Fall 2016 Edition

# WH Workplace Health

## "Who were the WC Vendors voted BEST OF THE BEST 2016?"


## WHO MADE THE CUT?

See page 19

# 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


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# A Long-Term Treatment For Facet Joint Disease

*Shalin Shah, D.O. – Alliance Spine and Pain Centers*

Radiofrequency Ablation(RFA), also known as radiofrequency neurotomy, is a minimally invasive technique used to treat facet joint pain syndrome of the spine. Special spinal needles are inserted near the facet joints of the spine. An electrical current then generates a heat lesion transmitted near the tip of a spinal needle in order to damage the surrounding tissues. This technique is used in an effort to damage sensory nerves that relay pain from the facet joints. When successfully accomplished, pain relief lasts for an average of six to nine months. Nerve regeneration usually occurs between six to nine months, although sometimes longer. The procedure may be repeated when the pain returns in order to provide continued long-lasting relief. Complications are rare when performed by an experienced physician and contraindications similar to other spinal procedures, which include patients on anticoagulation therapy and active infection.

Facet joints, also known as zygapophyseal joints, are a common cause of low back pain and neck pain. They are the posterior joints of the spine where each vertebrae adjoins to each other. Facet joint inflammation can commonly cause acute low back or neck pain resulting from whiplash injury, lifting a heavy object or direct trauma to the spine. Long-standing degenerative disc disease can contribute to arthritis of the facet joints as well. When inflammation occurs in the facet joint, pain is transmitted via the medial branch nerves then indirectly communicated with the spinal cord when a pain signal is sent to the brain for perception.

Facet joint pain syndromes are diagnosed clinically by excluding other common sources of pain originating from the spine. MRI or lumbar x-ray may aid in the diagnosis of facet joint inflammation or arthritis, but is not always useful.

In our practice, we begin with conservative measures such as non-steroidal, anti-inflammatory medications and physical therapy to treat facet joint pain when suspected. If there is no improvement, we proceed to perform a diagnostic facet joint steroid injection. Steroid is injected in and around the joints that are implicated.
If the patient reports greater than 50% improvement of their pain that lasts for three months or greater, we continue to repeat the steroid injections as necessary. For patients that obtain substantial relief, but for less than three months, we consider them a candidate for RFA. Prior to performing RFA, we perform one set of a diagnostic medial branch blocks (nerves that supply facet joints). A local anesthetic, such as 2% lidocaine, is injected near the target nerves to block their transmission. If the patient obtains greater than 50% relief of their pain for approximately four hours after the injection, this predicts a higher success rate for RFA of the medial branches.

Alliance Spine
AND PAIN CENTERS

*Shalin Shah D.O.*
*Alliance Spine and Pain Centers*
*Augusta, GA*
*American Board of Anesthesiology Certified*
*Chronic Pain*
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## WH CONTENTS




Be sure to detach the provider and physician list from the cover for future reference!

# workplace violence

*What is workplace violence?*

Workplace violence is any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse, to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors. Homicide is currently the fourth-leading cause of fatal occupational injuries in the United States. According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI), Of the 4,679 fatal workplace injuries that occurred in the United States in 2014, 403 were workplace homicides. However it manifests itself, workplace violence is a major concern for employers and employees nationwide.

*Who is at risk of workplace violence?*

Nearly 2 million American workers report having been victims of workplace violence each year. Unfortunately, many more cases go unreported. Research has identified factors that may increase the risk of violence for some workers at certain worksites. Such factors include: exchanging money with the public and working with volatile, unstable people. Working alone or in isolated areas may also contribute to the potential for violence. Providing services and care, and working where alcohol is served may also impact the likelihood of violence. Additionally, time of day and location of work, such as working late at night or in areas with high crime rates, are also risk factors that should be considered when addressing issues of workplace violence. Among those with higher-risk are delivery drivers, healthcare professionals, public service workers, customer service agents, law enforcement personnel, and those who work alone or in small groups.

***Resource: https://www.osha.gov/SLTC/workplaceviolence/***

# Hearing Conservation – What is Occupational Noise Exposure?

*U.S. Department of Labor | Occupational Safety & Health Administration | 200 Constitution Ave., NW, Washington, DC 20210*

Noise, or unwanted sound, is one of the most pervasive occupational health problems. It is a by-product of many industrial processes. Sound consists of pressure changes in a medium (usually air), caused by vibration or turbulence. These pressure changes produce waves emanating away from the turbulent or vibrating source. Exposure to high levels of noise causes hearing loss and may cause other harmful health effects as well. The extent of damage depends primarily on the intensity of the noise and the duration of the exposure.

OSHA's hearing conservation program is designed to protect workers with significant occupational noise exposures from hearing impairment even if they are subject to such noise exposures over their entire working lifetimes.

## What monitoring is required?

The hearing conservation program requires employers to monitor noise exposure levels in a way that accurately identifies employees exposed to noise at or above 85 decibels (dB) averaged over 8 working hours, or an 8-hour time-weighted average (TWA). Employers must monitor all employees whose noise exposure is equivalent to or greater than a noise exposure received in 8 hours where the noise level is constantly 85 dB. The exposure measurement must include all continuous, intermittent, and impulsive noise within an 80 dB to 130 dB range and must be taken during a typical work situation. This requirement is performance-oriented because it allows employers to choose the monitoring method that best suits each individual situation.

Employers must repeat monitoring whenever changes in production, process, or controls increase noise exposure. These changes may mean that more employees need to be included in the program or that their hearing protectors may no longer provide adequate protection.

Employees are entitled to observe monitoring procedures and must receive notification of the results of exposure monitoring. The method used to notify employees is left to the employer's discretion.

## What is audiometric testing?

Audiometric testing monitors an employee's hearing over time. It also provides an opportunity for employers to educate employees about their hearing and the need to protect it.

The employer must establish and maintain an audiometric testing program. The important elements of the program include baseline audiograms, annual audiograms, training, and followup procedures. Employers must make audiometric testing available at no cost to all employees who are exposed to an action level of 85 dB or above, measured as an 8-hour TWA.

