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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 19 locations including 12 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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Are You Getting Better? - A Different Approach to Measuring Pain Outcomes

Dr. Marshall is a Harvard-trained, double board certified anesthesiologist and fellowship trained interventional pain management specialist who now serves as the Director of Medical Outcomes at Alliance Spine and Pain.

The current healthcare environment has forced the chronic pain management specialty to analyze our economic model, and reshape the value proposition that we present to our patients, referring providers, and managed care organizations. In our current health care climate, patients are responsible for more of the costs associated with their care by paying higher premiums, deductibles, and co-pays. Practitioners are now challenged with differentiating themselves based on the quality of care they provide for a shrinking pool of health care dollars. This pressure has begun to force innovation and critical analysis of how we view treatment success.

In my practice, we are departing from using the traditional numerical pain scale (0/10 to 10/10) to measure patients' relative pain intensity, which is inherently subjective. Instead, we are focusing on more practical and objective functional outcomes that lead to improved productivity and quality of life. This approach is supported by a 2011 report, "Relieving Pain in America," published by the Institute of Medicine, which estimates the annual value of lost productivity to pain syndromes ranged between \$297 billion to \$335 billion based on hours of work lost, days of work missed, and lowered wages. The goal of treatment, therefore, should not focus solely on the patient's immediate pain, but on affecting functional outcomes. For many patients, there is no magic pill, and thus, the best indicator of the success of a treatment plan is whether the patient's pain is sufficiently managed to enable greater functionality at work, home, and throughout daily life.

It is in this context that interventional pain physicians, like myself, are broadening our armamentarium beyond interventions like epidural steroid injections. In the future, we are looking to develop objective pain measurement tools like "functional MRI," which takes dynamic images of the brain as it responds to painful stimuli. The results of these imaging studies can help us to identify patients who are at high risk for persistent disabling symptoms and those who are likely to recover with targeted therapy.

Additionally, the opioid crisis is devastating many of our local communities due to abuse and the ease of access to prescription medications. Moreover, the negative cognitive effects of some opioids can often impede the functionality that we are working so hard to achieve. Judicious use of appropriate tools allow us to better assess the likelihood that a patient will abuse opioids, and design a plan to manage pain with a comprehensive approach that prioritizes functional goals like reduction in daily morphine equivalents.

Pain management is a multi-disciplinary and comprehensive experience that should incorporate medical assessment, self-management tools, physical therapy, and interventional pain management procedures where appropriate. This approach is highly impactful and cost efficacious when one considers the alternative of surgical procedures. The key, however, is to deploy these interventions while using functional outcomes to measure the patients' responsiveness to treatment over time. The goal is always to increase work productivity and quality of life.



Zwade J. Marshall, M.D., MBA Director of Medical Outcomes Alliance Spine & Pain

Dr. Marshall is accepting new patients at his Camp Creek, Douglasville, and Gwinnett locations.







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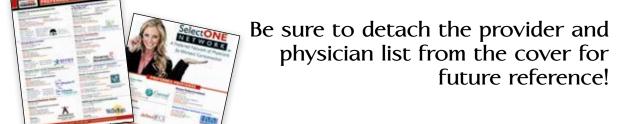
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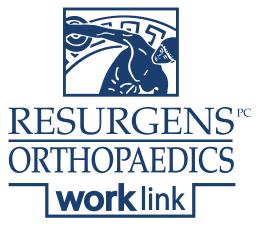






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ACL Injuries

Ryan C. Chen, M.D. - Resurgens Orthopaedics

What is the ACL?

The ACL (anterior cruciate ligament) is a band of tough, fibrous tissue that stabilizes the knee. Injuries to the ACL are very common, and are best known to occur in athletes, but they also occur on the job. The ACL connects the front of the shin bone to the back of the thigh bone. When it becomes injured, the knee is unstable and it is difficult to support weight on the knee.

How is the ACL Injured?

The ACL stretches across the front of the knee under the kneecap. It can be sprained or torn when the knee joint is:

- · Twisted
- Overextended
- · Unnaturally bent

In the workplace, this injury can occur when the job requires quick changes in direction or sudden stop. It can also occur if an employee has a traumatic injury from a motor vehicle or faces a heavy equipment accident.

Common Symptoms:

- A popping sound or sensation in the knee at the moment of injury
- · Pain and swelling within 24 hours of the injury
- · Loss of full range of motion
- · Knee may feel unstable
- · Tenderness at the joint line
- · Discomfort while walking

Treatment Options:

Treatment for the ACL injuries will depend on the individual and can include non-surgical and surgical options.

Non-surgical Treatment:

For sprains or employees who are not a candidate for surgery BRACING might be the most appropriate treatment option:

- Rest
- · Physical therapy
- · Braces or crutches to support the joint

Surgical Treatment:

A torn ACL will not heal without surgery. Rebuilding the ligament: Most ACL tears cannot be sutured (stitched) back together. To surgically repair the ACL and restore knee stability, the ligament must be reconstructed. The physician will replace the torn ligament with a tissue graft that acts as a scaffold for a new ligament to grow on.

Procedure:

Surgery to rebuild an ACL is done with an arthroscope using small incisions. Arthroscopic surgery is less invasive. The benefits of less invasive techniques include less pain from surgery, less time spent in the hospital, and quicker recovery times.

After an ACL injury, the injured worker may be restricted in the following movements:

- Lifting
- · Squatting
- · Kneeling
- · Other weight-bearing activities



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Getting the Most Bang for Your Investigative Buck

Darrell Cox, Private Investigator

If you have been in the Workers' Comp field for any length of time at all, you have no doubt heard the old adage, "surveillance is hit or miss." While it is true that some claimants are not always active and your investigative vendor is not always going to catch your claimant engaging in activities exceeding his/her alleged restrictions, there are several things the client could and should do to maximize your surveillance dollars.

