



The Ad**MIR**able Review

MIRR PHYSICIAN SPOTLIGHT KAREN OLDHAM, MD, MBA

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“Of all the different types of patients I see in this eclectic practice, I most enjoy caring for the injured workers, helping them get back to work as quickly as possible and dealing with any limitations imposed by their injuries,” says Dr. Karen Oldham. “I work in the MIRR because I consider it an honor to assist people who work hard for their living, and their employers, to quickly resolve their claims disputes.”

Dr. Oldham has faithfully served on the Medical Impairment Rating Registry since 2008. Her breadth of training in emergency, preventive, and occupational medicine allows her to rate a wide range of work injuries, making her an invaluable member of the registry. She currently collaborates with other physicians and mid-level providers at the Bradshaw Occupational Medicine Clinic, a private practice in Lebanon, Tennessee, and concurrently serves as the Chief Medical



KAREN OLDHAM, MD, MBA

Officer for Elite Emergency Services, an emergency staffing company. She holds privileges at nine different hospitals throughout Middle Tennessee and Northern Alabama.

Born in New York City to a military family, Dr. Oldham moved often as a child and eventually settled in Northeast

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“Dr. Oldham was called to active duty as an occupational medicine physician with the TN Air National Guard for Operation Iraqi Freedom.”

Ohio, where she spent her high school years. She enrolled in a six-year Bachelor of Science and Medical Degree program with the University of Akron and Northeast Ohio University’s College of Medicine. Upon graduating, she moved to Houston, Texas, for an anesthesiology residency with a focus in emergency medicine at the University of Texas’ Hermann Hospital, where she had the opportunity to work on Life Flight helicopters.

After residency, she worked for a medical staffing group that serviced suburban emergency rooms and occupational medicine and urgent care clinics. She fell in love with both types of work and continued working in Houston for four years before moving to Nashville, working again for medical staffing groups servicing emergency rooms and occupational medicine clinics. She also pursued a Masters in Business Administration at Cumberland University in Lebanon.

During the last two years of Governor Sunquist’s Administration, Dr. Oldham served as the Chief Medical Officer for TennCare. “I learned more about the business of medicine during those two years than in all my other

years of practice combined,” she says. “There is no other way to learn how the complex third party payer system really works than to participate in legislative sessions and discuss benefits management with the big health insurance companies.” Dr. Oldham then spent two years as a medical consultant for the state Chemical, Biological, Nuclear Threat Rapid Response team, operating through the 45th Civil Support Team National Guard, which responds to all toxin threats and exposures, suspected or real, in the State of Tennessee.

While consulting, Dr. Oldham pursued a residency and board certification for Occupational Medicine at Meharry Medical College, but it was interrupted during the third year when she was called to active duty as an occupational medicine physician with the TN Air National Guard for Op-

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The Bradshaw Clinic, Lebanon, Tennessee

HERNIA IMPAIRMENT RATINGS

James B. Talmage, MD

Jay Blaisdell, CEDIR

Of the many types of abdominal wall hernias, inguinal hernias are, by far, the most common type with the preponderance of injured workers being male and, in workers' compensation cases, the reported cause being heavy lifting. The *AMA Guides to the Evaluation of Disease and Injury Causation*, Second Edition, indicates that genetics (family history) is the strongest risk factor (537). Conditions that chronically increase intra-abdominal pressure (obesity, ascites, pregnancy) and smoking have been statistically associated with abdominal wall hernias. Severe abdominal trauma with surgery is associated with incisional hernias, but "there are no good studies showing an increased risk of hernia formation in laborers."