The audiometric testing program followup should indicate whether the employer's hearing conservation program is preventing hearing loss. A licensed or certified audiologist, otolaryngologist, or other physician must be responsible for the program. Both professionals and trained technicians may conduct audiometric testing. The professional in charge of the program does not have to be present when a qualified technician conducts tests. The professional's responsibilities include overseeing the program and the work of the technicians, reviewing problem audiograms, and determining whether referral is necessary.

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# What We Know About the Zika Virus

*Source: CDC Centers for Disease Control and Prevention at http://www.cdc.gov/zika/*

- Zika is spread mostly by the bite of an infected Aedes species mosquito (Ae. aegypti and Ae. albopictus). These mosquitoes are aggressive daytime biters. They can also bite at night.
- Zika can be passed from a pregnant woman to her fetus. Infection during pregnancy can cause certain birth defects.
- Zika is not currently being spread by mosquitoes in the continental United States*. The mosquitoes that can carry Zika are found in some areas of the United States.
- There is no vaccine or medicine for Zika.
- Many people infected with Zika virus won't have symptoms or will only have mild symptoms. Symptoms can last for several days to a week. People usually don't get sick enough to go to the hospital and they very rarely die of Zika. Once a person has been infected with Zika, they are likely to be protected from future infections.
- Diagnosis of Zika is based on a person's recent travel history, symptoms and test results.
- A blood or urine test can confirm a Zika infection.
- Symptoms of Zika are similar to other illnesses spread through mosquito bites, like dengue and chikungunya.
- Your doctor or other healthcare provider may order tests to look for several types of infections.

* *As of the time of publication*

At Georgia Bone & Joint, our WORKS program is focused on reducing medical costs and time lost from work. Our expert doctors provide compassionate care when treating injuries to get employees back on the job. We work with employers to provide a trouble-free process with one point of contact to address questions and concerns.

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# Occupational Shoulder Injuries

***Dr. Cushing of GA Bone & Joint***

The shoulder joint consists of several joints that connect to various tendons and muscles. The complexity of the shoulder is what enables you to do so much with your arms. It is also the reason so many people suffer from shoulder pain. The prevalence of shoulder pain in the general population is 11% for people under 50 years old and 16 – 25% for the elderly.

Shoulder pain is often cumulative rather than sudden. It may be hard to pinpoint the exact cause. Although trauma, ie a fall from a height or even ground-level fall, a motor vehicle accident can cause occupational shoulder injuries, they more commonly occur from cumulative or repetitive injury. Risk factors for occupational shoulder injuries are heavy work, awkward positions, repetitive movements, working at or above shoulder level and vibrations (power tools, driving). Awkward positions that predispose an employee to shoulder injuries include working in a twisted position (aircraft mechanics), working above shoulder level and working with static postures (when muscles have to hold the body in one position for a long time). Increased levels of muscle activity with few periods of low activity (rest) during awkward and static postures can result in shoulder pain.

It is not only physically intensive jobs that cause shoulder injury. Computer workers also have a high risk of developing neck and shoulder pain. Sedentary work environments and work habits can weaken your muscles and predispose to fatigue and subsequent shoulder injuries.

The key to treating occupational shoulder injuries is prevention. There are four approaches to prevention of occupational shoulder injuries: work place design, work method design, worker selection and worker training. Work place design includes reducing load and proper ergonomics. To reduce load a worker can keep loads closer to the body, divide into several smaller loads and use lighter tools and arm supports. Ergonomics is the streamlining of equipment and devices to function well with the human body. When sitting at your desk your feet should be firmly planted and flat on floor or on a stable footrest, thighs should be parallel to the ground, elbows should be supported and close to your body, wrists and hands should be in line with your forearms, low back should be supported and shoulders should be relaxed. As fatigue sets in through the day, we tend to slouch worsening the posture and strain on the body. Ongoing good posture is the key to avoid and relieve shoulder pain. Work method design can help prevent or reduce shoulder injuries.

Two techniques to reduce static load on the shoulder include rest breaks and job rotation. Rest breaks are recommended 10 -15 minutes every 2 hours. Active rest breaks are better, which include stretching or walking. Worker selection is not well established as to the effectiveness, however it is important to be sure the physical abilities of a worker equal the demands of their specific job. Worker training can include shoulder school, where employees are taught proper techniques and effective stretching exercises.

Shoulder injuries are common in the workplace. Prevention is the key. Early treatment will help decrease lost hours and productivity.

*Dr. Michael Cushing received his medical training from the Medical College of Georgia and also completed a shoulder fellowship at the Hughston Clinic in Columbus, Georgia, which involved extensive training in shoulder surgery and sports medicine.*

*He is one of the only surgeons in Coweta and Fayette counties performing the reverse total shoulder replacement. The reversed shoulder is one of the newest advancements in shoulder surgery. He lives in Fayetteville, GA with his wife, Christine, and their four children. He is an avid sports enthusiast and enjoys boating, water sports, scuba diving and snow skiing.*

*Dr. Cushing is board-certified and on staff at Piedmont Newnan Hospital, Piedmont Fayette Hospital, and Cancer Treatment Centers of America in Newnan, GA.*

# Preserving Human Capital

*Rushe Hudzinski, MBA, SHRM-SCP, GPHR*

With the recent events in our nation and around the world, an updated approach the difficult arena of responding to an active shooter in the new terroristic culture are now a matter of when and no longer just an if. Workplace violence incidents are statistically growing, but organizational preparedness and effective, crisis policy management has severely declined. In reaction to workplace violence incidents that has a widespread impact. Community leaders are primarily concerned with public safety and organizations are primarily concerned with business assets and ongoing operations - creating the "great divide." Human resource professionals, safety managers and business leaders provide the role of a perfect strategic liaison by bridging the gap between community and organization provided with the essential tools to analyze risk, improve crisis plan efficiency and provide preparedness training in collaboration with outside first responder entities and law enforcement. The Preserving Human Capital Education and Training Program Initiative was created in order to furnish these necessary components to organizations before a workplace violence incident occurs to achieve alignment between organizational policy, public safety response and minimization of loss of life.