- Keep tabs on your vendor. If the vendor is frequently reporting to you with little or no results, then you may want to take another look at who you have doing your work.
- If your vendor is repeatedly performing surveillance during the same specific hours with no positive results, then ask them to switch up their schedule.
- Be sure your vendor is performing ample preliminary efforts prior to initiating the actual surveillance. Often we find during an assignment, a previous vendor had performed multiple dates of surveillance at an address the claimant no longer resided, an issue that likely could have been avoided with proper database research.
- Preliminary investigation should always include at least a basic social media search. Almost every claimant or family member has a social media presence. More and more, we are seeing claimants post about things they have done or are planning to do on their social media accounts.
- Always insist on detailed reports which provide a timeline of any and all activites ongoing throughout the day. At least this way you know your vendor is putting in the time that you are paying for, even if your claimant is not active on a particular day.
- Do NOT order surveillance to be broken into half days if there is no immediate claimant active. The longer the surveillance is maintained, the better your chances of the claimant becoming active. Over and over again, on half-day assignements, we break off at the half-day mark, only to come back a few hours later and find the claimant no longer home.
- And FINALLY...ask your vendor if they will offer you a "Quality Guarrantee." We offer our clients an additional day of surveillance at no cost if we fail to

obtain video of their client during the initial two days of authorized surveillance.

As I mentioned, surveillance is not always going to be a game changer with regard to your handling of a claim.

However, it should, at the very least, give you insight into the daily activities and physical presentation of your claimant.

The above suggestions can help ensure you are getting what you paid for.

Darrell Cox is the owner and CEO of Alliance Investigations. His firm offers services for the insurance industry in most S.E. states.



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Employment Lemon (Protection) Laws and the Dangers of Hiring Previously Injured Employees

Erin A. Easley, Esq.

You own a package delivery company. Bob, a previous delivery worker for your company, returned and submitted an application for the same position. While Bob was a great employee, you have questions. The facts:

- The position requires regularly lifting 50 plus pounds
- Bob injured his back when he previously worked for you and received Workers' Compensation
- Bob's application said he is "completely healed"
- Your company has 54 employees in one location

Question #1: Can you require Bob to have a medical exam, before making an offer, to ensure he can physically do the job?

In a word, no. The Americans with Disabilities Act of 1990, as amended ("ADA") generally prohibits employers with fifteen or more employees from disability discrimination. It also prohibits any pre-offer medical exams. The ADA does let you ask Bob pre-offer questions about his position's physical requirements because they are part of the job's essential functions.

Question #2: What if Bob is rehired and his delivery work causes more back problems?

We are in the very state-specific world of Workers' Compensation. Generally, Bob can probably file a claim because this work aggravated his previous injury or caused a new one. You should also closely review the notice requirements, as some essentially require employers to ask if they see an employee do anything that might signal a work injury. Employers walk a tight line between Workers' Compensation laws and the ADA. If you hire Bob and later see him grimace while lifting, document these incidents, talk with Bob, and then make note of those conversations. Avoid using the words "disability" or "disabled." The ADA prohibits employers from asking if an employee is disabled or the nature or extent of the disability, unless "job-related and consistent with business necessity."

Question #3: What if Bob is rehired, gets hurt outside of work, and requires surgery?

This is when the Family Medical Leave Act ("FMLA") applies. Pretend Bob's injury occurs after working over 20 weeks. Because of that, and because you have over 50 employees in one location, your company must comply with the FMLA. Bob gets up to 12 weeks of unpaid leave for his surgery and recovery. When he returns, you must place Bob in his previous or an equivalent position.

Question #4: What if Bob is rehired and asks for a lifting belt to help him lift boxes?

Buy the belt. The ADA requires you to provide reasonable accommodations to help qualified employees perform the "essential functions" of the job, unless the accommodation is an undue hardship. You may personally think that Bob is not disabled, since he said he is "completely healed," but here it is not worth the fight. Buying the belt will help avoid both an ADA claim and a Workers' Compensation claim.

Question #5: Should you just not rehire Bob?

Are you seriously considering not rehiring Bob? Not so fast. The ADA prohibits discrimination against a qualified individual during the application process, so there is a risk of Bob claiming discrimination if not hired. This potential liability depends on (I) whether Bob has a disability; and, (2) whether Bob can perform the position's essential functions, with or without reasonable accommodation.



Erin A. Easley, Esq. is an attorney at Goodman McGuffey LLP, where she represents businesses and their owners throughout Georgia in complex commercial lawsuits filed in state and federal courts. Ms. Easley has experience defending cases involving employment discrimination and/or harassment, minimum wage and overtime, breach of contract, breach of fiduciary duty, and fraud.



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- Suzanne Tambasco, RN, BSN, MEd, CCM, CRRN, COHNS/CM, NCLCP, LNCC, MSCC



Back to Work After Hernia Repair: The Advantages of Minimally Invasive Surgery

Chad Copper, M.D., F.A.C.S

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Hernias are one of the most common workplace injuries leading to time off work and Workers' 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 go back 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, with laparoscopic hernia repair beginning in the early 1990s. After 25 years of laparoscopic hernia repair, we have many in-depth studies showing 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. Longstreet's 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. However, even with all this technology, the physicians at Longstreet never forget what's most important: personalized care.





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



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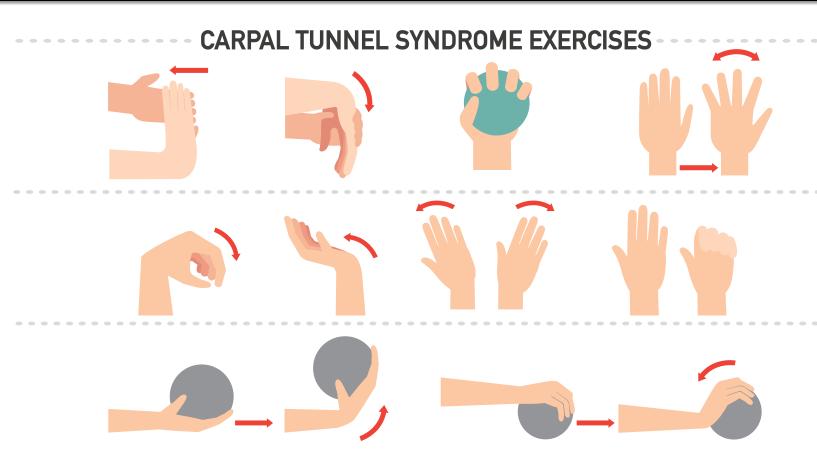
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Don't Let Carpal Tunnel Hold You Back

Tedman L. Vance, M.D.

