Fall 2015 Edition

WH Workplace Health

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Alliance Spine
AND PAIN CENTERS

Alliance Spine and Pain Centers is one of the premier interventional spine and pain practices in the U.S., and has been recognized locally and nationally for the achievements of our practice and our individual physicians. Our practice offers board certified, fellowship trained anesthesiologists practicing cutting edge interventional pain management between 15 locations including 11 state of the art ASC's in GA. The practice further boasts of former academic leaders who held positions of Director of Pain Management and Pain Fellowship at Emory, Associate Professor of Anesthesiology at Emory and faculty at Medical College of GA. in Augusta. Many of our physicians have been published and/or won awards. Alliance's highly skilled Anesthesiologist focus on non-surgical, image-guided procedures that help return patients to work and improve quality of life. In many cases, these patients can return to normal activities or avoid more invasive treatments. Spine treatment procedures are clinically proven and follow the guidelines of American Society of Interventional Pain Physicians. Our state-of-the art outpatient centers are Joint Commission accredited.

CONDITIONS TREATED

- Hip Pain – Degenerative Disc Disease
- Neck Pain – Spondylosis
- Back Pain – Disc Herniations
- Occipital Headaches
- Nerve Root Impingements
- Vertebral Compression FX
- Spinal Cord Injury nerve pain
- Radiculopathy/Sciatic – Cancer
- Reflex Sympathetic Dytrophy RSD/CRPS
- Diabetic Neuropathy
- Facet Pain – SI Joint Dysfunction
- Trigger Point Injections

NON-SURGICAL TREATMENTS

- Epidural Steriod Injections/Discograms
- Selective Nerve Root Blocks/Facet Blocks
- Diagnostic Nerve/Lumbar sympathetic blocks
- Radiofrequency Ablation
- Major Joint Injections/Stellate Ganglion Block
- SI Joint Injections/Medial Branch Blocks
- Peripheral Nerve Blocks
- Celiac Plexus Blocks/Spinal Cord Stimulator
- Occipital Nerve Blocks
- Hypogastric Plexus Blocks
- Vertebroplasty/Kyphoplasty

W/C Coordinator: Alicia Trammell 404-920-4952 atrammell@spinepains.com

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Treating Patients Appropriately With Opiate Pain Medications

Pickens A. Patterson, III, M.D. Board Certified in Anesthesiology and Pain Medicine
Alliance Spine and Pain Centers

A well-trained pain specialist is uniquely qualified to recognize and manage all of the many intricacies associated with prescribing narcotic pain medications, where appropriate, following a work injury. It has been shown that treating pain adequately in the early stages of injury increases the likelihood of recovery and return to function, whether requiring opioid or non-opioid pain medications.

Clearly **all patients suffering an injury do not require opiate medications.** However, those that do should be required to undergo screening to identify a high risk for opiate abuse and misuse. **Screening may be as simple as a questionnaire inquiring about the patient's family history as well as their personal history with opiates and illicit drugs.** Patients identified as high risk should be treated with opiates only if deemed absolutely necessary and monitored more closely than a low risk patient.

Patients treated with opiates on a chronic basis (generally greater than 90 days) should be required to read and sign an opiate agreement with the prescribing physician. This agreement describes the risks associated with narcotic medications, the reason they are being prescribed and what the physician requires of the patient as well as what the patient should expect from the physician. **If a patient and physician are unable to reach an agreement as to how the patient will be treated in writing, narcotic medications should not be prescribed.**

The urine drug screen is expensive, but provides invaluable information to the treating physician. It shows if the patient is taking the prescribed medication, taking a non-prescribed medication or taking illicit drugs or another medication that may interfere with their narcotic pain medication. **The state of Georgia requires a physician to test a patient's bodily fluid randomly at least every three months while being treated with narcotics.** Other forms of testing include blood and saliva. Physicians may employ random pill counts where a patient is called in and advised to bring in their bottle and the pills are actually counted. Most patients are required to be seen monthly.

The pain physician also has a responsibility to appropriately respond to any aberrant behavior which may include failed urine drug screens, frequently lost medications or prescriptions, frequent requests for early refills and appearing intoxicated. Depending the behavior, a physician may counsel a patient, advise the patient that they will no longer prescribe opiate medications, (continue to treat with non-opiates and interventional procedures) or discharge a patient from his care and even notify the authorities if warranted.

If a patient is discharged the physician should provide a clear treatment plan for the patient which may include substance abuse treatment. The physician should provide a list of other treating physicians in the area of the same specialty and a letter describing the reason for discharge.

Pickens A. Patterson, III, M.D.

Pickens A. Patterson, III, M.D. is Double Board Certified in Anesthesiology and Pain Management Medicine. He has eight years of experience in practicing Interventional Pain Management in South Carolina and Georgia.

Dr. Patterson attended the United States Naval Academy. He later completed his internship and residency in anesthesiology at Vanderbilt University where he was awarded "Best Bedside Manner" by the director of his fellowship program. He Patterson grew up in the College Park/Southwest Atlanta area, not far from the Camp Creek Medical Center where his office is located. His wife, Cristale, is also a native of College Park and they have two young sons. Dr. Patterson intends to provide the most up to date treatments for chronic pain to the Atlanta metropolitan community for many years to come.

WH Workplace Health

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WH CONTENTS

Be sure to detach the lists from the back cover for future reference!

Why Do I Need A Restricted Duty Job Program?

Best Practices

1. Return injured employees to meaningful employment.
2. Utilize employees' work skills during their period of partial disability.
3. Maintain a good employee attitude by providing meaningful employment.
4. Maintain communication with employees.

Benefits

1. Helps the injured employee maintain income levels.
2. Eliminates employees' fears concerning future employment.
3. Controls workers' compensation costs.
4. Reduces need for attorneys in the workers' compensation case.
5. Reduces employees' complacency caused by sitting at home.
6. Providing meaningful transitional-duty employment should help reduce workers' compensation fraud.
7. Employees return to work sooner.

How Do I Develop A Transitional-Duty Job?

Best Practices:

1. Identify jobs with physical demands consistent with restrictions placed on the injured employee by the physician.
2. Evaluate the essential functions of all jobs so you can identify portions of a job which would be within the physical restrictions of your injured employee.
3. Develop a written job description of the transitional-duty job.
4. Involve all the participants, (i.e. employees, supervisors, managers, physicians, company nurses, etc.), to develop an appropriate job.
5. Make sure the job is meaningful and productive.
6. Avoid isolation from other employees.
7. Be flexible regarding work and time limitations imposed by physicians. Some employees may be restricted to reduced hours.
8. Maintain consistent, continual employment.
9. Be sure the job is developed prior to the time you need it.
10. Be flexible about department and shift.
11. Be sure appropriate transitional duty is available when needed.
12. Establish an appropriate pay for a transitional-duty job. Temporary partial disability benefits will compensate for reduced earnings during the transitional duty.
13. Be creative in developing transitional-duty jobs.
14. Review the Early Return-To-Work Program available on the Board's website, ***www.sbwc.georgia.gov***.

Benefits

1. Job description will be available when the need arises.
2. Employee returns to work sooner.
3. Doctors, employees and management will have a better understanding of the job requirements.
4. Employees will accept the job more readily once it is clearly defined.
5. Assures your consistency in return-to-work programs.
6. Will help credibility with doctors, lawyers and judges in workers' compensation cases.
7. Employees return to full-duty work sooner.

These lists were sourced from the Georgia State Board of Workers' Compensation website. Please visit the site for forms, regulations, event announcements and other valuable information

404-656-3875
www.sbwc.georgia.gov

What Is A Certified Georgia Worker's Compensation Managed Care Organization?

Cheryl Gulasa, RN, CPHM, CCM

A certified Georgia WC/MCO provider must adhere to the components of the Georgia State WC/MCO Rule 208. The MCO system was created by O.C.G.A. § 34-9-208 and is based on successful MCO's in Minnesota and Oregon. The key to MCOs is that it centralizes the health care provided in a workers' compensation claim.

Managing care today means controlling access, unit costs, utilization, and total costs while monitoring, measuring, and reporting outcome information. It also includes systematically capturing, measuring and reporting utilization patterns and application of the appropriate fee schedules and reimbursement rates. All this must be done with the goal of providing quality health care and returning injured workers back to the worksite in a safe, efficient, and prompt manner.

Components of an effective MCO program must include Utilization Management services and a Certified Provider Network(s) in all 159 counties that offers the injured employees' choice and direction to appropriate care. The WC-P3 is displayed at the place of employment in contrast to the "traditional" posted panel which individually identifies required physicians and their specialties. The WC-P3 gives the Injured Employee the necessary information to access the approved MCO network. This removes the opportunity for the disqualifying of the panel due to invalid provider information.

Other components of the WC/MCO include a Utilization Review process, Case Management availability (telephonic and in the field), Transitional Work advisement, and aggressive Return to Work programs.

It is the goal of the WC/MCO to initiate early intervention actions to provide aggressive case management with a focus on early return to work. The medical case manager within the first 24 hours of a reported injury will conduct a 3 or 4-point contact. This will include an assessment of the initial medical treatment; evaluation of the treatment plan and the need for continued medical case management services will be evaluated. This is the first step in aggressive return to work coordination and establishing a strong rapport with the injured employee. The emphasis placed on return to work after an illness or injury results in multiple benefits for an injured employee and the employer. Those employee benefits include, but are not limited to physical, psychological, financial, and social optimal outcomes. Aggressive return to work also preserves a skilled and stable workforce for the employer and avoids indemnity costs.