Except for the word "primarily," the language in TN Code 50-6-212 (see right column) has been present for decades and is a bit dated. There is no general surgery definition of "radical" hernia surgery, and patients, in contrast to 50-6-212 (b), are free to accept or reject recommended surgery. However, declining surgery without major medical co-morbidity seriously elevating surgical risk would appear to make a persisting hernia not ratable. The intent of the statute seems to be that slowly devel-

TN Code 50-6-212 Hernia or rupture

(a) In all claims for compensation for hernia or rupture, resulting from injury by accident arising primarily out of and in the course and scope of the employee's employment, it must be definitely proven to the satisfaction of the court that:

- (1) There was an injury resulting in hernia or rupture;
- (2) The hernia or rupture appeared suddenly;
- (3) It was accompanied by pain;
- (4) The hernia or rupture immediately followed the accident; and
- (5) The hernia or rupture did not exist prior to the accident for which compensation is claimed.

(b) All hernia or rupture, inguinal, femoral or otherwise, so proven to be the result of an injury by accident arising primarily out of and in the course and scope of the employment, shall be treated in a surgical manner by a radical operation. If death results from the operation, the death shall be considered as the result of the injury, and compensation paid in accordance with this chapter.

(c) (1) In case the injured employee refuses to undergo the radical operation for the cure of the hernia or rupture, no compensation will be allowed during the time the refusal continues.

(2) If, however, it is shown that the employee has some chronic disease, or is otherwise in such physical condition that the court finds it unsafe for the employee to undergo the operation, the employee shall be paid compensation in accordance with this chapter.

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oping abdominal hernias are not covered under Tennessee workers' compensation law in that these are logically genetic and not "primarily" due to work activity, and that major violence (sudden, painful injury, with immediate hernia being detected) is required for work relatedness in Tennessee.

For Tennessee hernia injuries that occur on or after July 1, 2008, the rater uses the *AMA Guides*, Sixth Edition, Table 6-10 (pg. 122) found in Chapter 6, "The Digestive System." The rating scheme in the internal medicine chapter differs from that found in the musculoskeletal chapters in that the rater utilizes a "key factor" out of two or three potential variables—History, Physical Findings, and Objective Findings—to select the impairment class. Much like grade modifiers in the musculoskeletal chapters, the other variables are then used to modify the impairment rating within the impairment class. The key factor is clearly denoted with a footnote in each grid in all internal medicine chapters except Chapters 12-14, which do not utilize the same rating scheme.

In Table 6-10, "Herniation," the authors use footnote "c" to designate "Physical Findings" as the key factor used to choose the impairment class. The only other variable is "History," which is then used to modi-



fy the grade from the default grade of "B" by subtracting the impairment class integer from the variable integer. Clinical studies are not mentioned in the text, the table, or in any of the three examples in Section 6.6 of the *Guides*. Since there are only three possible grades within each impairment class, as opposed to the five different grades found throughout the grids in the musculoskeletal chapters, a positive adjustment moves the grade to the right of a default for a final grade of "C." A negative adjustment moves the grade to the left of the default for a final grade of "A." An adjustment greater than the number one cannot move the rating into another impairment class.

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Abdominal hernias with palpable defects or protrusions are usually corrected with surgery. A surgically repaired hernia without a current palpable defect or protrusion in the supporting structure of the abdominal wall usually warrants an impairment of zero percent. A recurrent hernia after an intra-abdominal repair with mesh is very unusual. Consequently, most hernias that are accepted in a workers' compensation setting result, generally speaking, in an impairment of zero percent. However, in the rare instances that a recurrent hernia is present after surgery, or that the patient elects not to have surgery due to medical comorbidity, then the resulting impairment rating may be as high as thirty percent. This would typically be only in huge anterior abdominal wall incisional hernias after major abdominal surgery.

A hernia is reducible if the examiner can in a supine patient "reduce" or eliminate the protrusion of abdominal contents by manipulating them with gentle digital pressure back into the abdominal cavity. Tenderness at the site of persisting hernia is not an "irreducible" hernia.

If the patient is at Maximum Medical Improvement (MMI) and still has a *reducible* protrusion in the supporting structure of the abdominal wall, then the impairment class will be either one or two, with a whole body impairment rating ranging from one to thirteen percent, depending on the impairment class and the patient's reported Activities of Daily Living (ADL). If the patient is at Maximum Medical Improvement and still has an *irreducible* protrusion in the supporting structure of the abdominal, then the impairment class will be either three or four, with a whole body impairment rating ranging from sixteen to thirty percent, depending on the impairment class and the patient's reported Activities of Daily Living.