Carpal tunnel syndrome can cause people to miss work and the activities they love, which is why understanding – and treating it properly – is the key to finding relief. The carpal tunnel is the passageway in the wrist that contains the median nerve.

"If the median nerve is compressed, people can feel pain, weakness, or numbness," says Tedman L. Vance, M.D., an orthopaedic surgeon with Saint Joseph's Hospital. To treat this condition, doctors at Saint Joseph's Hospital offer patients three types of carpal tunnel release surgeries, including: traditional open release, mini-open release, and endoscopic carpal tunnel release. "Your doctor can help you decide which option is best for you," Dr. Vance says.



Tedman L. Vance, M.D. is board certified by the American Academy of Orthopaedic Surgeons and fellowship trained in orthopaedic hand and upper extremity surgery. He earned his Bachelor of Science degree from the University of New Mexico and a Doctorate of Medicine from Louisiana State University – New Orleans. He graduated with honors in medicine and returned to the University of New Mexico were he did his orthopaedic surgery residency (1999). Following his residency, he served in the United States Navy at Camp Lejeune, North Carolina. The majority of his practice at Camp Lejeune was Sports Medicine, Trauma, and activity-related problems in young athletic patients. He went on to complete a fellowship in hand and upper extremity surgery at Duke University (2003-2004), and then served as active staff at the National Naval Medical Center (NNMC) in Bethesda, Maryland. At NNMC, he was primarily responsible for caring for and managing upper extremity injuries in service members returning from war in the Middle East.

Dr. Vance grew up in Springfield, Illinois, but spent most summers on his family's farm in Mississippi. He played one year of collegiate football as a walk-on (at UNM), and also has a Doctor of Veterinary Medicine degree from LSU (1988). He is active in running, racquetball, and weight training.



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Garlana Mathews, President

Vortex of Failure

Lydia Hendrix, RN, BSN, MSSL, CRRN, COO / Division CEO at NeuLife Rehab

While naturally there is significant focus on the early life-saving and acute phase of an injury, there is dangerously little attention and effort around the coordination of care for long-term management of these high-risk for failure patients.

Catastrophically injured patients are often discharged too soon and/or to the wrong setting, unarmed with the knowledge and insight required to navigate their permanently changed lifelong journey.

If the big picture of brain injury rehabilitation is not addressed from inception, these patients may travel down new catastrophic paths, including substance abuse, behavioral crises, misdiagnoses, incarceration, or hospital readmission. In other words, they get stuck in a desperate and costly "vortex of failure."

Post-acute therapeutic residential rehabilitation before sending a patient home can be the vortex breaker. Even after the patient achieves a level of functional independence, h/she may not have 24/7 care and support at home or be able to live alone safely.

A supported living facility can be a lifesaver within the post-acute care continuum. The Supported Living Program at NeuLife Rehabilitation provides patients with a safe, home-like environment where they can continue to improve their independent living skills while receiving 24/7 supervision and support from a team of rehabilitation professionals.

To read the full article and learn more about NeuLife Rehabilitation and its Supported Living Program, visit: www.NeuLifeRehab.com or 800.626.3876



Lydia Hendrix is the Chief Operating Officer / Division Chief Executive Officer of NeuLife Rehabilitation in Mount Dora, Florida. She brings more than 27 years of healthcare experience to NeuLife.

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A Word from the Chairman

The Honorable Frank R. McKay - State Board of Workers' Compensation Chairman and Chief Appellate Court Judge

It has been a number of years since a new judge was hired at the State Board of Workers' Compensation (SBWC). However, that changed in early 2017. The SBWC is pleased to announce the additions of Judge Richard Sapp, Judge Kimberly Stone Boehm, and Judge Sharon Reeves. Judge Sapp is handling the Dalton and Rome and northwest Georgia area of the state, Judge Boehm is managing metro Atlanta area cases, and Judge Reeves is in the Macon office dealing with a large part of middle and south Georgia.

The SBWC is pleased to have these new judges with their extensive knowledge of Workers' Compensation law and the issues facing employers and injured employees. The year 2016 saw the retirements of several judges from the State Board of Workers' Compensation after long and distinguished careers serving the State of Georgia. Judges Sallie Jocoy, Carolyn Weeks, Steve Fain, and Director/Judge and former Chairman, Hal Dawkins, retired. In February 2017, Judge Gordon Zeese announced he will retire July 1, 2017. All of these people will be missed tremendously for their judicial acumen and service to the Georgia Workers' Compensation system.

The Board is working on creating a physician registry linked to the Board's website that will allow any physician interested in Workers' Compensation to register by name and specialty and provide contact information. This will allow users of the website to search for physicians by specialty who accept Workers' Compensation patients and enables the Board to send notices of items of interest and changes in rules and statutes germane to physicians. The site will also have a section of frequently asked questions that will be of interest to physicians.

The United States has 4.4% of the world's population. In 2013, the U.S. consumed 99% of the world's supply of hydrocodone and 78% of the world's supply of oxycodone. According to data collected by the health care information company, IMS Health, doctors wrote 7.8 million opioid prescriptions in Georgia in 2015. From 2006 to 2014, more than 9,100 drug overdose deaths were reported in Georgia, which was an increase of 45 percent during that time span. Georgia participated in a recent study by the Workers' Compensation Research Institute (WCRI) examining longer term opioid use over a two-year time period ending March 2012. According to that study, Georgia showed a slight decrease in longer term use of opioids (0.2% percentage point change over the study period). That decrease, however, was not statistically significant and we remain concerned about the level of opioid use in Georgia, especially in non-surgical and longer term situations.