Case Management is the systematic evaluation of medical services, procedures, and facilities for medical necessity, appropriateness and efficiency. This promotes optimal patient outcomes, reduces period of disability and assures high quality of care while controlling costs. The use of case management is protected under the WC/MCO, in other words, it cannot be prohibited by the opposing counsel.

Another WC/MCO tool utilized is Peer Review. Peer review is a process where a physician advisor evaluates the Authorized Treating Physician's plan of treatment to offer insight as it relates to evidence based guidelines and conversation regarding the requested treatment. This is done with the goal of reaching to an agreement on what is the best course of medical action for the injured worker, and offers assistance to the claims' adjuster in making compensability determinations.

It is essential that a managed care program effectively work with the employer/carrier and/or the employer's claim administrator in the provision of managed care services in the Workers' Compensation environment. For successful outcomes, the programs must complement each other and support the other's efforts.

Ultimately, the WC/MCO goal is to always to provide the highest level of quality care in the most cost effective manner on behalf of the injured employees and the employer.

Cheryl Gulasa
RN, CPHM, CCM

Cheryl is currently the Vice President for AmeriSys. Her primary responsibilities include overseeing the Professional Operations of AmeriSys which is Telephonic Case Management, Field Case Management, Provider Relations and Utilization Management, including Bill Review. Cheryl has 30 years experience in nursing, the last 14 years in workers' compensation case management and utilization management. She has successfully implemented large public entity programs. Cheryl's experience coupled with her energy and leadership skills brings valuable asses to our organization.

Hand Laceration Treatment

Joshua A. Ratner, M.D.-The Hand & Upper Extremity Center of Georgia, P.C.

Among the most common reasons for hand surgery consultation after a work-related accident is a hand laceration. The complex anatomy of the hand makes even a seemingly simple cut a potentially serious injury. While urgent evaluation by an emergency room or urgent care center is recommended, subsequent follow up with a physician experienced with the detailed examination of the injured hand is essential.

Initial management should always include infection prevention. Wounds should be irrigated to eliminate contamination. Antibiotics and tetanus prophylaxis are given when indicated. In the event of excessive bleeding, pressure is applied to the wound either by hand or with a reinforced bandage. Uncontrolled bleeding or gross contamination may be an indication prompt surgical care. When possible, a thorough examination to assess tendon function, nerve function, and vascular status should be performed. Findings should be documented. Wounds should be covered with non-stick dressings and loosely placed bandages.

If there is concern about injury to structures deep to the skin, prompt (within 2-3 days) evaluation by a hand surgeon is required. Early recognition and treatment of hand injuries is an important predictor of successful outcomes. Delayed treatment in the case of tendon and nerve injuries complicates surgical care and compromises rehabilitation.

Surgical management and rehabilitation of patients with hand injuries requires the expertise of those specially trained in the field. Hand surgeons and certified hand therapists have completed specialized training to ensure accurate diagnosis, skilled surgical and non-surgical management, and optimized patient outcomes.

Dr. Ratner graduated cum laude from Jefferson Medical College, where he was selected to the Alpha Omega Alpha Medical Honor Society. He completed an orthopedic surgery residency at the University of Pittsburgh Medical Center and Children's Hospital of Pittsburgh. Dr. Ratner continued his training at the Philadelphia Hand Center where he served a fellowship in Hand and Upper Extremity Surgery. Prior to joining the Hand and Upper Extremity Center of Georgia, he was a member of the medical staff at the Shriners Hospital for Children in Philadelphia where he specialized in treating pediatric hand trauma, congenital differences, spinal cord injury, and brachial plexus palsy. Dr. Ratner is Certified by the American Board of Orthopaedic Surgery. Dr Ratner holds a Subspecialty Certificate in Surgery of the Hand from the American Board of Orthopaedic Surgery.

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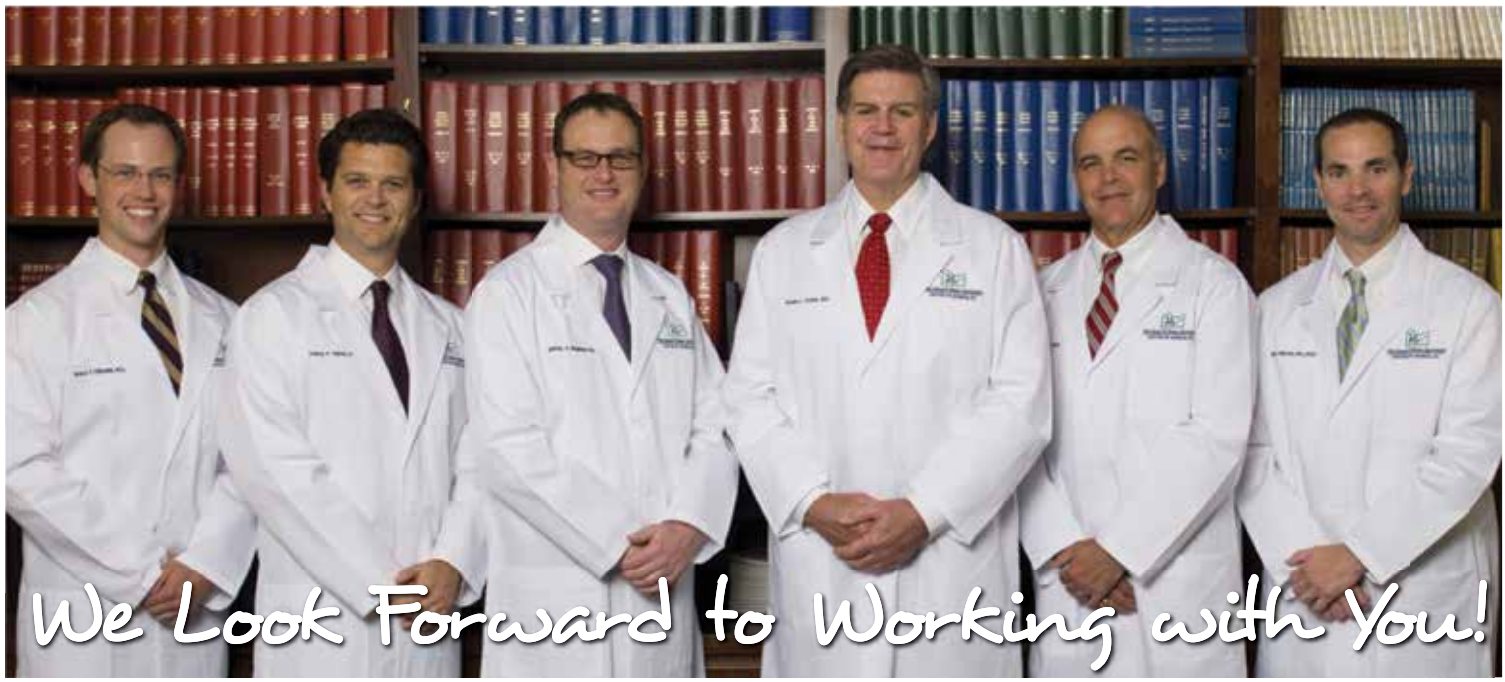

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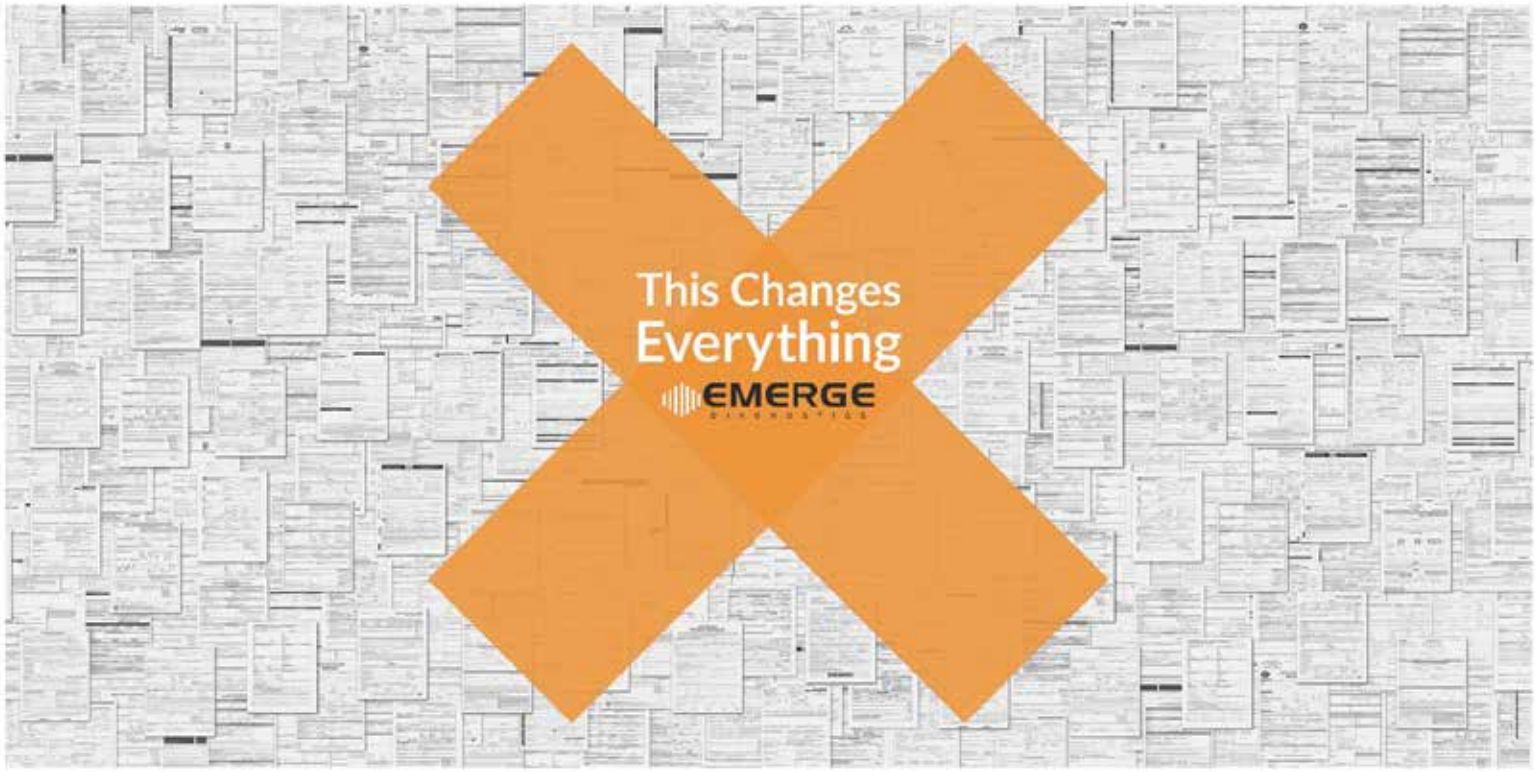