## Questions for the Organization:

- Do you have a policy and training program in place to assist staff in identifying potential dangers and what does it include?
- Do you have mental health support structures in place to assist after a work place violence event occurs?
- Do you have a policy and training program in place to assist staff in reacting to an incident if it occurs and how to minimize chaos?
- Are new hires prepared to enter the work force if an active shooter or terroristic incident occurs?
- What should you expect from Law Enforcement, EMS, and Fire Department when they respond to your location? (It is definitely not like it appears on TV or in the media)
- What essential information does Law Enforcement, Emergency Medical Services, and Fire Department need from you when they respond to be the most efficient?
- How do you let those on the outside know which areas are safe, which areas are in crisis, and which areas have injured people without the ability to use normal means of communication?
- Are organizational emergency plans in check with the reality of public-safety response?
- Are you prepared for a lone wolf incident?
- Do you have the correct organizational insurance and worker's compensation plans in place that include coverage for this type of event?
- Is your organization prepared for the liability involved as lawsuits are triggered?

Examining how organizations and businesses approach crisis management planning is a vast opportunity to uphold employee safety, protect employee wellbeing and simultaneously create value within the organization and the surrounding community. Proactive planning provides strong overall insight and protects potential liabilities. It is good business, good safety practice and good sense to move forward immediately rather than waiting for the aftermath of a terroristic event.

For further questions on programs and training contact Rushe Hudzinski, MBA, SHRM-SCP, GPHR at rushehr@gmail.com.

Training Session Options:

- Preserving Human Capital: A Tactical Guide to Active Shooters and Minimizing Loss of Life
- Packing a Punch: Employee Domestic Violence and Active Shooter Preparation
- Expect the Unexpected: The Check List for Organizational Business Continuity Planning
- Tornadoes, Explosions, Gun Shots & Millions; OH MY! Corporate Social Responsibility via Strategic Insight on Risk Management
- Denied! Lack of Organizational Terroristic Incident and Worker's Compensation Coverage Should Not Be A Surprise

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# DeQuervain's Disease

*Derek R. Moore, M.D.*

DeQuervain's disease is a painful condition of tendon irritation along the radial (thumb) side of the wrist. Its technical name, stenosing tenosynovitis of the first dorsal compartment of the wrist, gives information about the location and pathology of DeQuervain's disease. The two tendons that move the base of the thumb travel through a tunnel or pulley (first dorsal compartment) located on the side of the wrist. As they travel through this tunnel, the tendons themselves, as well as the smooth lining of the tunnel, become irritated and constricted (stenosing tenosynovitis), which leads to pain with thumb motion.

**Symptoms:**
The primary symptom most patients notice is pain located at the base of the thumb along the wrist, most commonly with thumb motion, lifting, gripping and twisting. It may radiate down the thumb or up the forearm as well. It is often noticed following periods of increased activity using these motions and has been associated with jobs, household and recreational activities involving repetitive typing, lifting and manipulation. While DeQuervain's disease can result from a single traumatic event, most commonly it results from chronic or increased repetitive injury and activity. Studies show women are affected more commonly than men, most often between the ages of 30 and 60. Other risk factors include pregnancy, recent delivery and rheumatoid arthritis.

**Diagnosis:**
The most important component of diagnosis is the history, location and character of the pain. The time of onset, aggravating and relieving factors, and duration of the pain often lead to this diagnosis. Other diagnoses which may be considered, include arthritis of the basal joint of the thumb, sprain or injury of the ligaments of the wrist or base of thumb, and bony fractures of the underlying wrist bones. The most common examinations used involve stressing the tendons in question to evaluate the resulting pain. One common test (often called Finkelstein's test) involves tucking the thumb into the palm, then shifting the entire thumb and wrist toward the little finger to determine if pain results from the affected tendons. Other tests involve extending the thumb against the examiner's resistance, also looking for pain from the tendons. Other tests will examine for fluid filled cysts that may form over the tunnel or triggering (popping) of the tendon as it passes through the tunnel. The surrounding joints are also examined for range of motion and stability to ensure another source of pain is not present. Depending on the history and examination, x-rays of the affected wrist and hand regions may be taken to evaluate for arthritis and fractures of these areas.

**Conservative Treatment:**
Once the diagnosis of Dequervain's disease is made, an appropriate treatment plan can be selected by the patient and physician. In most cases, conservative (nonsurgical) treatment is not only the appropriate first step, but often highly successful. Numerous studies have been performed involving various combinations of rest, splinting, home exercises, physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs) and corticosteroid injections. The results show further exercise and/or therapy is not effective at relieving the symptoms, which is not unexpected from an overuse injury. NSAIDs have shown minimal effectiveness alone and only mild effectiveness in combination with other forms of treatment. Splinting and rest are as moderately effective as splinting combined with corticosteroid injection. The most successful, conservative treatment combines a corticosteroid injection with rest from the aggravating activity. Several studies show success in 80-83% of patients after injection and rest. Injection involves placing a combination of local anesthetic and corticosteroid inside the tendon sheath alongside the tendon to decrease the inflammation and constriction causing the pain. If a single injection is partially successful at relieving the symptoms or if the effect is temporary and the pain reoccurs, a second injection may be successful at complete relief of the symptoms.

**Surgical Treatment:**
In cases where conservative treatment has been unsuccessful, DeQuervain's release is a highly effective treatment. Surgery is typically performed in the operating room as an outpatient under either local anesthesia with sedation or general anesthetic. A small incision is made overlying the affected area of the wrist, the skin nerves crossing the area are identified and protected, and the tendon sheath is surgically released to free all portions of the involved tendons. Afterward a dressing is applied and possibly a splint to protect the surgical site. Once the patient follows up for suture removal a gradual return to activity and work is allowed as pain improves over a period of several weeks to allow the surgical pain to resolve, strength to return, and to allow the tendon time to heal. In some cases, occupational therapy will be used to restore range of motion and strength. Several studies show successful surgical results and a return to preinjury work activity in 91-94% of cases.

*Dr. Derek R. Moore M.D. is a graduate of the University of South Carolina, School of Medicine. He completed his Orthopedic Surgery Residency at the Greenville Hospital System in Greenville, South Carolina. Board Certified with the American Board of Orthopedic Surgery, Dr. Moore has privileges at the Northeast Georgia Health System in Gainesville, GA.*

*Dr. Moore's practice has an emphasis on Worker's Compensation as he specializes in Hand, Upper Extremity cases including Carpal Tunnel, Rotator Cuff, and Labrum repair. Dr. Moore also has a Sports Medicine interest, thus he performs ACL surgery and Meniscus repair. He also performs total joint replacements of the knee, shoulder, and hip.*

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# A Word From the Chairman

***The Honorable Frank R. McKay – Chairman – State Board of Workers' Compensation***

The new release of ICMS II, the Board's electronic claims management system, was rolled out in February of 2016. Some of the major enhancements of the new system include better and more stable access for current users. Another much-anticipated feature of ICMS II is that Board forms filed in ICMS now appear as regular Board forms in the claim file. The next phase of ICMS II, scheduled for completion by the end of 2017, will allow claims offices to file documents in the system.