The National Drug Summit, held in Atlanta in 2016, unveiled several initiatives aimed to curb the opioid problem. One such initiative is the Center for Disease Control's (CDC) guideline released in March 2016 for prescribing opioids for chronic pain. (See www.cdc.gov/drugoverdose/prescribing/guideline.html) Both the American Academy of Orthopaedic Surgeons and the American Academy of Neurology have also issued position statements on the risks of prescribing opioids. Among other recommendations, the CDC guideline states that opioids should not be used as first-line or routine therapy for chronic pain. The guideline advises clinicians to consider opioid therapy only if clinically meaningful benefits for both pain and function are expected to outweigh risks to the patient. Further, the guideline emphasizes the importance of counseling patients on the risks of opioid therapy to help facilitate an informed risk/ benefit assessment. When opioid therapy is considered, the guideline specifies opioid selection, duration, follow up, and discontinuation.

While recognizing that opioids have a place in medicine, we see far too many instances in Georgia's Workers' Compensation system where the prolonged opioid use has ended in tragedy for injured workers and their families, and more commonly, where it has unnecessarily delayed getting injured workers better and back on the job to the detriment of both the workers and their employers. We are working with stakeholders (including several doctors) on the Chairman's Medical Advisory Committee to vet potential solutions to target inappropriate and overuse of opioids. Options discussed have ranged from physician education to a drug formulary. We rely upon the advisory committee to help us assess the advantages and disadvantages of various approaches and in finding a solution to the opioid problem.

On the judicial side, the Board is mindful of cases in which opioids appear to be used inappropriately, particularly for long-term use. The Board has the authority to order a change in treatment or physician when the situation warrants. While the Board prefers those decisions be made between the parties, often these issues are litigated.

When these matters come before us, one of many factors we consider is the impact and propriety of the drug regimen in place under the current treating physician. While the Board lacks treatment guidelines, we do consider prescribing practices (and their effectiveness toward better worker health outcomes) when exercising Board discretion over medical authorization and change in physician decisions. The Board's Steering Committee is hard at work planning the Annual Conference for August 28-30, 2017 at the Hyatt Regency Downtown Atlanta Hotel. The Advisory Council committees are working hard on several medical issues and rules and procedures that will go into effect this year.

As we settle into 2017, we are excited for the new year for the SBWC and the Georgia Workers' Compensation system which continues to be one of the highest rated systems in the US. Georgia continues to lead the nation in economic development and business expansion. Hardly a day goes by without an announcement of a new business locating to Georgia or an expansion project by an existing business. Under Governor Nathan Deal's initiatives, Georgia is a leader in many industries, including healthcare, technology, national cyber security defense, manufacturing, film and movie production, agriculture, tourism, logistics and transportation, and many others. The stability, balance, and fairness of our Workers' Compensation system continue to earn it high marks and it is held in high regard by employers and employees alike.



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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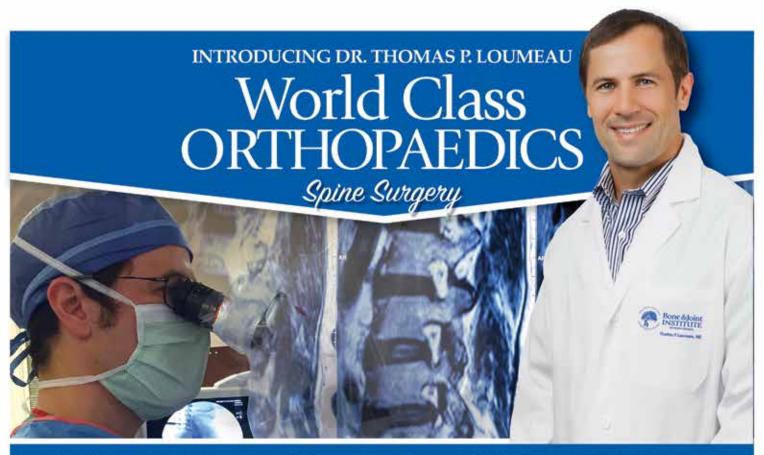


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Dr. Loumeau is internationally recognized, attending many conferences and presenting innovative research from Canada to Spain. His vast knowledge and experience makes him a valuable asset to BJISG and our entire community. Dr. Loumeau treats spinal conditions such as Compression Fractures, Degenerative Disc Disease, Disc Herniation, Motor Vehicle Related Injuries, Spinal Stenosis, Sports Injuries, Vertebral Fractures and more.

Loumeau's approach to workers' compensation patients, as well as all patients, is to first offer the patient non-surgical, non-invasive treatments such as physical therapy, pain controlling injections and medications. However, if surgery is required, Dr. Loumeau brings a wealth of knowledge in many innovative spinal surgeries.

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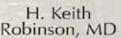


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Outpatient Joint Replacement: Improving Patient Outcomes and Satisfaction

Christopher Cullen Scott, M.D.

Outpatient total joint replacement is now an available surgical option for select patients who are healthy enough to be candidates for this pathway. Partial and total knee replacement, shoulder replacement, and hip replacement can be done on patients that are medically low risk have the appropriate home setting and support to discharge home the same day. With the advances in less invasive techniques, better blood loss management, and multimodal pain control including nerve blocks, outpatient joint replacement is being performed more frequently with significant increases in patient satisfaction scores and equivalent or better outcomes compared to inpatient joint replacement.

The disadvantages of outpatient joint replacement include the chance of having a complication at home, inadequate pain control, and an increased risk of a hospital readmission. To reduce these risks, a multidisciplinary team approach is necessary. Postoperative expectations and preoperative education are important steps in reducing complications. A health care team provider must check daily on the patient postoperatively, be available to answer questions, and troubleshoot any issues that may arise. Often, a daily phone call or visit from an outpatient therapist for a few days post operatively reduces the likelihood of an expensive emergency room visit and/or subsequent hospital testing. Availability for work in office visits results in avoidance of costly and often unnecessary testing, and patient comfort and satisfaction. Urgent issues may be addressed in the office setting the majority of the time.