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GWCA is Georgia's resource for workers' compensation professionals. Our activities and services include:

- Working closely with the State Board of Workers' Compensation on regulatory issues.
- Daily presence at the State Capital during Legislative sessions.
- Monitoring case law and advising members of workers' compensation issues, legislative changes and court cases.
- Spring and Fall Conferences provide members with networking opportunities, educational seminars, as well as opportunities for open discussions with state and business leaders.

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GWCA has always been an advocate and voice for employers but previously represented only self-insured and high-deductible companies. It is our belief that all employers should have a supporter and a way to be heard, so we have expanded our membership to all employers that do business in Georgia. It is our goal to be part of an ongoing dialogue between the members and those at the state level to facilitate change and improve our workers' compensation system.

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LABSOLUTIONS is a state-of-the-art Molecular Diagnostics and Toxicology Laboratory, located in Atlanta, GA. Our world-class facility houses the most advanced genomic and toxicology testing equipment, to ensure we keep your practice on the cutting edge! Our team of highly qualified scientists and professional support staff are always available to answer any questions you may have.

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PHARMACOGENETIC TESTING:

Promoting And Practicing Better Medicine In The 21St Century By Using Genetic Testing To Help Predict Drug Response.

Bernadette Wildemore, MD, Molecular Pathologist
Robert Williams, PhD, Clinical Toxicologist

The way in which physicians care for patients is constantly evolving – the 21st century promised to herald in an era of personalized medicine, tailoring therapies to patients to avoid dangerous, costly and time-consuming trail-and-error dosing schemes. Technological advances as well as great strides in the way we process and interpret genetic data finally allow for these types of genetic tests to be used as routine tools in the clinic.

What is Pharmacogenetics?

Pharmacogenomics is the study of how human genetic variation affects an individual's response to drug therapies. Understanding the genetic makeup of a patient allows a physician to predict how a prescribed drug will interact with that patient – giving the clinician insight into efficacy and potential undesired drug effects and interactions.

How does the interrogation of genetic data help a clinician better prescribe?

Large families of enzymes (and transporters) involved in first-pass metabolism reside in our liver and wait for their target substrates to present themselves, setting off a chain reaction of metabolic events. In order to predict how efficiently an enzyme or transporter will perform its duties, we look to an individual's DNA. By isolating and examining the regions of a patients DNA that code for the enzymes of interest, we can better predict how the enzymes will interact with their targets – thereby giving us a peek into the overall metabolic efficiency of a given enzymatic pathway. This data can then be used to help physicians stay clear of drugs that would be metabolized by inefficient pathways and guide them towards drugs that use stronger metabolic pathways. Greater understanding of how a patient processes medications also allows for us to predict the buildup of often toxic drug products as well as better predict dangerous interactions between drugs and/or their metabolites.

Why Test?

Every Year more than 8 million adverse drug events (ADEs) are reported in the US – more than 2 million of them are severe. Adverse drug events are the fourth leading cause of death nationwide and cause tremendous financial burden on our healthcare system. More than 85% of the patient population have detectable variations in their DNA that increase their risk for an ADE. Proper pharmacogenetic testing will highlight these variations, allowing the clinician to predict harmful drug response (or non-response) before initiating a therapy.

Currently, the US Food and Drug Administration provides pharmacogenetic guidance/information (directly on the label) for more than 120 approved prescription medications, indicating strong support for this type of testing to be utilized regularly. Pharmacogenetic testing (PGT) has shown great utility in aiding physicians to prescribe drugs in numerous fields of practice, including but not limited to, Pain medicine, Cardiology, Internal medicine, Psychiatry, and Oncology. Furthermore, PGT is a non-invasive, once-in-a-lifetime, genetic test: The patient's test results can be used as a tool to better prescribe for the rest of their lives.

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Direct Anterior Hip Replacement

Todd E. Kinnebrew, MD

Total hip replacement is among the most successful operations that are performed, not only in orthopedics but in all aspects of surgical procedures as well. A study done several years ago, in fact, listed total hip replacement as the number two operation, in patient satisfaction, second only to cataract surgery. The reason for this is two fold. The first is that hip arthritis is so debilitating and the second is that replacement presents such a good result to a bad problem. Hip Replacements, were originally done in England in the 1960's by Sir John Charley, who actually did a lot of his early prosthesis in his own metal lab!

Since then, there has been a lot of evolving of the prosthesis (the replacement) but the concept remains the same, replacing the socket with a shell and a plastic liner and replacing the head with a ball and a stem that supports it. The most recent evolution of this operation involves the approach. Instead of going from behind, which is the traditional approach, we are able to go through the front. This allows us to actually go between the muscles and put the hip in. This has several advantages including less pain and quicker recovery time. One of the biggest complications of hip replacement is dislocation; this problem is greatly lessened by the anterior approach.

The problem with the anterior approach has been the difficulty getting the hip parts into place. This has been greatly relieved by design of components that are easier to get in, but at the same time are well designed and durable. Overall, the anterior approach is a nice adaptation of a proven procedure that adds to the benefits of this very successful operation.

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Todd E. Kinnebrew, MD

"Dr. Kinnebrew sites his strong family military ties as one of the reasons he has made a commitment to our nation's armed forces. Treating military personnel is both an honor and a privilege to him and he is proud to care for our nation's military."

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Workers' Compensation And Initial Authorized Medical Treatment In Georgia And Florida

Ashik R. Jahan

Aside from emergency medical treatment that may be required for a worker injured on the job, Florida and Georgia have established rules regarding the initial authorized medical treatment for injured workers. Knowing what to do to authorize this initial medical treatment for an injured worker can be critical to appropriately manage and reduce costs from the very beginning of a claim.

In Florida, the employer/carrier has the right to select the initial physician for the injured worker. However, a one time change request is permitted, and the employer/carrier must provide a new physician within a reasonable period of time, i.e. five days. If no new physician is provided, the employee may choose a physician of their choice.

In Georgia, the employee selects the initial physician from a panel maintained by the employer. If the employer fails to provide a valid panel, if the panel was not posted at the worksite at the time of injury, or if the panel is invalid, the injured worker may treat with a physician of their choice.

Therefore, it is critical to provide timely responses and notices to injured workers regarding their requests for treatment with physicians, as well as to provide and maintain appropriate panels/lists of conservative physicians. Failure to do so can often lead to the employee becoming free to treat with a physician of their own choice.

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The Georgia Conference is a non-profit organization providing a quality educational forum for the improvement of the workplace

Smoking And The Employer/Workplace

Henry Garfield, PhD
Senior Principal, HJG Associates Consultants

Many employers have assumed that smoking is decreasing, and therefore not a serious issue, or they have been afraid to tackle the issue because they fear losing employees they consider to be essential for their workplaces. In this article we will review why smoking remains an issue for employers, and ways they can try to deal effectively with smoking employees.

First we will look at the statistics. 17.8% of the US adult population still smokes. This is 42.1 million people. Smokers have 1.65 times more accidents than non-smokers. A high percentage of their accidents are at work. There has been a significant, on-going decline in smoking in the USA. But the decline is too little, and too late for many employers trying to control their workplace injuries. Do these injuries occur when employees are waiting to take their smoke breaks, or are the when they return to work from such breaks? Does it really matter, if the better way to control such injuries is to help to reduce the issue?

From smokers who have been surveyed in the USA, an interesting statistic pops up consistently. No matter how long workers have smoked, if they are given help in stopping smoking, and a supportive environment, over 68% say they would like to stop smoking.

Employers have used both carrots and sticks to help achieve reduced numbers of smokers as part of their goals to reduce injuries.