The Board recently completed its series of 2016 Regional Seminars. This year's seminars were held in Columbus, Gainesville, Tifton, Savannah and Kennesaw. The program, with a 2016 presidential campaign theme, included an informative and entertaining discussion of issues, such as return to work and panels of physicians, as well as updates on rules and case law. We are also finalizing the program for the Board's Annual Conference that will be held at the Atlanta Hyatt Regency Hotel from August 29-August 31, 2016. The Annual Conference provides three event-packed days of education, networking and fellowship with colleagues from all sectors of the workers' compensation arena. The keynote speaker for the Ethics Program on the final day of the conference will be Herschel Walker, former University of Georgia football star and Heisman Trophy winner.

Other issues under consideration by the Board include the assessment of penalties for widespread failure to timely file required Board forms, delays in authorization of medical treatment recommended by an authorized physician and the possibility of implementing a drug formulary to address the proliferation of the use of narcotics and opiates to control chronic pain. We welcome the input and ideas of all of our stakeholders as we continue to grapple with these and other issues that have the potential for significant impact on the effectiveness and efficiency of our system.

*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.*


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**The last return bus leaves Johnny's Hideaway at 12:30 AM**

# Keyboard Use and Carpal Tunnel Syndrome: The Debate Continues

*Dr. Joshua A. Ratner*

In 2007, the AAOS (American Academy of Orthopedic Surgery) released their first Clinical Practice Guideline on the evaluation and treatment of carpal tunnel syndrome. Based upon a thorough literature review, the authors drew conclusions that they hoped would allow for practitioners to make evidence-based clinical decisions. Recently, the AAOS issued an update to the CPG, which modified several of the positions previously opined. None among them stands to create more debate and discussion than the position that computer work is associated with the development of carpal tunnel syndrome.

Citing several studies published since the original CPG was authored, the revision guidelines do not plainly state that computer work causes carpal tunnel syndrome. Rather, the authors state that "moderate evidence" supports that computer work is a risk factor for the development of CTS. They did not regard the reviewed evidence as "strong evidence", which is the guideline's highest-level designation. The previous position cited "pregnancy, advancing age, female gender, specific occupations, hand-related repetitive motions, strong family history, specific medical disorders such as hypothyroidism, diabetes, autoimmune diseases, rheumatological diseases, arthritis, obesity, renal disease, trauma, anatomic predisposition in the wrist and hand due to shape and size, infectious diseases, and substance abuse" as risk factors.

This departure from their previous position was based upon a reconsideration of the current evidence. Several prior studies that were considered less "powerful" studies due to small patient group size or lack of an objectively measured outcome were eliminated. The results seem to swing the pendulum back towards keyboard use being considered an independent risk factor for the development of CTS.

The diagnosis of CTS requires a discussion of the patients' symptoms, risk factors, a careful physical examination, and frequently, obtaining an Electromyogram/Nerve Conduction Study (EMG/NCV). Outside of the worker's compensation arena, the development of carpal tunnel syndrome is often "blamed" on these factors, with those without risk factors being considered "idiopathic" carpal tunnel syndrome cases. For those clinicians treating patients in the workers compensation system, the ever-present challenge is to answer the question of causation. Is typing solely to blame for the development of carpal tunnel syndrome? The answer is probably: very rarely. Once patients with the other accepted risk factors are excluded, the population of patients diagnosed with CTS whose only risk factor is keyboard use are few in number- though possibly, and based upon current best-available evidence, they do exist. And so, the debate continues.


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*Dr. Joshua A, 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.*

www.handcenterGA.com

# Genetic Testing in Workers' Compensation

*Paul L. Mefferd, D.O.*

As an adjuster, employer or nurse case manager, you've been asked to approve many things for the diagnosis, treatment and management of the injured worker. These range from the routine to the ridiculous. A physician asking for approval for four weeks of physical therapy would most-likely not get a second glance. What happens when the physician asks for an in-ground, hot-tub in the back yard for "therapeutic purposes?" Almost universally that would catch your attention and be rejected in record time. So what do you do when a physician asks you to approve genetic testing? Frequently, these requests are being rejected. Why? Most likely because the decision-maker doesn't know what genetic testing entails, why the physician needs this information or how this testing can control costs in a workers' compensation claim. A common misperception is that genetic testing is used to determine someone's potential for becoming addicted to the drugs they are taking. It's important to understand this is not what the physician is testing for.

The science of genetic testing is a relatively new, intricate and maddeningly complex. Luckily, the purpose for genetic testing is surprisingly simple and straightforward: it provides a roadmap to utilize medications more effectively and safely – oh, and it can also save you money! Genetic testing may show that an expensive medication is poorly metabolized by the patient and is altogether ineffective. Eliminating a costly and ineffective medication could save tens of thousands of dollars over the life of a claim.

As stated above genetic testing is complex, but understanding the basics is enough to understand why genetic testing is the future in all of medicine, not just in worker's compensation. Genetic testing involves a simple cheek swab that first looks at the genetic make-up of an individual and determines if they are a poor metabolizer (PM), intermediate metabolizer (IM), normal/extensive metabolizer (EM) or ultra-rapid metabolizer (UM). Secondly, it then compiles a list of the enzymatic activity of the individual and determines not only how well the medication is metabolized, but also if there are any medication interactions that may be dangerous or inhibitory. For example, someone who is an ultra-rapid metabolizer for CYP2D6 may have very little therapeutic effect from Hydrocodone, due to the medication being rapidly metabolized and excreted from the system. The medication simply cannot "stay around" long enough to provide benefit.

The converse can be true with a poorly metabolized medication, which would be slowly metabolized and remain in the system for longer, causing increased effect and even side-effects. This is where the genetic test can help limit costly, ineffective or dangerous medications, thus reducing patient side effects and costs.