The advantages of outpatient joint replacement surgery include a reduced hospital stay with decreased exposure to the inpatient hospital environment with a possible reduced chance of infection. A reduced cost to the health care system is also an advantage, along with increased patient satisfaction. With outpatient joint replacement, patients say they like being in their own bed, not being disturbed through the evening; and they tend to rest better. The ability to control pain medication and get pain medication in a timely fashion is also a common theme that patients like about being at home. No more waiting for nurses to bring medications, waiting for doctors to do rounds, endless blood draws, or all night interruptions. Early mobility in the comfort of the home along with familiar sleeping arrangements and food are also very high on patients' satisfaction list.

A newer way of thinking about joint replacement is here, and has many potential benefits, with downsides that can be minimized with the right team of healthcare providers. Financial considerations and cost savings were the early driving force of this movement, and as our experience grows in this field, it is becoming a viable option that satisfies patients. With better medications, better implants and instruments, an increased understanding of blood management, and improved anesthetic technique, outpatient total joint replacement has become a viable option in select patients.



Christopher Cullen Scott, M.D. earned his medical degree from Mercer University in Macon. He completed his internship and residency in Orthopaedic Surgery at Atlanta Medical Center Department of Orthopaedic Surgery. He comes to Gainesville

from Vidalia Georgia where he focused on general orthopaedics including trauma, fractures, occupational injuries, joint replacement, hand surgery, pediatrics, and sports medicine. Dr. Scott is board certified by the American Academy of Orthopaedic Surgeons.

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New CDC Guidelines for Opioids and Implications within Workers' Compensation

Paul Mefferd, D.O., Medical Director Atlanta Surgery Center, The Physicians' Spine and Rehabilitation Specialists of GA

In March 2016, the CDC released "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016." These guidelines were intended to give proper guidance to primary care physicians in order to more appropriately and safely prescribe opioids for non-cancer or end-of-life pain. The guidelines were issued in response to the opioid epidemic sweeping this country and the shocking levels of addiction and overdose deaths.

The United States contains less than 5% of the world's population, yet uses 80% of the global supply of opioid drugs. The reasons for this are varied, but primarily stemmed from a World Health Organization (WHO) statement in 1996 that primary care physicians were not addressing pain sufficiently. Although WHO was specifically referring to cancer pain treatment, the medical community suddenly faced scrutiny for not treating pain adequately. This led to a significant increase of prescribed opioids across the country. Methadone prescriptions alone increased by 1,000% between 2002 and 2007. In addition to the WHO statement, the emergence of "Pill-Mills," initially in Florida—and later in other states—created an environment for rampant opioid prescriptions which dramatically elevated levels of addiction and overdose. This trend also paved the way for a frightening influx of very cheap and easily accessible heroin from across our southern border. Heroin is now in our local communities and it is catastrophic.

The new CDC Guidelines are based on a meta-analysis of numerous independent studies, case reviews, and epidemiologic data. To briefly summarize, the CDC found that the evidence supporting long-term use of chronic opioids for non-cancer pain was "inconclusive." More importantly, the CDC Guidelines found that people who exceed a specific opioid dose per day were found to have significantly increased risk of overdose and even death. The CDC also learned that those taking more than the equivalent of 100 mg of morphine per day had 3-9 times greater risk of overdose than those under 100 mg morphine equivalent doses. This new dosage guideline is much lower than the previous recommendation of 450 mili-equivalents per day. Anyone receiving over the 100 mg morphine equivalent dose is at risk, regardless of the origin of the prescription.

The opioid epidemic is as prevalent in workers' compensation as it is in the country as a whole. Seventy percent (70%) of Georgia workers with pain from non-surgical injuries receive a prescription for an opioid with the average amount equivalent to 1200 mg of morphine per claim. Evidence provided by the CDC reports a significant increase in adverse events once the morphine equivalent dose exceeds 100 mg per day.

Our practice believes we, as physicians, can help mitigate the opioid epidemic by being conservative in the early use of opioids, as well as following the CDC guidelines when treating injured workers. If a provider is ignoring the CDC guidelines, we would strongly encourage you to request a change of provider or Independent Medical Evaluation.

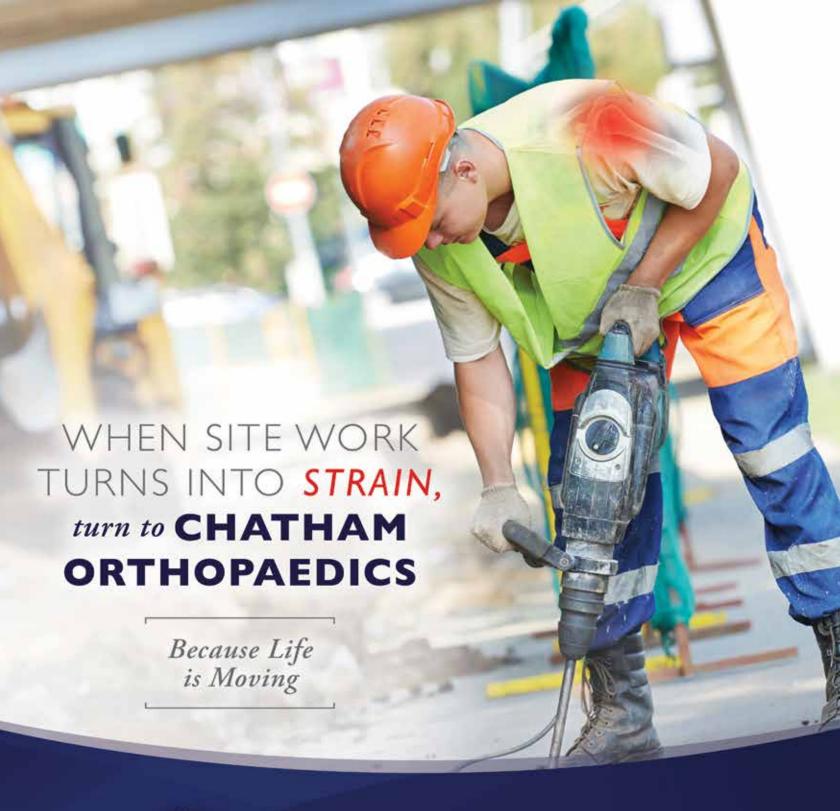


Paul Mefferd, D.O., is a partner with The Physicians' Spine and Rehabilitation Specialists and practices in the Marietta and Calhoun locations. He received his undergraduate degree in Biology from the University of South Carolina and his medical degree from the University of Health Sciences, College of Osteopathic Medicine in Kansas City, Missouri.