1. Offer reduced insurance rates for non-smokers. And conversely increase rates for smokers for health insurance.
2. Offer free or reduced rate programs for helping employees to stop smoking. These usually include physicals, and various prescriptive drugs or items such as patches, to be used with medical supervision.
3. Support from other employees trying to stop and the non-smokers can be obtained if they understand that injuries will decrease with time after employees stop smoking. Some employers have then been able to buy insurances for lower prices using their non-smoker pool data.
4. Employers should be willing to have employees tested for nicotinic acid or other metabolites as part of signing up for lower rate policies.
5. If your place of employment is a union shop, meet with the union and discuss how the program reduces injuries, and improves health. If they won't buy in on those grounds, the union is not living up to its specified objectives. We have found this only once in over 50 union shops with which we have worked.
6. Get your safety committee(s) to study 10 years of accidents prior to starting, and note which employees were smokers. This helps to document your smoker injury rates versus the non-smokers in similar jobs at your worksite.

While this is not the major source of injuries in many workplaces, we have found that employers who incorporate the Smoking Cessation programs into their Health and Wellness programs derive significant benefits not only in accident reduction, but also in their overall employee health. The gains are quantifiable, sustainable, and worth the effort in improved employee morale, reduced insurance costs, and reductions in Workers' Compensation benefits.

kids' chance

Robert Clyatt, a workers' compensation attorney from Valdosta, Georgia, founded the first Kids' Chance organization in 1988. Through his work, he had witnessed the life-shattering impact that a serious workplace injury had on the children of seriously or fatally injured workers, who were now faced with the difficulty of having to fund their own education.

Scholarships are supported by donations from individuals, groups, organizations, companies & foundations. Also, from special activities organized by volunteers such as our annual Kids' Chance tennis, golf and bowling tournaments, celebrity roasts and Fun Run/Walk events. All funds raised support the children of Georgia workers.

Who's Eligible? Students between the ages of 16-25 whose parent's on-the-job injury resulted in death or serious residual effects and a substantial decline in family income are eligible. Each applicant must meet the approval of the academic selection committee.

Be sure to check out these upcoming auctions to benefit Kids' Chance of GA!
SBWC Annual Educational Conference & Auction for Kids' Chance
(You'll find us at the registration table.)

August 31- September 1, 2015 Hyatt Regency - Atlanta, GA

Georgia Safety, Health & Environmental Conference & Auction

September 9-11, 2015 Savannah Marriott Riverfront - Savannah, GA




Our Mission at Kids' Chance of Georgia, Inc.

The mission of Kids' Chance of Georgia, Inc. is to provide educational scholarships to the children of Georgia workers who have been seriously, catastrophically or fatally injured in work-related accidents.

Contact by phone (770) 933-7767
or visit http://kidschancega.org to make a donation

Back To Work After Hernia Repair: The Advantages Of Minimally Invasive Surgery

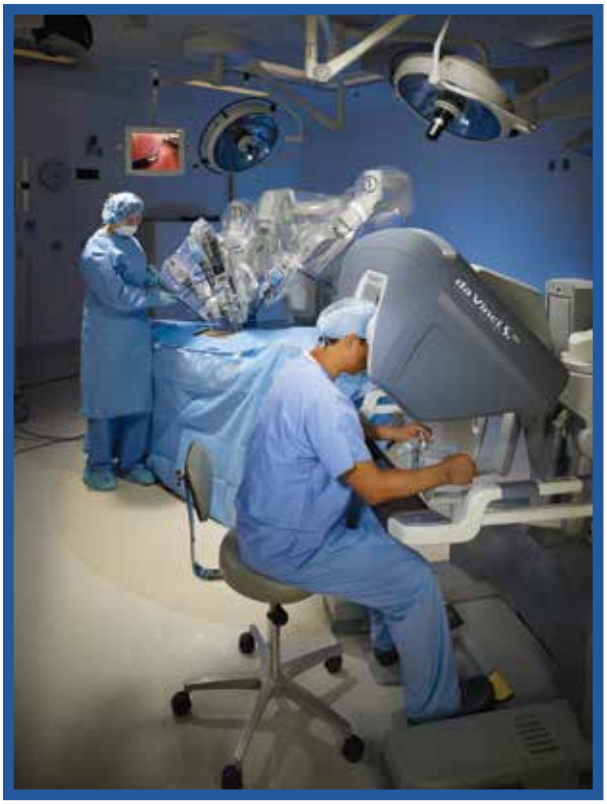
Chad Copper, M.D., FACS

The Longstreet Clinic, P.C.
Doctors You Know. Care You Trust.

Hernias are one of the most common workplace injuries leading to time off work and worker's compensation claims. More than 90 percent of these hernias are inguinal, or groin, hernias, and more than 95 percent occur in men. The only effective treatment for symptomatic inguinal hernia is surgery. With minimally invasive hernia surgery, patients are returning to work faster.

Traditionally, these hernias were repaired through an open incision in the groin. Patients were then out of work for 1-2 weeks and did not usually return to full activity for 6 weeks. However, minimally invasive surgery is changing that traditional norm.

The adoption of new technologies and techniques has challenged the practice of recommending a prolonged period of convalescence after hernia repair. Most patients can return to work within a few days of laparoscopic surgery and may return to normal activity without restriction in 2 weeks. Recommendations must be patient-centered and take into consideration both regular work activities and individual pain experience
Laparoscopic surgery has been around since the 1980s, and laparoscopic hernia repair first began in the early '90s. After 25 years of laparoscopic hernia repair, we have multiple large studies which have shown the advantages of this type of surgery.



Laparoscopic hernia repair uses very small incisions (5mm) to repair the hernia, or hole, in the abdominal wall. Mesh is placed in the abdominal wall, usually in between the muscle layers of the abdominal wall, to reinforce the repair. The natural outward pressure of the abdomen helps to keep the mesh in place and prevent recurrence of the hernia. With minimally invasive hernia repair, patients can expect less pain, faster recovery and fewer complications than with traditional "open" surgery. The risk of hernia recurrence may also be lower.

The surgeons at The Longstreet Clinic have over 50 years of combined experience in laparoscopic and minimally invasive hernia repair. They are trained in robotic hernia repair with the da Vinci® Surgical System, which holds much promise in being the next big advancement in hernias. Their surgical suites feature the area's most advanced technology – including a state-of-the-art HD video system that provides superb visualization during laparoscopic hernia surgical procedures. But even with all this technology, they never forget what's most important: personalized care.

The main campus for The Longstreet Clinic, P.C. (TLC) is located at 725 Jesse Jewell Parkway, in front of Northeast Georgia Medical Center in Gainesville. Please see our website for additional convenient locations.

www.longstreetclinic.com or call 770-536-2323

Chad Michael Copper (M.D., F.A.C.S.)
Special Practice Interests: Minimally invasive surgery, laparoscopic and robotic Colorectal surgery

The Longstreet Clinic, P.C. is a multi-specialty medical group with over 160 providers in 16 specialties and offices across Northeast Georgia. Our Worker's Compensation services include:

- General Surgery (Hernias)
- Neurosurgery
- Orthopaedic Surgery
- Vascular Surgery
- Physical Medicine & Rehabilitation
- Neurology

Two full-time worker's compensation coordinators are available to assist you and your patients.

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Worker's Compensation Provider

longstreetclinic.com/workers-compensation

TLC

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RESURGENS ORTHOPAEDICS
worklink

YOGA & BACK PAIN: BACK INJURY PREVENTION

Marly Dows-Martinez, M.D.
Resurgens Physician

Back pain is one of the most common reasons Americans seek medical treatment each year. Some jobs require prolonged standing, lifting, bending, and squatting, which can put strain on your body and at times provoke musculoskeletal back pain. Whether it's muscle strain or underlying degenerative changes (arthritis), yoga can help improve how you feel. By improving your overall muscle tone, strength, and flexibility, yoga helps improve your biomechanics and reduce the burden of physical stress on your body. If you want to be more flexible, stronger, and help prevent or limit back pain in the future, yoga is one way that you may find helpful. It can help you stay fit and is beneficial for people of all age groups.

History of Yoga

Yoga has been practiced for thousands of years and is becoming more popular in the United States. Its principles center around the idea that body posture, breathing and meditation help promote health and prevent disease. Some of our patients with back pain have found that yoga increases their strength and flexibility, helps provide relief of their pain, and promotes relaxation and stress relief.

How Can Yoga Help Back Pain?

Yoga helps back pain in several ways. Yoga can help strengthen the small muscles that help support your neck and back. Often in regular work outs, these muscles are neglected or more stress is placed on these muscles that can cause pain during or after the workout. Yoga is able to focus on these smaller muscles and help to make them stronger over time. Another benefit of yoga is the flexibility gained by stretching the core muscles. The benefit of working out these muscles is that your spine is better able to stabilize itself. If your core muscles of your back and abdomen are strong, this helps decrease back pain and decreases your chance of injury to your back.

Is Yoga for Everyone?

Yoga can be a safe for patients with back pain, but as with any new exercise or therapy routine, you should talk to your medical doctor before starting a yoga regime. Depending on your medical condition, your physician may suggest modifications to the various poses to make yoga safe for you. An experienced yoga instructor can assist you and your physician in determining which movements are safe for you.

Some examples of patients who may want to avoid certain poses are:

- Patients diagnosed with advanced spinal stenosis may be advised to avoid any yoga position that causes extreme extension of the spine
- Patients with advanced cervical spine disease may be advised to avoid doing headstands and shoulder stands in yoga.