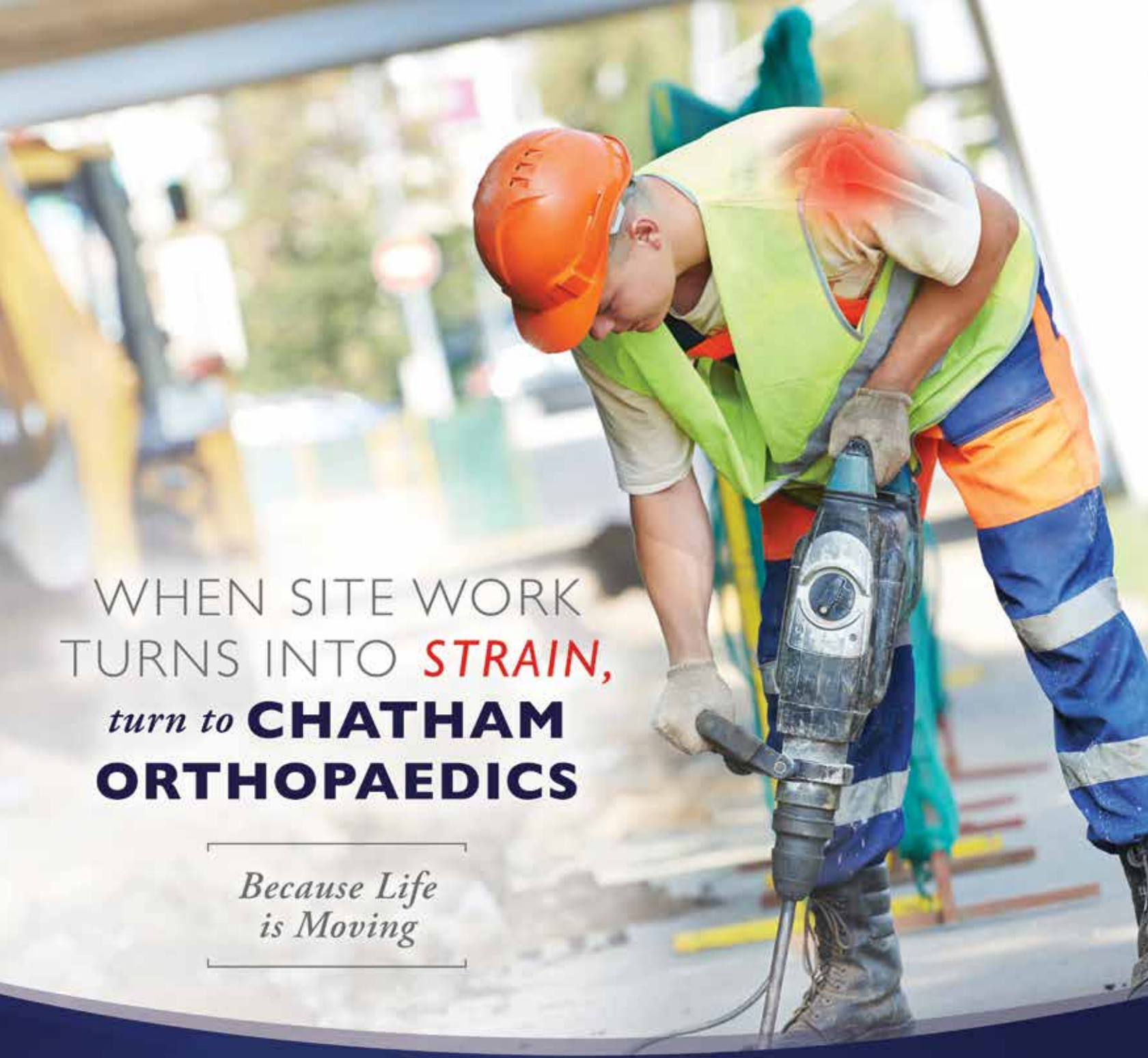
Genetic testing is going to be implemented in all of medicine very soon and will have significant impact on the treatment efficacy and costs of workers' compensation claims. Genetic testing covers numerous drugs that are used to treat conditions such as chronic pain, osteoarthritis, GERD, migraines, hypertension, hypercholesterolemia, depression and even cancer. Genetic testing is relatively affordable, needed only once in a lifetime (as genetic information does not change over time) and can be the difference between the practice of effective and safe medicine versus costly, ineffectual and dangerous medicine.

*Paul L. Mefferd, D.O. is a partner with The Physicians and practices in their Marietta and Rome/ Calhoun locations. He received his undergraduate degree in Biology from the University of South Carolina and his medical degree from the University of Health Sciences, College of Osteopathic Medicine. Dr. Mefferd completed his internship at Florida Hospital in Orlando and went on to complete his residency training at Emory University Hospital. He completed his fellowship training at Emory through the Anesthesiology Pain Medicine Fellowship program. Dr. Mefferd is board certified in Physical Medicine and Rehabilitation and subspecialty board certified in Pain Medicine.*

## The Physicians' Spine and Rehabilitation Specialists of Georgia is pleased to welcome Michael Schurdell, M.D.

Dr. Schurdell is now seeing patients in our Rome location. He received his Bachelor's Degree in Microbiology from Brigham Young University. He completed his medical degree at University of Texas Medical School at Houston. Dr. Schurdell served as an intern at Baylor College of Medicine and completed his residency in Anesthesiology at the distinguished, Emory University School of Medicine. He completed subspecialty training at the highly sought after interventional pain management fellowship at Wake Forest School of Medicine.

Dr. Schurdell's training has brought him to various parts of the country allowing him to work alongside leading experts in the fields of anesthesiology and interventional pain medicine, such as the world-renowned Dr. Richard Rauck. He has acquired advanced training in multimodal therapeutic approaches to chronic pain, which include the use of minimally invasive techniques such as epidural steroid injections, selective nerve root blocks, sympathetic blocks, spinal cord stimulation, dorsal root ganglion stimulation, vertebral augmentation for vertebral compression fractures, lumbar and cervical facet joint radiofrequency ablation, ultrasound and fluoroscopic guided peripheral nerve blocks and radiofrequency ablation.