Dr. Mefferd completed his internship at Florida Hospital East in Orlando and went on to complete his residency training at Émory University Hospital, in Physical Medicine and Rehabilitation. He then completed fellowship training at Emory in the Anesthesiology Pain Medicine Fellowship program.

Dr. Mefferd received board certification in both Pain Medicine and Physical Medicine and Rehabilitation from the American Board of Physical Medicine and Rehabilitation.

He is a member of the American Academy of Physical Medicine and Rehabilitation, International Spine Injection Society, North American Spine Society, American Osteopathic Association and numerous other national and regional associations.





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Cervical Spine - Update on Motion Preservation

Raphael Rey Roybal, M.D.

Anterior Cervical Discectomy and Fusion (ACDF) has been a gold-standard treatment for Cervical Spine Pathology including spinal stenosis and herniated cervical discs with corresponding radiating arm pain (radiculopathy). Since at least the 1950s, ACDF has been an efficient, reproducible, and safe treatment for pinched nerves, spinal cord compression, and even cervical myelopathy, characterized by severe neurologic deficit.

The anterior approach to the spine is also characterized by a muscle sparing, gentle blunt dissection which was minimally invasive before its time. Accordingly, patients throughout the years have enjoyed quick recoveries and a return to full activity and function. However, the procedure involves removing completely the pathologic disc thereby requiring the replacement of that disc which has been traditionally a fusion device rendering that segment of the spine immobile.

Interestingly, the cervical spine often accommodates one through three levels of fusion in the cervical spine without loss of total cervical spine motion. Additionally, no clear cut evidence exists for the occurrence of increased degeneration adjacent to fused segments. However, there remains a theoretical and philosophical appeal for preserving motion when possible in the cervical spine.

Within the last few decades, Total Disc Arthroplasty (TDA) or artificial discs have become an increasingly popular and researched alternative to cervical fusion after decompression of the cervical spine via an anterior approach. Numerous FDA studies have been conducted that demonstrate an equivalent efficacy of TDA compared to ACDF, which are both very good. There have been additional studies that show a clear improvement of TDA vs. ACDF in terms of a quicker return to work and function. However, the majority of these studies have been limited to single disc disease as all available disc replacements have been limited by the FDA to single levels.

In the last few years, a pivotal prospective randomized study has been completed comparing 2 level ACDF to 2 level TDA in the cervical spine. It is important to know that both groups did very well, meeting extraordinarily strict criteria defining surgical and clinical success. However, the TDA group significantly out-performed the fusion group in terms of less need for additional surgery after the index procedure as well as overall neck pain and disability. Although the single level ACDF and single level TDA in this same study had equivalent excellent results, the addition of the second level demonstrated this significant difference.

Why is that? Historically, single level cervical fusions fuse with almost 100% certainty. When attempting to fuse 2 levels, the fusion rate begins to drop. Therefore, symptomatic patients with a failed fusion (termed a pseudarthrosis) often require a second revision surgery to achieve successful arthrodesis (fusion). With a Total Disc Arthroplasty, the surgical goal is to preserve motion and fusion is definitely not required or even desired for surgical technical success.

One has to hypothesize why the two study groups (2 level ACDF vs. 2 level TDA) exhibited such a difference in overall neck disability and pain measured by the NDI (neck disability index). Hypothetically, preserving motion may spare the other non-operative segments from extra or excessive forces needed to compensate for a fused segment in the cervical spine. Because 1 level ACDF and TDR produce equivalent and excellent NDIs, the extra level fused in 2 level ACDF may cause the clinical difference explaining the better NDI in 2 level TDR.

However, it is important to remember that both 2 level surgeries reliably and excellently relieve radicular arm pain, improve quality of life, and earn high marks for patient satisfaction. When two levels are pathologic in the cervical

spine, 2 level TDR may provide an even more excellent outcome with less residual neck pain and less risk of a need for revision surgery at the index level of surgery. However, consistent with recent comprehensive literature review and research, this study once again confirmed that even fusion of the cervical spine does not increase the risk of adjacent level degeneration or pathology. This would indicate that for single level pathology, ACDF or TDR is an equivalent excellent option. On the other hand, if the patient meets strict indications for disc replacement, 2 level TDR seems to be a superior option for 2 level pathology.

Raphael R. Roybal, M.D. The Spine Institute at Chatham Orthopaedic Associates













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Understanding Knee Injuries

Dr. Ballantyne, M.D.

The knee is the largest joint in the human body. It is a complex joint that has bones, ligaments, and menisci which provide both rotational and longitudinal stability. All of us are aware of athletes injuring their knees in sports activities, but each year, there are over 500,000 work-related knee injuries in the United States.

Though knee injuries only comprise 5% of work-related muscular skeletal injuries, they are the second most injured body part that resulted in one or more days away from work. Only back injuries led to more missed work time. Acute injuries most commonly are caused by blunt trauma secondary to a fall. Excessive tension or twisting applied to the joint can also lead to injury. Collateral ligament or cruciate ligament sprain, meniscal damage, patellar dislocation, or subluxation and fractures can all occur due to these injuries. Overuse injuries such as iliotibial band syndrome, bursitis, patellar tendinopathy, and cartilage wear can be caused by accumulative micro trauma from repetitive knee flexion and extension. Comorbidities, such as obesity, preexisting arthritis, and previous knee surgery can greatly affect the course of treatment and recovery of the patients.

The highest incidence of injuries in male workers occurs in those 18-40, decreasing as the male worker ages. The opposite is true of female workers with incidents of injuries increasing in workers 50 and older.

Across industries, few preventative knee injury strategies have been evaluated. However, new designs and working methods for floor layouts were found effective in reducing knee strains. Knee pad designs that redistribute pressure are beneficial for kneeling workers. Preferred selection of foot wear in assembly plant work reduces lower extremity fatigue. Comprehensive occupational fall preventative programs have been effective in reducing trips, slips, and fall claims that account for the highest percentage of knee injuries.