Yoga poses should not cause pain, numbness or tingling. If you experience these symptoms while performing any pose, gently move out of the pose to the beginning position.

Conclusion

Although no one treatment or exercise program works for everyone, yoga may be a good option in helping you prevent or treat your neck and back pain.

A Guide To Regenerative Medicine

Arnold J. Weil, M.D.

Regenerative medicine is the new frontier in treating patients with chronic pain and workplace injuries. Our office offers our patients new, natural treatment options that promote healing and regeneration of damaged tissues as a result of an injury.

Prolotherapy
Prolotherapy is a process which promotes healing through the use of a proliferative agent. This is a great treatment option for anyone suffering with pain from the joints in the neck, mid-back, low back, hip, knee, ankle, toe, shoulder, elbow, wrist, finger or thumb. Prolotherapy injections contain dextrose (sugar) and local anesthetic, and are placed at the attachments of ligament and tendon tissue to initiate inflammation and promote a healing response. This creates a stronger bond at these attachment points, lessening the load on the individual fibers and resulting in increased structural integrity and decreased pain.

Platelet Rich Plasma Injections (PRP)
PRP is a non-surgical treatment that accelerates the healing by activating the stem cells in the patient's own body. The process involves taking a patient's own blood, spinning it down in a centrifuge and concentrating the blood into a mixture high in growth factors that stimulate stem cell activity. This is injected into the injury site. This treatment is great for anyone suffering with ligament and tendon tears, joint weakness, muscle strains or fibrosis, arthritis, tendinitis, and back pain.

Intradiscal Platelet Rich Plasma Injections
Intradiscal PRP injections are injected directly into a damaged intervertebral disc, to help reduce pain by causing growth factors to promote healing and regeneration from stem cells. Non-Surgical Orthopaedics is one of the only practices in Georgia offering intradiscal PRP injections. Discogenic pain often originates from a damaged intervertebral disc, sometimes resulting from herniated or degenerative disc disease. Similar to PRP we draw and process the blood, concentrating growth factors and cytokines (small proteins that promote stem cell activity). This is then injected directly in to the disc under fluoroscopy.

Amniotic Stem Cell Therapy
Amniotic stem cell injections contain the growth factors that help to stimulate tissue growth and naturally reduce inflammation. Amniotic fluid is highly concentrated in stem cells, proteins, cytokins and other important compounds, which promote tissue repair and regeneration. Studies have shown this fluid to be naturally regenerative and can reduce inflammation and scars. This treatment is great for those suffering with Osteoarthritis, soft tissue injuries, achilies tears, tendon or ligament tears, sacroiliac pain, any joint-related pain, tennis or golfer's elbow, rotator cuff injuries, hip pain and low back pain.

Bone Marrow Aspirate Concentrate (BMAC)
BMAC is similar to PRP, but instead of using blood we obtain the stem cell-rich concentrate from the bone marrow, which is high in mesenchymal and homeopathic stem cells. This is then injected into an area where the patient is experiencing pain to promote healing and tissue repair and regeneration. This is high in stem cells with a cellular equivalence to iliac crest bone grafts. This procedure is good for anyone who has joint or muscular pain, including spine disorders and extremity injuries.

Arnold J. Weil, M.D.

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Specializing in Spine Care & Pain Management

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www.lowbackpain.com

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Marietta, GA 30060

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Suite 300
Canton, GA 30114

Carrollton
1004 Bankhead Hwy
Suite A5
Carrolton, GA 30017

A Word from the Chairman

The Honorable Frank R. McKay – Chairman

We are currently making final preparations for the Board's Annual Seminar at the Atlanta Hyatt Regency on August 31, 2015 through September 2, 2015. Our Steering Committees have been working throughout the year on our program. We have a wonderful program set for this year. The program and registration information is available on our website at www.sbwc.ga.gov. I encourage you and your clients to attend.

The Legislative, Rules, Medical, Licensure and Rehab Committees of the Advisory Council have been working hard and are in the process making a number of recommendations to the Board in 2015.

The Legislative Committee of our Advisory Council recommended a number of amendments to our workers' compensation laws. These recommendations were encompassed in HB 412. This bill passed the Legislature and was signed by Governor Deal. The updates are on our website.

In addition, the Medical Committee recommended a number of changes to our Medical Fee Schedule. These changes were implemented in the spring of this year. To purchase a Fee Schedule, please go to our website.

Finally, our Rules committee recommended a number of amendments to our rules. For this year, of particular importance, the Rehab Committee recommended a number of recommendations to improve Board Rule 200.1 dealing with catastrophic cases. These changes were adopted by the Rules Committee. This revamped rule change, as recommended by both committees, was adopted by the Board on July, 1, 2015. To view this updated rule and all our updated rules, please visit our website.

This is going to be a challenging year for the Board as we look to upgrade ICMS, our web-based paperless system.

As a practicing lawyer for over 20 years, I valued the Board's foresight in going paperless with ICMS in 2005. When ICMS was implemented, it revolutionized the practice of workers' compensation. I personally enjoyed being able to view a file, along with filing documents instantly. To this end, when I first became Chairman, I noticed our technology infrastructure, along with ICMS, was aging. As such, my top priority has been to ensure we implement ICMS – II, an upgrade to our current ICMS system.

Our primary goal in 2015 is implement ICMS II. From the initial proto-types, ICMS II will provide the same functions as IMCS I—online filings, ability to view files, etc., but will be accessible to more users. When implemented, I believe you will appreciate the benefits of ICMS II.

STATE BOARD OF WORKERS' COMPENSATION

(404) 656-3875
270 Peachtree Street, NW
Atlanta, GA 30303-1299

www.sbwc.georgia.gov

Frank R. McKay, Chairman

Judge McKay was appointed Chairman of the State Board of Workers' Compensation on March 1, 2013 by Governor Nathan Deal. Prior to becoming Chairman and the Presiding Judge of the Appellate Division, Judge McKay was a partner in the Gainesville firm of Stewart, Melvin & Frost where he concentrated his practice primarily in workers' compensation.

2015 ANNUAL EDUCATIONAL CONFERENCE

August 31 – September 2, 2015
Hyatt Regency Atlanta Hotel
265 Peachtree Street, NE
Atlanta, GA 30303

NEW FOR 2015!

- Meet the Exhibitors Reception **(Monday evening)**
- Chairman's Reception/Kids' Chance Silent Auction **(Tuesday evening)**
- Extended breaks to allow more time to visit the exhibit areas
- Daily drawings in the Exhibit Hall
- Overnight parking rate at the Hyatt - $14.00
- Daily parking rate at the Hyatt - $11.00
- Option to purchase daily Exhibit Hall passes for those who only want to visit the Exhibit Hall
- **This year's theme is Superheroes!**

Minimally Invasive Surgical Procedures Can Be Maximally Damaging

Vidyadhar S. Chitale M.D. F.A.C.S Board Certified Neurosurgeon
Premier Neurosurgical Institute

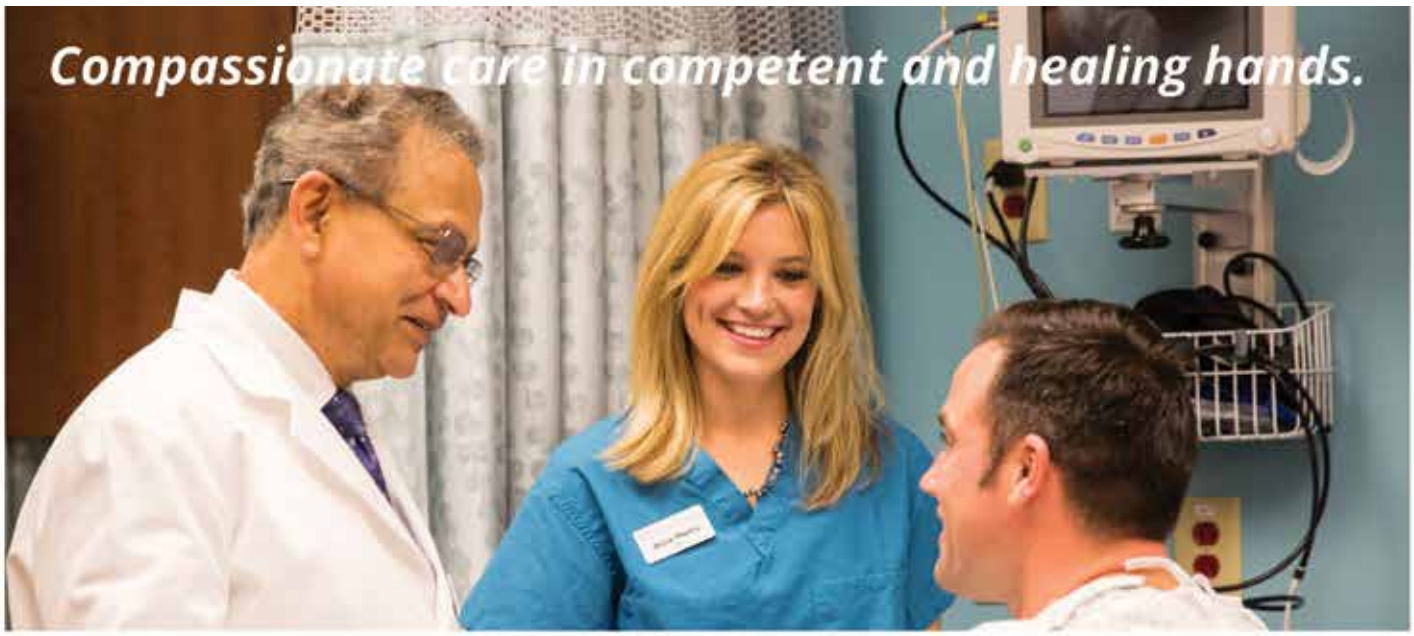
There is a copious amount of sources with advertised information regarding minimally invasive surgical procedures done through a tiny skin incision. Many patients fall to become a prey to the terminology used such as, "minimally invasive" and "laser surgery." More often than not, in an attempt to avoid a larger skin incision, unnecessary compromise is made that will result in a complication or suboptimal outcome at best. Despite the appeal of using the term, "minimally invasive," a surgeon must often choose an optimally invasive surgical technique for a given procedure to ensure the greatest results.

