



The AdMIRable Review

MIRR PHYSICIAN SPOTLIGHT Robert M. Dimick, M.D.

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Robert M. Dimick, M.D. , has been an MIR Physician since August 2005. He served as an instructor for the spine chapter of the *AMA Guides, 6th Edition*, during the 2012 MIRR summer training seminar.

In 2004, Dr. Dimick joined Nashville's Premier Orthopaedics & Sports Medicine, PLLC, where he currently specializes in spine and general orthopaedics. He is Board Certified with the American Board of Orthopaedic Surgery and is licensed to practice in Tennessee, Alabama, and Florida. He served as Chairman of the Department of Orthopaedics and Neurosurgery at Summit Medical Center in Her-



Robert M. Dimick, MD

mitage, Tennessee. He is currently affiliated with Centennial Medical Center, Saint Thomas Midtown Hospital, and Southern Hills Medical Center, all in Nashville, Tennessee. Dr. Dimick is a member of the Nashville Academy of Medicine,

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MIRR PHYSICIAN SPOTLIGHT

Robert M. Dimick, M.D.

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Tennessee Medical Association, Tennessee Orthopaedic Society, North American Spine Society, American Academy of Orthopaedic Surgeons, and American Medical Association. He is a past president of the Nashville Academy of Medicine, a graduate of the Tennessee Medical Association Leadership College, and a member of the Tennessee Medical Association Legislative Committee.

Earning a Bachelor of Science degree in chemistry from the University of Alabama, Dr. Dimick capped a very distinguished undergraduate career by graduating *Magna cum Laude*, qualifying for the 1980 Olympic trials in swimming, and being named a Rhodes Scholar Semifinalist. He was a member of *Phi Beta Kappa* Honor Society and *Omicron Delta Kappa* all the while becoming a seven-time All American in swimming. It is no wonder why the

University of Alabama's Athletic Department recognized Dr. Dimick with the Scholar Athlete Award.

Dr. Dimick earned his medical degree in May 1984 from the University of Alabama School of Medicine in Birmingham, Alabama. He served his residency in General Surgery and Orthopaedic Surgery at University of Alabama Hospital and was Chief Resident there from 1989 to 1990. He received a Fellowship in Spinal Surgery at Allegheny General Hospital in Pittsburgh, Pennsylvania, an AO Fellowship in Spinal Surgery in Bern, Switzerland, an AO Fellowship in Trauma at *Rechts der Isar Hospital* in Munich, Germany, and a Knee Surgery and Sports Medicine Fellowship at North Sydney Orthopaedic and Sports Medicine Centre in Sydney, Australia. We thank Dr. Dimick for his excellent service to the MIRR and his leadership in the evaluation of permanent impairments.

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

DIGITAL NERVE IMPAIRMENTS

James B. Talmage, MD

Jay Blaisdell, CEDIR



The digital nerves in the hand are purely sensory nerves. Each digit has two main nerves that supply sensation to the volar (palmar) side of the digit – one on the radial side and one on the ulnar side of the digit. The diagnoses based impairment (DBI) method commonly used throughout the *AMA Guides, 6th Edition*, is not employed when rating digital nerve impairments. Rather, the method used is derived from a process implemented and revised in previous editions. To rate digital nerve impairments, consider simplifying the process by dividing it into three steps: (1) Determine the degree of sensory loss (none, partial, or complete) , (2) Determine the distribution or extent of the sensory loss , and (3) Apply your results to Table 15-16 on

page 427 (for thumb and little finger) or Table 15-17 (for index, middle, and ring Fingers).

(1) Determine the degree of sensory loss:

You may use the two-point discrimination test or the monofilament test and Table 15-15 on page 426. The table broadly defines sensory loss and sensory quality impairment as “none” (0%), “partial” (50%), or “total” (100%). Static two point discrimination is more reliable, and consensus on the definitions of “normal,” “partial,” and “total” sensory loss has been present for decades across all editions of the *AMA Guides*. Monofilament testing may detect very subtle sensory loss, but as the *6th Edition* states, there is disagreement over what filament stiffness should define “almost abnormal but still normal” versus “just barely abnormal”. In manual laborers with calloused hands, testing adjacent uninjured digits and digits on the other hopefully uninjured hand should help the examiner decide on what filament to choose as defining abnormal in a given individual.

DIGITAL NERVE IMPAIRMENTS

(continued from page three)

(2) **Determine the distribution of the impairment:** The distribution, or area, of the sensory loss is defined in terms of (A) the percentage of the digit length affected and (B) the individual digital nerves affected. To determine the percentage of the digit length affected, use Figure 15-4 on page 426 (for the thumb) or Figure 15-5 (for a finger). To determine the individual nerves affected, distinguish between traverse sensory loss and longitudinal sensory loss. Traverse sensory loss occurs when both digital nerves are affected at the same level. Longitudinal sensory loss occurs when the digital nerve on either the ulnar side or radial side is affected. The table entry for longitudinal loss is also used when both nerves in a digit are injured, but at significantly different locations in the digit, as occurs with oblique lacerations of a digit. The most common reason for digital nerve sensory loss is

laceration of the nerve, and thus the location of where sensory loss begins in a digit usually corresponds with the location of the scar in the skin from the laceration.

(3) **Apply your results to Table 15-16 or 15-17 on page 426:** For example, according to Table 15-17, a partial sensory loss (two point discrimination of 6-15 mm) involving 80% of the length of the radial side nerve of the index finger would be 12% impairment to the digit. Using conversion Table 15-12, 12% to the index finger converts to 2% of the hand, which is a 2% upper extremity impairment, or a 1% whole person impairment.

Medical Impairment Rating Registry
TN Department of Labor and Workforce Development
Division of Workers' Compensation
220 French Landing Drive
Nashville, TN 37243
[Phone] 615.253.5616; [Fax] 615.253.5263
Jay.Blaisdell@tn.gov

NEW MEDICAL DIRECTOR FOR DIVISION OF WORKERS' COMPENSATION



Robert B. Snyder, MD

The Medical Impairment Rating Registry welcomes Robert B. Snyder, M.D., as the new Medical Director for the Tennessee Department of Labor's Division of Workers' Compensation. He is certified by the American Board of Orthopaedic Surgery and previously practiced with the Lipscomb Clinic-Harding Care Center of Tennessee Orthopaedic Alliance in Nashville, Tennessee.

Dr. Snyder earned a B.S. in chemistry from Kalamazoo College, Kalamazoo, Michigan, and a B.S. in mathematics from Belmont University in Nashville. He is a 1972 graduate of Wayne State University School of Medicine in Detroit, Michigan, and served two years of surgical residency at the University of Pitts-

burgh. He completed his orthopaedic training at Vanderbilt University. While in active practice with Tennessee Orthopaedic Alliance, Dr. Snyder frequently presented lectures and taught Orthopaedics in Lima and Arequipa, Peru. His medical interests include fitness, general musculoskeletal care, and joint replacement, with an emphasis in minimally invasive surgery for knee and hip replacement.

During the 1980s, he served as an associate team physician for athletic teams at Tennessee State University and Vanderbilt University, including Vanderbilt's NIT basketball championship at Madison Square Garden. He is a past president of the medical staff of Saint Thomas Hospital, the Nashville Orthopaedic Society, and the Vanderbilt Orthopaedic Society. During Operation Desert Storm, he worked as an orthopaedic consultant at Fort Campbell, Kentucky.

Outside the office, Dr. Snyder enjoys reading, gardening, and traveling. He and his wife of 42 years, Paula, have two children and one grandchild.