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# Chatham Orthopeadic Associates is Excited to Introduce a New Imaging Modality PedCT:

*Mikki Cheatham RT(R)*

Chatham Orthopaedic Associates introduces cutting edge technology in imaging services. The practice as acquired a new computed tomography machine that looks to be quite different compared to average CT imaging machines one might have seen in the past. The new PedCAT unit is manufactured by Curvebeam out of Warrington, Pa. Curvebeam was founded in 2009, and FDA approved in April 2012. Chatham Orthopaedics is pleased to be the first to bring this state of art technology to the Savannah region.

Curvebeam created a new way of using Cone Beam Computed Tomography System (CBCT) geared toward the podiatric and orthopedic specialties. This cone beam technology is not necessarily new; it has just been used in a different medical imaging modality in which one might be more familiar – dental and orthodontist offices currently use this in imaging panoramic x-rays of the mouth. This new unit is convenient and easily fits in physicians' office. A traditional CT machine is large and a patient must lay down to scan their body part within a gantry. The patient stands in the PedCAT which allows weight bearing images of the foot and ankle to get the most anatomically correct images. The larger CT scans the alignment and measurably is not always reliable. The PedCAT has been found to be accurate and fast for the patients. The PedCAT scans take less than a minute for a foot and less than 30 seconds for an ankle.

Imaging plays a vital role in orthopaedics evaluation and management. Often when visiting our practice, X-ray imaging is necessary for the initial visit and as well as follow-up visits. Our Foot and Ankle Specialist is now better equipped to evaluate deformities of the foot, For example, Charcot's, Lis francs injury, hind foot alignment, arthritis, and even preparation for operative procedures with the use of PedCAT because the images that are produced are highly detailed. The PedCAT's reconstructed images are brought up in Axial, Sagittal, and Coronal, as well as 3D Rendered images.

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MPR or Multiplanar reformatted images are 2D reconstructed, these are the images that usually allow the best image for viewing fractures. The software with the PedCAT also has an option to create X-ray images for a foot or ankle. With the reconstruction of these images, our physicians can virtually see greater detail than ever before of the foot and ankle.

Patients have reported high satisfaction with the wait time to get an appointment, as well as actual scan time. PedCAT scans are read in house by our own foot specialist making for a more seamless experience.


To learn more contact Mikki at Chatham Orthopaedic Associates at mcheatham@chathamortho.com


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# Subrogation: the good, bad and ugly

*Jenifer E. Cummings*

Your employee was injured by a third party in the course of her employment. After accepting the claim as compensable, you provide the injured employee with all appropriate workers' compensation benefits. Did you know that it may be possible for you to recover some of the benefits you paid?

The Good: O.C.G.A. § 34-9-11.1(b) grants an employer a subrogation lien against any recovery an employee receives from a third party for the medical and income benefits paid by the employer.

The Bad: The statute specifies certain conditions that must be met for the employer to recover. The most difficult of these to fulfill is that the injured employee must be "fully and completely compensated" before the employer can recover. It further stipulates that the burden is on the employer to prove the employee has been fully compensated. To make this determination, courts consider the benefits paid by the employer, the amount recovered from the 3rd party and all of the losses incurred by the employee. Canal Ins. Co. v. Liberty Mut. Ins. Co., 256 Ga. App. 866, 871 (2002).

The Ugly: Courts have routinely dismissed subrogation liens if the employee settles with the third party. Its reasoning is that the only way to determine if an employee has been completely compensated is with a special jury verdict that specifies how much of the award is for pain and suffering, medical expenses, lost wages, and other damages. Bartow County of Education v. Ray, 229 Ga. App. 333, 335 (1997). The courts have stated that in the absence of such a verdict, the employer cannot meet its burden of proving that employee has been completely compensated.

Unfortunately, dismissals of subrogation liens are generally made AFTER the employer intervenes in and participates at a trial involving the third party. At this point, the employer may have thrown good money after bad because there is no guarantee of recovery. Furthermore, Courts have also awarded attorney's fees to be paid by the employer to the employee's attorney for defending against the subrogation lien.

Why then would an employer seek recovery? It boils down to a cost-benefit analysis. Sometimes, it is more cost effective to waive the subrogation lien and cut your losses. However, if you have paid out a million dollars in benefits for an employee who stands to recover multi-millions from the third party, the costs of pursuing recovery may be worth the risks.

Some claims need to be waived, some need to be settled and some need to be litigated. Our expertise in both tort subrogations and workers' compensation defense is here to assist you with determining how your claim should be handled.

*Jenifer E. Cummings earned her Juris Doctor with a Certificate in International Law from Loyola University New Orleans School of Law. Admitted to the Louisiana Bar in 2006 and the Georgia Bar in 2013, Jenifer is also admitted to the U.S. District Court for the Eastern and Western Districts of Louisiana. Her practice includes general liability defense, workers' compensation defense, corporate law, federal criminal defense, and litigation.*
*jenifer@rossandburriss.com*

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# New OSHA Reporting Rule and Intoxication Defenses

*James G. Smith, Esq., Hall Booth Smith, P.C.*

O.C.G.A. 34-9-17(b) allows an employer to deny compensation to an injured worker "Due to intoxication by alcohol or being under the influence of marijuana or a controlled substance." Under Georgia's "drug-free workplace" program, post-accident drug testing must be done, irrespective of the type of injury sustained, in order to qualify for the insurance premium discount under the program. However, with the publication of OSHA's final rule on electronic reporting of workplace injuries and illnesses, which will go into effect on August 10, 2016, employers will need to examine existing drug testing policies to avoid facing heightened scrutiny for potential violations of 29 CFR 1904.35(b)(1)(i).

Among other things, the new OSHA rule is intended to deter employer retaliation against an employee who reports a workplace injury and mandates that employers implement a "reasonable procedure" for the reporting of such incidents. In effect, the new rule indicates that across-the-board drug testing after an injury is reported could deter an employee from reporting the injury for fear of facing "retaliation." OSHA commentary indicates that testing should only be done when "drug use is likely to have contributed to the incident, and for which the drug test can accurately identify impairment caused by drug use." While the new OSHA rule allows for continued blanket drug testing in the context of workers' compensation law (denying a claim under O.C.G.A. 34-9-17(b) is not "retaliation"), employers should review and revise procedures where necessary to ensure OSHA compliance. However, employers need not abandon blanket drug testing in all situations of a workplace injury, so long as it is directly tied to the decision of compensability of the injury.