A skin incision heals from side-to-side, whereas the length has no adverse effect on healing time. Thus, a small and big incision will take the same amount of time to heal. Depending on the area of interest, a surgeon may choose a different length for the incision to provide necessary working room. Laparoscopic procedures for abdominal organs are different because of the ability of the abdominal wall to distend with judicious inflation. This creates working room for the surgeon. Spine surgery does not have such potential space to be inflated. Therefore, words such as, "arthroscopic" and "laparoscopic" approach should not be used in the discussion of spine surgery. One can describe it as a microscopic assisted surgery instead. Using a microscope, one can magnify the area for careful dissection and surgical resection.

Lumbar microdiscectomy, anterior cervical discectomy/fusion, and keyhole foraminotomies are common surgical procedures that can be performed with optimal small incisions and microscope assistance. The primary goal of these surgical procedures is to take away the offending element that produces pain, weakness and/or numbness, while attempting to preserve the stability of the structure, such as the facet joints. Paraspinal dilated tube assisted surgical procedures, by design, require you to move facet joints in order to visualize the structures properly. This creates instability at that segment, creating the need for fusion. Iatrogenic destruction of the facet should be avoided at all costs, when not needed. The mesial one third of the facet joint can be sacrificed without creating instability.

This is a microdiscectomy technique that is typically described as keyhole laminotomy for resection of a herniated disc fragment. Such approach also allows a surgeon to treat possible intraoperative complications. Meticulous hemostasis, gentle tissue handling, respect to the neural structures and skilled dissection techniques are vital requirements for a spine surgeon to exercise.

As an experienced brain surgeon, who also performs spine surgery, these diligent qualities easily transfer in the technique of performance. Every operation is a work of art and should be reproducible, obsessive and compulsive in adhering to those techniques. Fast surgery is not always a good surgery – extra time spent during the procedure will pay off later.



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PREMIER NEUROSURGICAL INSTITUTE LLC


Dr. Vidyadhar Chitale


Dr. Alan Maloon

Premier Neurosurgical Institute and Ambulatory Surgical Center provides exceptional attention to patient's neurology and neurosurgical needs with a personalized experience.

On site MRI,EEG,EMG/NCV capabilities to deliver same day results, minimizing time before receiving treatment.

Dr. Vidyadhar Chitale has been a board certified neurosurgeon for over 30 years and has performed of 10,000 surgical procedures.

His major interests include cranial brain tumors and anerusims, cervical/lumbar disc surgeries and complex spinal fusions.

Dr. Alan Maloon is certified by the American Board of Psychiatry and Neurology. His special interests include dementia and disorders of aging, headache and multiple sclerosis.

Under the skilled care of Dr. Chitale and Dr. Maloon, we provide compassionate and skilled care in most efficient manner, unmatched by any other practice.

Vidyadhar S. Chitale M.D. F.A.C.S
Alan Maloon MD
211 Chicopee Drive Marietta, GA 30060
678-872-8750

Critical Thinking In Workers' Compensation

Ernest R. "Buck" Burriss, IV

Workers' compensation claims vary in severity and complexity, a fact that we deal with regularly in handling claims. A focus on effecting a cure, providing relief, and restoring the employee to suitable employment is of primary concern in administering benefits pursuant to the Workers' Compensation Act. Of course, situations undoubtedly arise that call into question whether a specific anatomical area or treatment modality would provide the aforementioned benefits. In such a situation it can be beneficial to step back and review the claim from "10,000 feet" rather than losing the forest for the trees.

In a recent claim an employee injured a lower extremity during the course of his employment. The claim was accepted as compensable and medical and indemnity benefits were properly commenced. Thereafter, and prior to a minor surgery, the employee alleged a superadded injury resulting in complaints of pain to the low back. This unwitnessed event was only reported to the nurse case manager after several days during which time the employee sought emergency medical care and also scheduled an appointment with a provider not listed on the employer's posted panel of physicians.

A quick decision was made between the adjuster and employer to authorize treatment for the employee's low back following discussions of his credibility, truthfulness, and an understanding of the costs associated with litigation and an effective loss of control of medical care should the alleged superadded injury have been denied. Ultimately, the employee received increased conservative treatment modalities for his low back from the ATP and physical therapy over the next few weeks while recovering from his minor knee surgery for which he continued to receive indemnity benefits. Thereafter, the employee was released by his ATP and this case was brought to a favorable resolution. Had the employer and insurer disputed treatment for the employee's alleged superadded injury this case would have transitioned from relatively straight forward to more complex while substantial litigation would have ensued and the possibility for a quick closure would have been eliminated.

It is important to consider all factors related to an active claim prior to making a decision that might overly complicate a claim that could be more quickly resolved.

Choose Interventional Pain Management First

Workers' Compensation objectives are "to provide direct, immediate, necessary and reasonable medical, rehabilitation and income benefits to employees for work-related injuries…"

The medical care the injured employee receives is based on the diagnosis. Proper, prompt and correct diagnosis is of the utmost importance to maximize time and get the injured worker back to work as soon as possible. Sending an injured employee to an interventional pain management physician at the onset of pain, from repetitive motion or muscular injuries, can be hugely beneficial. Unfortunately, pain management has received the distinction of being a "black hole" for Workers' Compensation. Although some practices may have warranted the label, it is not true for all. Often when an employee is injured they will see other specialists first, then visit a pain physician last, when other caregivers feel nothing else can be done. By this point, many times the injured employee has already been placed on opiates, along with other medications, and may have become dependent and/or addicted. The process of taking patients off of their "pain" medication is quite difficult.

In cases for low back pain, taking opiates long term has never been shown to be effective in improving function beyond six months. It is best to get the patient back to work in the shortest amount of time without the use of opiates. Not all patients in pain require opiates; people often have a misconception concerning this. Proper diagnosis and reassurance can help the patient understand the condition, outcome and set positive, achievable goals. Interventional procedures can help with localization of pain or pain reduction. Physical rehabilitation can help with continued pain reduction and reeducation on proper posture and body mechanics to avoid the same injury.

The role of interventional pain management in Workers' Compensation can be an advantage in progressing the patient to a pre-injury state and return to work.

Reginald Strother, M.D.
Spine Care & Pain Management
Board Certified: American Board of Anesthesiology & American Board of Pain Medicine
Board Eligibile: American Board of Addiction Medicine

A Patient's Guide to Carpal & Cubital Tunnel Syndrome

Carpal Tunnel Syndrome

Carpal tunnel syndrome is a common source of hand numbness and pain.. It occurs when the tissues surrounding the tendons in the wrist swell and put pressure on the median nerve, narrowing the confined space of the carpal tunnel, and crowding the nerve.

The most common symptoms of carpal tunnel syndrome include: numbness, tingling, and pain in the hand; an electric shock-like feeling mostly in the thumb and fingers; and strange sensations and pain traveling up the arm toward the shoulder. Symptoms are usually more severe on the thumb side of the hand, and begin gradually, without a specific injury. Symptoms frequently occur when holding something like a phone, or when reading or driving, and may occur at night while sleeping with the wrists curled. A feeling of clumsiness or weakness may also be experienced, and in severe cases, muscles at the base of the thumb may become visibly wasted.

Cubital Tunnel Syndrome

The ulnar nerve is one of the three main nerves in the arm, travelling from the neck down into the hand. When nerve compression occurs at the elbow, it is called cubital tunnel syndrome.

Several things can cause pressure on the nerve at the elbow, like keeping the elbow bent for long periods, repeatedly bending the elbow, or leaning on the elbow for long periods. Fluid buildup can also cause swelling that may compress the nerve, or a direct blow to the inside of the elbow can be a cause.

Symptoms may include aching pain on the inside of the elbow; however, most symptoms occur in the hand, including a feeling of falling asleep, or numbness and tingling in the ring and little fingers, especially when the elbow is bent, as well as weakening of the grip, and difficulty with finger coordination. In severe cases, muscle wasting may occur.

To determine whether you have carpal or cubital tunnel syndrome, your doctor will discuss your symptoms and medical history, examine your arm and hand, and perform a number tests, including physical tests, electrophysiological tests, and X-rays.

If diagnosed and treated early, carpal and cubital tunnel syndromes can be relieved without surgery. Simple medications like anti-inflammatory drugs such as ibuprofen, can help relieve pain. A brace or splint worn at night can help keep the wrist in a neutral position, or the elbow in a straight position. Splints can also be worn during activities that aggravate symptoms. Changing patterns of hand use to avoid positions and activities that aggravate the symptoms may be helpful. If work requirements cause symptoms, changing or modifying jobs may slow or stop progression of the disease.

