documentation to [WC.eBill@tn.gov](mailto:WC.eBill@tn.gov). The correspondence should be on the organization's own letterhead and addressed to Bureau Administrator, Abbie Hudgens.

Medical bill processing for workers' compensation treatment and services is inherently different from commercial medical billing because workers' compensation medical bills normally must be accompanied by medical records that are necessary to authorize payment.

Medical providers should start by assessing the capabilities of their current medical records and billing systems. Providers that already have practice management/electronic medical records software systems in place should contact their software vendors to determine the system's current workers' compensation capabilities.

When assessing practice management software for workers' compensation billing, consideration should be given to systems that are able to create HIPPA compliant electronic medical bills (ANSI-X12 EDI 837 file) and to software that can electronically export select medical records in standardized formats. (Some systems do not have this capability and rely on an operator to manually extract the record and then convert it to a digital file.) Software must also be able electronically to attach selected medical records to their respective medical bills and export them as one file to the payer.

While some practice management/EMR systems can readily generate a standardized electronic medical bill, many of these systems are not able to electronically export medical records without manual intervention, nor are they able to attach supporting electronic medical records to their respective electronic medical bills and export them as one file to the payer.

If the practice management and electronic medical record software can do all three of these tasks (select, attach and transmit), then the provider is ready to contact the payer

to establish a communications interface that will allow the provider's practice management/EMR system to communicate with the payer's software system directly or through the payer's designated electronic billing clearinghouse vendor.

Once this interface is established, the provider should be able to electronically send medical bills and their supporting documents as one file, and the payer able to receive them. The payer will close the loop by submitting an electronic explanation of review (EOR) or an Electronic Remittance Advice (ERA and X12 835) and a payment. The final step may be an electronic funds transfer (EFT) that can accommodate auto-reconciliation if the claim is accepted and payment is due. Providers may want to contact their largest insurers to work through these steps.

Providers may find it easier and more cost-effective to use a clearinghouse that specializes in workers' compensation bill processing. Not only have these clearinghouses already established communication interfaces with thousands of payers, they also have the technical ability to compensate for practice management software systems that cannot electronically match up and transmit the electronic medical bill with its supporting medical records. Some clearinghouses have the ability to accept paper bills and medical records and then convert them to standardized electronic formats for matching and submission.

Clearinghouses that specialize in workers' compensation include WorkCompEDI, Jopari Solutions, Inc., StoneRiver P2P Link, and DaisyBill. These clearinghouses may also have trading partner relationships with each other and commercial insurance billing clearinghouses to provide a more seamless service and take advantage of the full array of established communication interfaces.

When choosing a workers' compensation clearinghouse, it is important that it can communicate (either directly or through a partner) with the insurance carriers and third-party administrators that the provider routinely bills. The clearinghouse properly formats their electronic communications per Accredited Standards Committee (ASC)X12. Electronic Funds Transfers (EFT), EOR, and reconciliation activities are dependent on other capabilities of the practices, clearinghouses and payers.

The workers' compensation clearinghouse will assess the capabilities of the provider's current medical record and billing system and customize a solution that is right for the practice. If it is not able to meet the provider's needs given its present system capabilities, it may be necessary to contact another clearinghouse that can. Cost comparison may be needed.

The Tennessee Bureau of Workers' Compensation is aware that achieving compliance with electronic billing may be a difficult process. However, this innovation is a step that can benefit medical providers and payers.

Additional information may be found [here](#). Information resources can also be found at our e-billing [webpage](#). If you have questions, please contact Jay Blaisdell at 615-253-5616 or [WC.eBill@tn.gov](mailto:WC.eBill@tn.gov). The Bureau will do whatever it can to help facilitate your practice's transition.



The Tennessee Department of Labor and Workforce Development is committed to principles of equal opportunity, equal access, and affirmative action.

Auxiliary aids and services are available upon request to individuals with disabilities.

Tennessee Department of Labor and Workforce Development; Authorization No. 337621, December 2019; This public document was promulgated for electronic use only.