Pain after successful repair of an abdominal wall hernia is sometimes a complaint. Remember that for injuries on or after July 1, 2014, that pain (discomfort) is not to be the basis for a Tennessee impairment rating. Activities of Daily Living difficulty would have to be based on some other believa-

TN Bureau of Workers' Compensation
Medical Impairment Rating Registry
(MIRR)

220 French Landing Drive, Suite 1B,
Nashville, TN 37243

P.615.253.5616
F.615.253.5263

CG.WCMIRProgram@tn.gov

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ble limitation to be rated. After intra-abdominal hernia repair with mesh, pain would rarely be due to injury to either the genitofemoral or the ilioinguinal nerve, as these nerves are “deep” and covered by muscle, and not in the location of the typical anchor points of the mesh. These nerves were much more at risk of surgical injury with the now antiquated open inguinal hernia repairs. Presumably, only documentable injury to

these nerves from surgery would be ratable for injuries on or after July 1, 2014. This means sharp versus dull discrimination would be absent in a distribution roughly equivalent to that depicted in the *Guides*, Sixth Edition, Figure 16-3, page 537. This nerve injury would be ratable from Table 13-20, page 344, as class one, at one percent whole person impairment. (END)

Happy Holidays



MIRR PHYSICIAN SPOTLIGHT KAREN OLDHAM, MD, MBA

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Dr. Oldham commanded the rescue medical-triage effort at the New Orleans airport during the first two weeks after Hurricane Katrina.

eration Iraqi Freedom. She served as Chief of Occupational Medicine, an office which included issuing medical impairment ratings for the 118th Airlift Wing. “I was proud to wear the uniform in the service of my country,” she says. “It was a privilege to prevent occupational injuries in the wide variety of duties performed by our soldiers and airmen. I am always humbled when caring for ones injured in the line of duty.” Part of her job

also involved expediting injured airmen through the post-deployment healthcare system and providing VA benefits.

Dr. Oldham received a medal for valor for her military service, and upon returning from active duty, took the Occupational Medicine Boards, becoming board certified. She returned to active duty during the first two weeks after Hurricane Katrina as commander of the rescue medical-triage effort at the New Orleans

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In 1998 Dr. Oldham and her husband Brad started “Circle 3 Farm Performance Quarter Horses,” whose mission is to create champion horses for the racing industry.

airport, which was completely surrounded by water and unreachable by ground vehicles. She managed the movements of victims brought by helicopter to the airport and medically triaged and sent them to appropriate care. Victims were either evacuated by civilian or military airplanes to hospitals in the north, including Nashville and Memphis. “We moved an estimated thirty-thousand people—and many pets—through the airport location during the first six days.”

Dr. Oldham lives in Lebanon, Tennessee, with her husband, Brad, her three dogs, twelve horses, and

scores of other pets rescued over the years. In 1998 they started “Circle 3 Farm Performance Quarter Horses,” whose mission is to create champion horses for the racing industry. “We breed and train quarter horses for barrel racing and other performance events. For ten years we traveled with our youngest son in Tennessee and surrounding states as he raced in junior and professional rodeos. We are now raising grandchildren to do the same. Our favorite pastime is working with local children who barrel race and compete in various saddle club activities.

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We help them train, sponsor entry fees, buy helmets and cheer for them at the show. It's wonderful to watch these children care for their horses, work hard at training, and see smiles on those faces as they finish their runs and leave the arena on race day.”

A retired paramedic and firefighter, Brad Oldham is now a full-time farmer with a large hay-cutting business. Together Dr. Oldham and her husband have five children who are now grown and raising their own families. (END)

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The Oldhams traveled with their youngest son, Brandon, in Tennessee and surrounding states as he raced in junior and professional rodeos.



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