# Exciting news for 2017!

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# Distal Radius Fractures (DRF)/Wrist Fractures

*Michael S. Shuler, MD*
Hand, Wrist & Elbow

Wrist fractures are the most common fracture, with over 600,000 occurring each year in the US. Wrist fractures typically occur due to a fall on an outstretched hand, crush injuries or automobile accidents. In the vast majority of wrist fractures, the most common broken bone is the distal part of the radius, one of two bones in the forearm.

## Management

Distal Radius Fractures (DFRs) can require surgery in some cases. Surgery is typically not needed when the bones are well aligned, specifically when the joint surface is intact. When surgery is not required, close follow up is needed to ensure the fracture does not move.

Specific factors determine if wrist fractures will require surgery. When the skin is broken and the bone protrudes, urgent surgical intervention is required to prevent infection. Surgery is required when breaks involve the joint surface, when there is significant malalignment or displacement, significant comminution (broken in many pieces), or shortening of the radius compared to the ulna, the other bone in the forearm (Figure 1).

If surgery is required, different techniques can be used, such as pins, plates and screws (Figure 2) or an external fixation. Techniques are chosen based on fracture types, patterns of breaks, age of the patient, as well as other factors. Different techniques offer different levels of stability but also require different levels of invasiveness.

## Recovery

If a fractured wrist is treated non-operatively, the cast is maintained for approximately six weeks. For fractures requiring plates and screws, the splint is removed after 1 to 2 weeks and motion is begun. A potential benefit from surgery is that it allows for early mobilization, which may improve range of motion due to increased stability of the fracture. Specialized occupational therapy, conducted by a certified hand therapist, plays an important role in regaining function. Weight bearing activities are typically restricted for approximately two months. Full recovery can take up to 3 to 6 months after a significant injury. In some cases, removal of hardware may be necessary to prevent tendon injury.

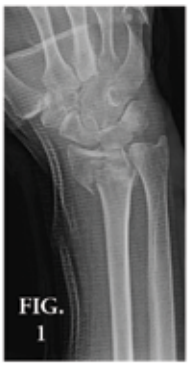

FIG. 1

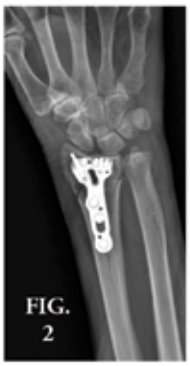

FIG. 2

## Return to work

Patients can usually return to light duty within a couple of days pending the need for narcotic pain medication. No use of the arm is recommended for approximately two weeks. From 2 weeks to roughly 12 weeks post-op, the patient is able to use the upper extremity on a limited basis with increasing capability to bear weight. After 3 months of fracture healing, most patients are able to return to regular duty. Recovery depends on multiple factors including severity of the injury, patient motivation, job requirements, and can take up to a year or more. Early and appropriate management is critical for a good outcome and expedited recovery.

## Concerns

Malalignment or incongruent joint surface can result in long-term pain, loss of motion, instability or the development of arthritis. Concomitant ligament tears or additional fractures can occur in combination with DRF. Tendon ruptures rarely occur during non-operative and operative management. Additionally, other concerns such as Carpal Tunnel Syndrome (CTS) or compartment syndrome can require urgent surgical intervention. Lastly, Complex Regional Pain Syndrome (CRPS) or reflex sympathetic dystrophy can be associated with wrist fractures and can cause long-term dysfunction. Aggressive management of CRPS with release of any peripheral nerve compression (CTS) as well occupational therapy have been shown to maximize functional outcomes.

## Summary

Distal radius fractures are common, and in most cases, can be managed successfully with the appropriate care. Wrist fractures come in many shapes and sizes. Each injury requires specific management based on the patient, the type of fracture and the potential risks for complications. In many cases, surgical intervention will provide the best opportunity to recover at or near full function. Experienced and specialized care allows the best chance at minimizing permanent impairment.

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 manager, adjustors and attorneys, resulting in prompt care and more positive outcomes.

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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Contact: Ellen Miller Goldberg
Direct Line: 912-355-3255
Email: egoldberg@CoastalHomeCare.us
Web address: www.coastalhomecare.us
PHONE: 912-354-3680 x 3255 FAX: 912-352-3905

### Defined FCE Group
316 California Avenue, #121
Reno, NV 89509

### Work Capacity Diagnostics
Jessica Tehas
Email: jtehas@dfcegroup.com
Direct Line: 770-658-7255
Web Address: www.dFCEgroup.com
PHONE: 866-813-5888

### Downey Medical Consultants
1100 Peachtree Street Suite 200
Atlanta, GA 30309

Contact: Karen Greer
Email: downeymedicalconsultants@aol.com
Direct Line: 404-664-1693
Web Address: www.downeymedicalconsultants.com
PHONE: 404-664-1693

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# PREFERRED PHYSICIANS

## Atlanta Orthopaedic Institute

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Atlanta, Georgia 30327

1035 Southcrest Drive, Suite 100
Stockbridge, Georgia 30281

1309 Milstead Road, Suite A
Conyers, Georgia 30012

1235 Indian Trail Road,
Suite 200 A,
Norcross, GA. 30093

### Worker's Compensation Coordinator

Mendi Holtzclaw
Direct Line: 770-389-9005 x 27
Email: mendi.holtzclaw@yahoo.com
Web address: www.atlantaorthopaedicinstitute.com
PHONE: 770-389-9005 FAX: 770-389-5251

### Physicians

Raj Pandya, M.D.
Gregory Lee, M.D.
Saurabh Khakharia, M.D.
Frank Chevres, M.D.
Bryan Whitfield, M.D.

Atlanta Orthopaedic Institute

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## Chatham Orthopaedic Associates, P.A.

4425 Paulsen Street
Savannah, GA 31405
With locations in Richmond Hill, GA, Pooler , GA and Effingham County, GA

### Worker's Compensation Coordinators

Kim Redding
Direct Line: 912-525-1312
Email: kredding@chathamortho.com

Kim Morris
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Email: kmorris@chathamortho.com

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PHONE: 912-355-6615 FAX: 912-351-0645

### Physicians

John T. Prather, M.D.
Spencer M. Wheeler, M.D.
James E Holtzclaw, M.D.
Greer E. Noonburg, M.D.
Mark A. Jenkins, D.O.
Robert Dow Hoffman, M.D.
Raphael R. Roybal, M.D.
Ronald H. Levit, M.D.
Gerald Chai, D.O.
D'Mitri Sofianos M.D.