Surgery may be considered if you do not gain relief from nonsurgical treatments, and the decision is based mostly on the severity of the symptoms. In most cases, carpal tunnel and cubital tunnel surgeries are performed on an outpatient basis under local anesthesia.

For carpel tunnel syndrome, a cut is made in the palm, and the roof of the carpal tunnel is divided, increasing the size of the tunnel to allow more space for the nerve and tendons, and decreasing pressure on the nerve.

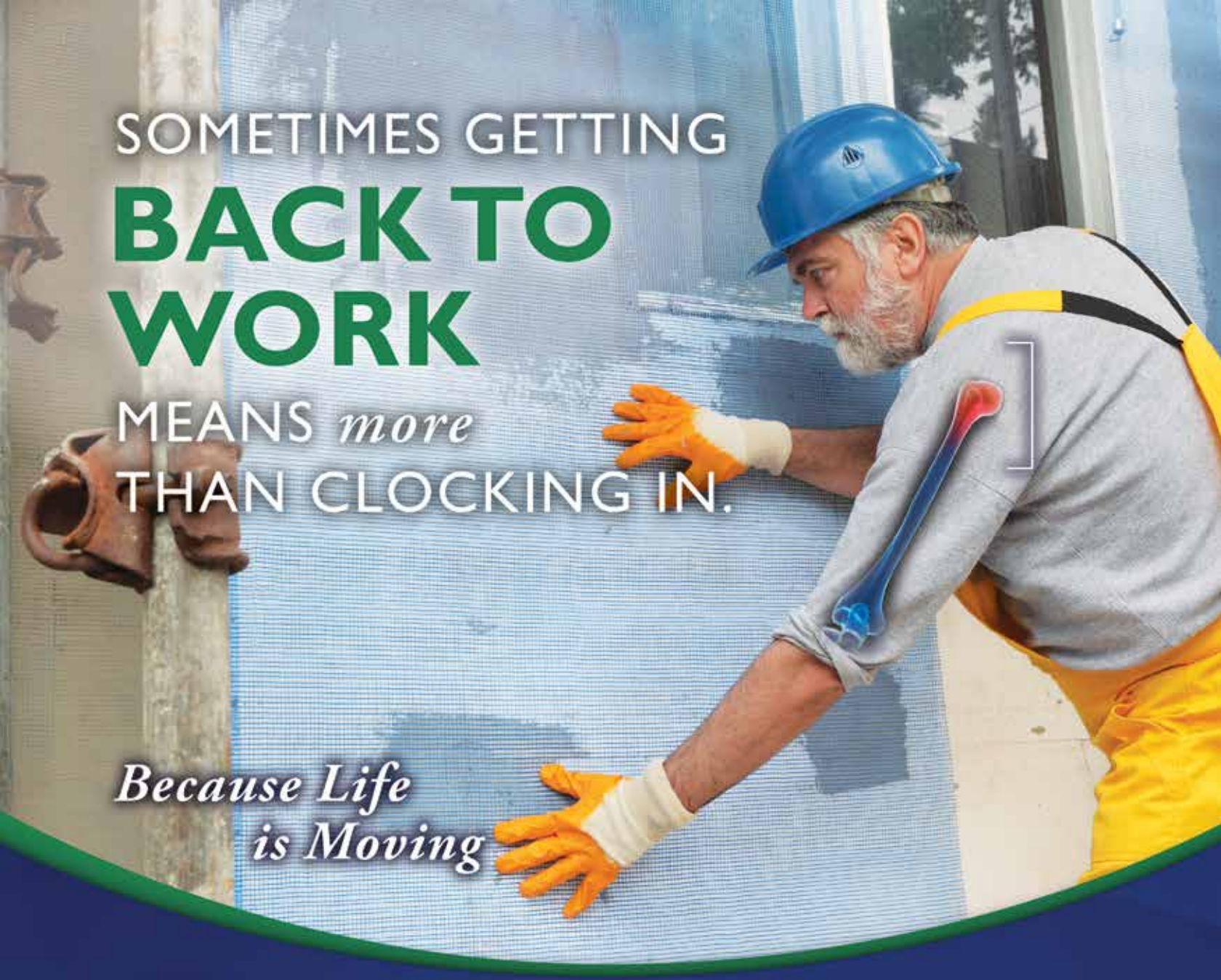
For cubital tunnel syndrome, a cubital tunnel release may be performed. The ligament roof of the cubital tunnel is cut and divided, increasing the size of the tunnel, allowing more space for the ulnar nerve, and decreasing pressure.

A more common procedure is ulnar nerve anterior transposition. The nerve is moved from its place behind the medial epicondyle to a new place in front of it to prevent the nerve from getting caught on the body ridge and stretching it when you bend the elbow.

Following surgery for either condition, you may be required to wear a wrist brace for to 3 to 5 weeks, using your hand and arm normally, taking care to avoid significant discomfort. You surgeon may also recommend physical therapy to help you regain strength and motion in your arm.

Your doctor will determine when you should return to work and whether there should be any restrictions on your work activities.

*Only your surgeon can help you decide what treatment is best for your carpal or cubital tunnel or other condition. Talk to orthopedic surgeons Dr. Lex Kenerly, Dr. Matt Valosen, Dr. Amber Aragon, and the staff at the **Bone & Joint Institute of South Georgia** if you have questions about the best treatment for your condition, or visit **BJISG.com***



SOMETIMES GETTING

BACK TO WORK

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Ganglions

Mark A. Jenkins, D.O.

Ganglions make up about 50-70 percent of all soft tissue tumors of the wrist and hand. They occur in females about 3 times more than in males. Seventy percent of all ganglions occur between the second and fourth decades but can occur at any age – including childhood. Preceding trauma is only reported close to 10 percent of the time. There is no correlation with any occupation. There are no scientific reports of a benign ganglion changing into a malignant tumor.

Ganglions usually occur in a single mass. The size can decrease with rest and increase with activity. Ganglions can even resolve spontaneously. A ganglion usually originates from a nearby joint or tendon sheath. Plain x-rays of the mass are generally normal. The recurrence rate with incomplete excision is about fifty percent. The most common presentations are pain, weakness and cosmetic complaints. The first reported ganglion was reported in 1746.

Ganglions are further defined by their locations. Three ganglions, the volar wrist ganglion, the volar retinacular ganglion and the DIP joint ganglion make up 90 percent of the wrist and hand masses.

The Dorsal Wrist Ganglion usually comes off of the scapholunate ligament on the back of the hand. Early recurrence after surgery excision is rare and again, usually due to incomplete excision. Later recurrence, years later, is felt to be the formation of a new ganglion in most cases. Initial treatment is aspiration of the mass with an injection of a steroid preparation. Surgical excision is reserved for semiautomatic painful ganglions.

The Volar Wrist Ganglion occurs on the front of the wrist and is the second most common ganglion at about 20 percent. These generally come off of the ligaments between the radius bone and the scaphoid bone (wrist joint). Treatment is the same as the dorsal ganglion but must be careful with aspirations due to the close proximity of the radial artery.

Flexor Sheath Ganglions are the third most common ganglion at around 12 percent. It generally arises from the pulley system in the fingers. Recurrence is rare with surgical excision, but most of these respond well to aspiration and injection.

As you can see, most lumps and bumps of the hand and wrist are benign. They generally respond well to treatment but most are not surgically treated unless they remain symptomatically painful. Any mass that is painful or enlarging quickly should be examined by a physician to rule out the few that are cancerous.

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www.ChathamOrtho.com

Mark A. Jenkins, D.O.
Chatham Orthopaedic Associates, P.A.
Specialist in Orthopaedic Trauma and Total Joint Replacement

CHATHAM ORTHOPAEDIC ASSOCIATES, P.A.

Q&A with Azalea Customers

Q. What were your expectations in implementing Azaelea's Electronic Health Record system across so many practices at once?

"In looking at rolling out EMR, we were all expecting a great deal of complexity, which we did not end up experiencing. Considering our complex structure, with 34 locations across 11 states, rolling it out was thankfully an ease compared to what we were preparing for. I think Azalea's function certainly is a big component of why this was so easy for us to implement and why our workflow within the clinic is simpler than it used to be with paper charts. "

-Taylor Blackwood, Owner, Ageless Men's Health

Q. How has Azalea Practice Management impacted your multi-specialty practice?

"Now that the system is up and running, it is amazing! We can see so many more aspects of our practice and our patients compared to our old system. The billing aspect of it is amazing. We can see what's going on with our patients and their outstanding balances and send our claims electronically, all right at our fingertips. The system is making our workflow much smoother. Tasks like scheduling patients and verifying insurance take time off our hands. With Azalea PM we don't spend as much time doing things we used to have do, and this has significantly sped things up. The more were learning about the system, the better it gets. "

-Bonnie Kitlas, Biller at Dynamic Health Associates, P.A.

Azalea HEALTH™

Why Azalea Health?