When an occupational knee injury does occur, the cornerstone of proper treatment is a timely, thorough physical exam by a qualified medical professional. The vast majority of injuries can be treated properly with modalities such as bracing, non-steroidal anti-inflammatories, and activity modification. Diagnostic tools such as x-ray and MRI are utilized when the physician is concerned about significant injuries.

If surgery is required to treat the injury, the arthroscopic tools and techniques available to the orthopedic surgeon have advanced greatly in the past decade. These techniques, coupled with a coordinated post-operative physical therapy program, are providing us the ability to return personnel sooner to work. In my experience, the biggest obstacle returning employees quickly are preexisting conditions such as large body mass index, arthritis, or previous knee surgeries. The ability of the physician and workplace to coordinate modified work skills also is beneficial to returning employees back to their job.

In summary, knee injuries are responsible for a significant amount of time out of work in American industry. A comprehensive program involving proactive measures, timely medical intervention, and a coordinated program with the physician and therapist can reduce the time the employee is out of work.



Dr. George Ballantyne, M.D. received his medical training and completed his general surgery internship and orthopaedic residency at The University of Texas Medical Branch in Galveston, Texas. Dr. Ballantyne has a special interest in joint surgery and performed six months of extensive study at Emory University. He is on staff at Piedmont

Newnan Hospital, Piedmont Fayette Hospital, Cancer Treatment Centers of America in Newnan, Summit Out Patient Surgery Center, and has served as both chief of staff and chief of surgery at Newnan Hospital.



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Health Trends in the Workplace

Todd S. Handelman, Esq.

We would all like to know what the future holds for workplace medical claims. In the past, the only question was whether a claim was covered under the Workers' Compensation Act. The most significant trend in recent legislation, however, and which should be most concerning for employers and insurers, is the movement in Georgia to broaden compensation for certain workers and illnesses that are not compensable under the Workers' Compensation Act. Last year, House Bill 216 would have created a presumption for firefighters that certain ordinary diseases of life, such as hypertension, heart disease, respiratory disease, and cancer, would be work-related and compensable under the Georgia Workers' Compensation Act. These provisions would have circumvented the occupational disease provision of the Act, O.C.G.A. § 34-9-280, that requires an employee meet a five-prong test, one of which is that a disease is not an ordinary disease of life to which the general public is exposed. HB 216 was defeated by the slimmest of margins.

This year, House Bill 146 passed the State House and Senate. This bill would mandate that fire departments provide insurance coverage for each member of the department to pay for claims for specific forms of cancer. Another proposal, House Bill 152, would cover claims through the Workers' Compensation system for cancer that is contracted by firefighters. Although HB 146 seems preferable at first blush, it still requires public entities to carry coverage for specified forms of cancer.

This trend of covering certain illnesses for certain occupations is troubling. In essence, it requires employers to pay claims as though they are work-related, but it lowers the proof and causation requirements of the workers' compensation system. House Bill 146 is simply taking certain diseases for certain employees out of the health insurance system and making it an add-on cost for employers, providing lump sum benefits of between \$6,250 and \$25,000, and if the firefighter cannot work, a monthly benefit of up to \$5,000. It would seem, therefore, that the trend is to require employers to cover more claims for favored employees that do not meet the causal relationship required by workers' compensation claims. In addition, once these types of statutes pass, the General Assembly can always decide to have these conditions covered under workers' compensation with an easier standard of review.

Perhaps more troubling than this would be for the General Assembly to expand the types of occupations or the type of illnesses that would be included for these special benefits that do not require the same type of proof requirements that workers' compensation provides for. If firemen are covered, why shouldn't policemen be covered, or linemen for that matter? If cancer is covered, why shouldn't hypertension or heart attacks be covered? This trend erodes the causation requirements of the workers' compensation system, and represents an unfair cost to public entities in Georgia. It could also lead to additional costs to private employers in the future.



Todd represents many public and private employers. He is well known for his statewide workers' compensation practice, which is successful in part due to his vigorous defense strategies and extensive experience. Todd has successfully defended many employers in significant cases, including the City of Albany before the Georgia Supreme Court in the landmark case of Abernathy v. City of Albany, 269 Ga. 88 (1998), which protects employers and their insurers from liability for a purely psychological work injury. He is at the forefront of legal developments in workers' compensation. Todd and his wife Bonita, share a passion for traveling and spending time with family.

Todd was born in Chicago, Illinois. He is a magna cum laude graduate of the University of Illinois where he was a member of Phi Beta Kappa. Todd earned his Juris Doctorate degree from the University of Georgia. Admitted to the Georgia Bar, Todd is also admitted to the U. S. District Court for the Middle District of Georgia, the Georgia Court of Appeals and the Georgia Supreme Court. He is a member of the State Bar of Georgia and the Dougherty Circuit Bar Association and is also active in the Georgia Self Insurers Association and the Atlanta Claims Association.

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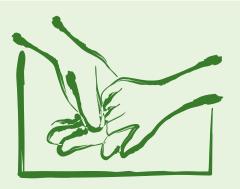
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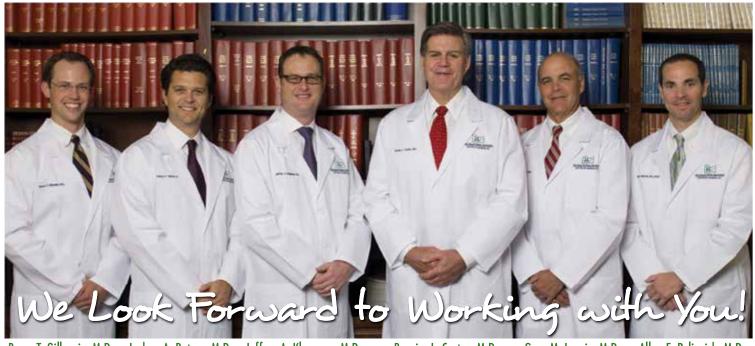
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Cervical Disc Disease and Arm Pain

Wayne Kelley, M.D.