COA Chatham Orthopaedic Associates, P.A.

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## The Hand & Upper Extremity Center of Georgia, P.C.

Northside Hospital Doctors Center
Suite 1020
980 Johnson Ferry Road, NE
Atlanta, GA 30302

Northside/Alpharetta Medical Campus
Suite 350
3400A Old Milton Parkway
Alpharetta, GA 30005

### Workers' Compensation Coordinator

Roxanna Fredrick
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Direct Line: 404-255-0226 x 130
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PHONE: 404-255-0226 FAX: 404-256-8968

### Physicians

Bronier L. Costas, M.D.
Gary M. Lourie, M.D.
Allan E. Peljovich, M.D.
Jeffrey A. Klugman, M.D.
Johsua A. Ratner, M.D.
Bryce T. Gillespie, M.D.

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## Georgia Bone and Joint

The Summit Healthplex
1755 Highway 34 East, Suite 2200
Newnan, Georgia 30265

### Worker's Compensation Coordinator

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PHONE: 770-502-2175 FAX: 770-502-2131

### Physicians

Jack H. Powell III, M.D.
George M. Ballantyne, M.D.
Michael P. Gruber, M.D.
Chad M. Kessler, M.D.
Michael V. Cushing, M.D.
Jayson A. McMath, M.D.
David J. Heinsch. M.D.

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## Specialty Clinics of GA Orthopaedics, PC

1240 Jesse Jewell Parkway
Suite 300
Gainesville, GA 30501

Corner of Friendship Road & Hwy 211/Old Winder
Hwy, Bldg. #100
Braselton, Georgia 30517

### Workers' Compensation Coordinator

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Web address: www.scg-ortho.com
PHONE: 770-532-7202 FAX: 678-707-7156

### Physicians

W. David Weiss, M.D.
Robert Marascalco, M.D.
John Vachtsevanos, M.D.
Gary Davis, III, M.D.
Ben Puckett, M.D.
Kris Wheeler, M.D.
C. Cullen Scott, M.D.
Filippo Chillemi, M.D.
John Hemmer, M.D.

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## Wellbeings Occupational Healthcare

3300 Holcomb Bridge Road, Suite 110
Norcross, GA 30092

Contact: Melissa Platt
Email: mplatt@wellbeingsocc.com
Web Address: wellbeingsocc.com
PHONE: 770-449-5161

### Physicians

Jane T. St. Clair, M.D., M.P.H.

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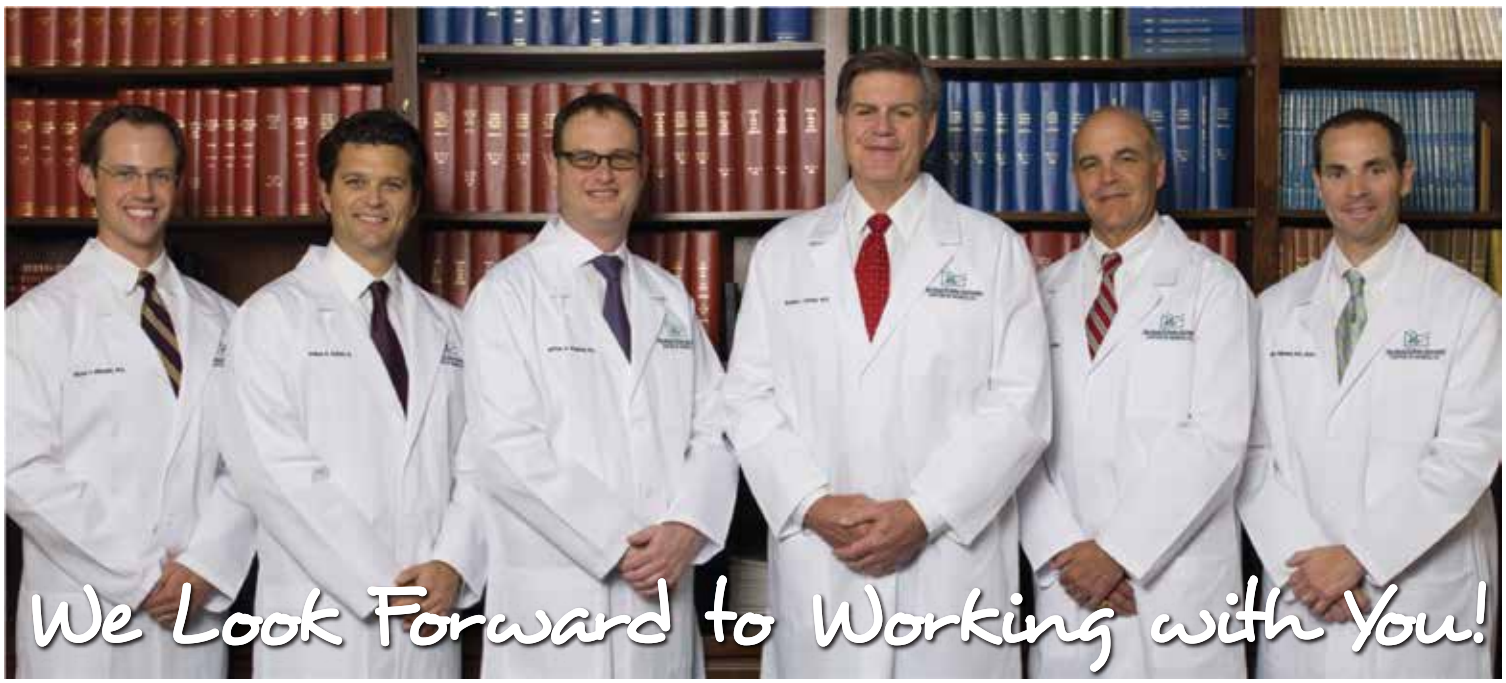


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993D Johnson Ferry Rd. NE, Suite 200
Atlanta, GA 30342 - **404-969-1996**

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