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- **Get paid faster** – With an integrated clinical and billing system, your practice runs smoother.
- **Easy data conversion** – We make the transition easy.
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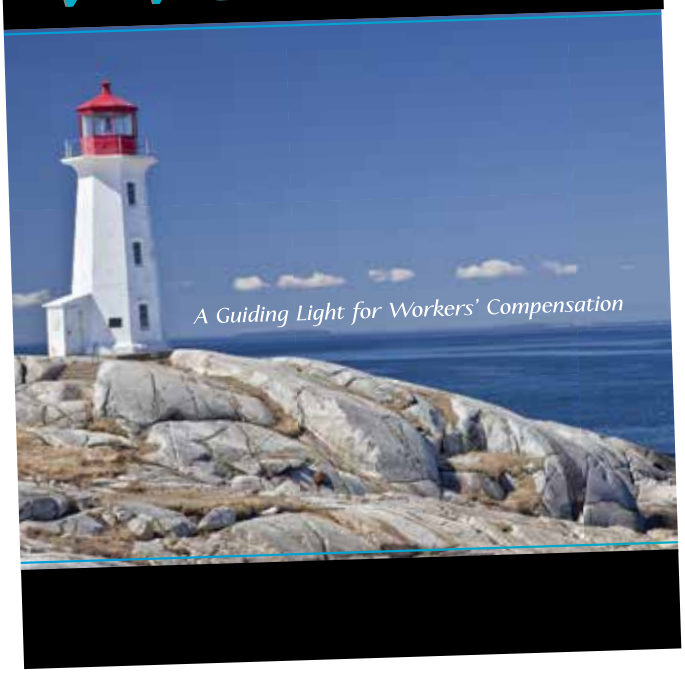

We are pleased to offer our 2016 full-color magazine, *Workplace Health*. This is a specialty publication with the sole focus being health and safety in the workplace and injury prevention. We will distribute the magazine to those professionals in the Workers' Compensation industry. These include referring physicians in Georgia and Florida, employers, nurse case managers, TPA's and safety engineers.

The deadline for submitting advertisements and articles is March 1st, 2016. The Spring 2016 issue will be published in late mid-April 2016.

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1. Space Costs (All Issues Cost)

• 1/2 page	**$750**	• Inside Front Cover	**$1,800**
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2. 15% discount on ads that run more than once a year

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A New Approach To Hip Replacement Gets The Injured Worker "Back In The Game"

Michael P. Gruber, MD Orthopedic and Sports Medicine Surgery

In the past, joint replacement was a rarely used option in the world of Worker's Compensation. Generally, osteoarthritis is considered a degenerative disease of joints and predominantly age related. Progression of osteoarthritis is inevitable but that progression can be accelerated with an on-the-job injury.

The exacerbation of the osteoarthritic condition may be the proverbial "last straw" that pushes that osteoarthritic condition to the point that it impairs one's ability to work. With today's aging workforce, this scenario leading to the need for knee and hip replacement is becoming much more common. Fortunately, joint replacement is one of the most predictably reliable operations available today. In fact, joint replacement reflects the philosophy of Worker's Compensation in that it is very successful in returning the worker to productive employment. As an orthopedic surgeon and sports medicine specialists, it allows me to get the injured worker "back in the game".

A recent case is a good illustration of how recent advancements in technique in hip replacement can benefit the injured worker. A very nice lady sustained a trip and a fall at her workplace resulting in a hip fracture. We were able to offer her a hip replacement done through a tissue sparing technique that has allowed her an accelerated returned to work.

Over the past year, I have been able to transition to the direct anterior approach to the hip as my preferred approach. This particular approach is a conservative and minimally invasive alternative to the traditional approach for hip replacement. The incision is generally not much wider than the width of one's hand. Through this cutting edge approach, we are able to replace the painful hip through a natural space between certain muscles on the front of the hip. The muscles are not split or fully detached as is commonly done in other approaches to the hip. In my experience, my patients have encountered much less postoperative discomfort and have enjoyed a quicker return to normal activity.

Another great advantage to this innovative approach is that the hip is much more stable. Preserving the short rotator muscles of the hip greatly enhances the stability of the hip and greatly decreases the chance of dislocation. In fact, the risk of dislocation is felt to be less than 1% and postoperative range of motion restrictions are felt to be unnecessary. It is quite possible to walk the day of surgery. It is common for patients to go home after a 1 or 2 day stay in the hospital. I actually envision offering this procedure on an outpatient basis in the near future.
The implants available for this procedure have continued to improve to the point that, for most people, we can offer a hip replacement that is likely to last their lifetime. The breakthrough in technology in recent years has been the plastic. The plastic is now treated in a way that greatly increases its durability. In fact, younger patients are also electing for this procedure knowing that they have an excellent chance of 20 years or more of pain-free function of the hip.

Total hip replacement is one of the great success stories in medicine. Enthusiasm for anterior hip replacement continues to grow and I am excited to be able to provide this service to our local community. This procedure perfectly reflects my philosophy of orthopedic care. It applies the sports medicine principles of less invasive surgery, rapid recovery and restoration of function. **So as our workforce ages, we will be able to help these patients get back to work sooner and stronger than ever!**

Michael P. Gruber, MD
Orthopedic and Sports
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"There is more and more we can do to treat early disease for our patients, with great advances in orthopedic treatment. We are able to provide our patients big city care without leaving the community."

Dr. Gruber is a native Georgian and was raised in Stone Mountain. He is a volunteer physician for the Coweta Samaritan Clinic. Dr. Gruber has lived in Newnan since 1994 with his wife, Sharon, and their three children.

Rotator Cuff Disease: Shouldering the Pain

By: Brad Register, MD

Brad Register, MD

Do you ever have pain in your shoulder when playing overhead sports such as tennis and swimming, or during painting and construction work? Does this pain worsen with activity? Is it located in the front or side of your shoulder? If so, you may have damage to your rotator cuff. The rotator cuff is the term used to describe four muscles in the shoulder that play an important role in shoulder function. These muscles help hold the ball (humeral head) in the socket (glenoid), playing a vital role in lifting and rotating the shoulder. Comprised of many muscles, ligaments and joints, the shoulder has a wide range of motion. The rotator cuff helps to provide stability and strength throughout this motion, making it susceptible to injury and pain.

Pain in the rotator cuff can come from tendinitis, subacromial bursitis (inflammation of the tissue surrounding the rotator cuff), or rotator cuff tears. Tendinitis and bursitis often result from a condition known as subacromial impingement syndrome. When the arm reaches overhead, the rotator cuff is caught between humeral head and the bone on top of the shoulder (acromion). People who frequently hold their arms in this position are susceptible to rotator cuff damage. Initially this causes inflammation, but over time can lead to partial or full-thickness tear. This explains why rotator cuff pain may develop after an injury to the shoulder, or present with seemingly no inciting event.

Rotator cuff tears can result from a combination of extrinsic and intrinsic causes. Chronic impingement on the undersurface of the acromion bone can eventually lead to a partial or a full-thickness tear. Tears can also result from a fall where the patient lands directly on the shoulder or arm. Likewise, the tendons of the rotator cuff can fail over time from intrinsic degeneration caused by repetitive use and tensile overload.

Patients with rotator cuff pain often develop tenderness in the front or side of the shoulder and discomfort when lifting the arm or lowering the arm from an overhead position. Initially pain can be related to arm movement and relieved by rest, but eventually pain at night develops. Weakness and stiffness commonly progress, making it difficult for patients to reach behind the back also.

The initial treatment of rotator cuff disease is conservative by utilizing rest, anti-inflammatory medications and physical therapy. The goals of therapy are to improve motion and strength, often leading to pain reduction. A steroid injection into the bursa just above the rotator cuff can help reduce pain, but relief from this is often temporary, and these shots cannot be repeated too many times for fear of damaging the shoulder's soft tissues.

When nonsurgical methods fail to relieve pain, surgery may be recommended. If pain is coming from bursitis or a partial thickness tear, the physician may only have to remove the bursa and flatten out the underside of the acromion bone to relieve the impingement. Patients will typically feel much better within 2-3 months. If the patient has a full-thickness or high-grade partial-thickness rotator cuff tear, the surgeon can repair the cuff using minimally invasive arthroscopic surgical techniques. Following rotator cuff repair, physical therapy is utilized and full recovery can take 6 months or more. Occasionally the tear is irreparable but fortunately several treatment options exist for these cases as well.

As an added convenience for patients, we offer a dedicated Internal Case Manager who works closely with our Workers' Compensation clients to ensure optimal care and attention. Having our own case manager allows for frequent and effective communication among employers, nurse case managers, adjustors and attorneys, resulting in prompt care and more positive outcomes.

If you would like to discuss the care of your employees, or if you have questions about any of the services we offer, please call Dr. Joseph Sativz, Medical Director of the Occupational Health Center, or Jennifer Herring, Director of Workers' Compensation/Internal Case Manager, at (706) 433-3259.

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Many of you only know me as the owner of SelectOne Network. Before starting SelectOne Network, I worked for many years as a Workers' Compensation Adjuster. The need to be fast, efficient, and multi-task was often stressful. I have a firsthand understanding of the dilemmas faced by adjusters and employers in successfully navigating the Workers' Compensation system. That experience led me to create SelectOne Network, a network of physicians who appreciate the unique process of treating Workers' Compensation patients.

I am excited to announce the rolling out of a new website, ***www.workplacehealthmag.com*** with links and tools needed to make your job easier. Whether it is locating recommended physicians with knowledge of the best practices in Workers' Compensation or creating a printable panel for employers, the goal is to help the user create the panel as required by the Georgia State Board of Compensation. Our new website is here to help!

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