Neck and shoulder pain are a common sign of degenerative changes in the cervical spine. The cervical spine consists of seven bones (CI-C7) and is separated from one another by intervertebral disc. These discs allow the spine to move freely and act as shock absorbers during activities. At each level in the cervical spine, a pair of spinal nerves exit through small holes called foramina (one on the left and right side). These spinal nerves provide function to the body and muscles, skin, and tissues in the arms.

If you experience pain in your neck or shoulder, or tingling, numbness, or weakness, you may have an injury to the spinal nerves in your neck. The most common reason for this would be a "pinched nerve" or herniated nucleus propulos (HNP). This is when the intervertebral disc pushes on the spinal nerve. It can also be caused by degenerative changes like osteoarthritis in the neck that causes narrowing around the spinal nerves. The common presentation for this is weakness, numbness, or tingling in the arms, neck or shoulder pain, balance issues, clumsiness, and falls.

The natural history of an HNP in your neck is improvement by six weeks. Those patients that are not improving by six weeks may need to be seen by an orthopaedic spine surgeon to determine the cause of the pain or weakness and diagnose treatments. Most people will see improvement with conservative care consisting of antiinflammatories, modification of activities, muscle relaxants, physical therapy, limited use of cervical collar, cervical traction, and steroids.

During the work up by your physician, you may require certain tests to identify the cause of your pain or to see which spinal nerves are involved. This work up also helps to rule out other causes of the pain, since many different ailments can cause similar symptoms. Some of these tests include, x-rays, MRI, CT scan, and nerve studies. After undergoing conservative care for six weeks, if the pain is still disabling or the patient is continuing to have weakness or balance issues, they may require surgery to relieve pressure off the spinal nerves; a procedure called decompression. There are many different ways to decompress the nerves in your neck, but the most common is called anterior cervical decompression and fusion (ACDF). This means the surgeon makes an incision in the front part of the neck to get down to the HNP. The herniated disc is removed and a bone graft replaces the disc material. A small plate with screws is also used to hold the graft in place and allow the bones to fuse together (meaning becoming one solid bone) to prevent recurrence at that level.

Another option is called a cervical disc replacement, which means instead of fusing the bones together, they replace the disc with an implant that allows you to keep your motion. Most of these surgeries can be done as an outpatient, which means you would be able to go home the same day of your surgery. The results are greater than 90% of relieving pain. If you are having these symptoms, you may need to be evaluated by an orthopaedic spine surgeon.



Wayne Kelley Jr., M.D., is a Georgia native raised in Newnan, Georgia. He completed degrees in Biochemistry and Chemistry at the College of Charleston in Charleston, South Carolina graduating Cum Laude. He received a Doctor of Medicine from the Medical University of South Carolina where he served as Class President all four years. Dr. Kelley received the prestigious award of Junior AOA and served as President of the AOA as a senior. Dr. Kelley also received the President's Basic Science Award and the Gross Anatomy Achievement Award. Dr. Kelley then matriculated to Duke University to complete an orthopaedic residency at Duke University Medical Center where he was awarded the Annual Excellent Orthopaedic Research Award. Following residency,

Dr. Kelley spent a year completing a Spine Fellowship appointment at OrthoCarolina in Charlotte, NC. Dr. Kelley's professional memberships include the American Academy of Orthopaedic Surgeons and the North American Spine Society. Dr. Kelley specializes in conditions of the spine and is board certified by the American Academy of Orthopaedic Surgery. He has authored many national journal articles and book chapters and has presented on a national level. Dr. Kelley is a Veteran having served in the US Navy for eight years. Dr. Kelley is married with four children and enjoys spending time with his family, running, hunting, fishing, and team sports.



What is a Physiatrist?



Physiatrist

I am known by my orthopedic colleagues as the "WCD" (Workers' Comp Doc), but I'm actually a Physiatrist. A Physiatrist is a specialist in Physical Medicine & Rehabilitation (PM&R). There are many misconceptions about Physiatry, so we are continually educating our peers, as well as the public, in what we do. Many of our Workers' Compensation patients initially think of us as "company doctors" who work in the interest of a company and not the patient. In my opinion, Physiatrists work for our patients, with the goals of restoring function and returning them to their preinjury status, allowing them to continue to be productive workers.

Physiatrists routinely perform inpatient and outpatient musculoskeletal and neuromuscular diagnoses and treatments that emphasize function and rehabilitation. We treat musculoskeletal disorders of the spine, peripheral joints, and soft tissues such as sprains/strains, disc herniations and athletic injuries. PM&R specialists also diagnose and treat degenerative, developmental, acquired and traumatic neuromuscular conditions of the upper and lower limbs, spinal cord, and brain. It is this unique blend of orthopedic, neuromuscular, pain and rehabilitation training

and experience that makes the PM&R specialist an ideal primary or secondary care physician for patients with occupational or sports related musculoskeletal or neuromuscular injuries. This multidisciplinary training also qualities the Physiatrist to lead the team of medical specialists and rehabilitation therapists who are involved in the patient's care.

Physiatrists are specially trained to prescribe therapeutic exercise and other rehabilitation modalities and are experts in the performance and interpretation of electrodiagnostic studies including EMG/NCV (electromyography and nerve conduction studies). We routinely use laboratory and radiographic studies, but are also trained in more sophisticated diagnostic studies that evaluate a patient's musculoskeletal and neuromuscular systems such as CT, myelography, bone scan, MRI and more recently musculoskeletal ultrasound (both diagnostic and therapeutic injections). With specific training, many PM&R specialists routinely perform fluoroscopically directed spinal and large joint procedures such as interlaminar and transforaminal epidural injections, facet injections, Sacro-iliac (SI) injections and other advanced interventional pain management techniques.

In summary, Physiatry allows its clinicians to pursue many different roads including numerous subspecialties. Many PM&R doctors are integrally involved in university and private practice based orthopedic/spine centers, pain clinics and care of athletes from all levels of participation.

Physiatrists can assist with non-surgical solutions for many spine and occupational injuries and should be considered for first line/triage unless an obvious surgical condition exists. With this in mind, perhaps now Physiatrists will be recognized as more than just the "WCD."



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