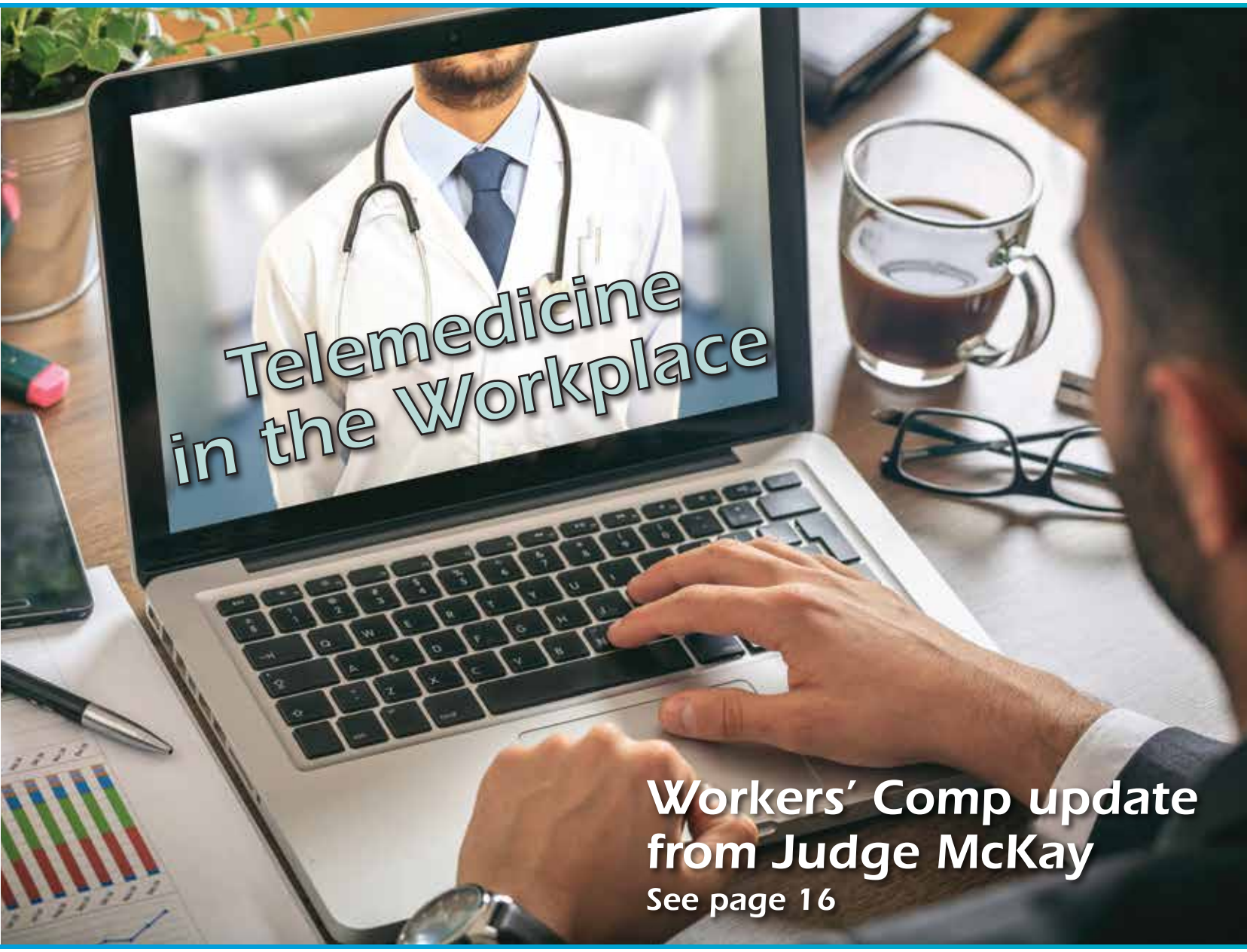
Spring 2018 Edition

WH Workplace Health



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Alliance Spine
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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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Injecting Relief in the Current Opioid Epidemic

Myrlynn Delille, M.D.

In 2016, per the Bureau of Labor and Statistics, private industry employers reported approximately 2.9 million nonfatal workplace injuries. Often, opioids are prescribed.

Opioid abuses are burdening the workers' compensation system. According to the Center for Disease Control (CDC), "forty-two percent (42%) of workers with back injuries got an opioid prescription in the first year after injury… one year after the injury, sixteen percent (16%) of those workers were still getting opioids." According to the American College of Occupational and Environmental Medicine, "acute or chronic opioid use is not recommended for workers who perform safety-sensitive jobs, such as operation of motor vehicles, forklift driving, overhead crane operation, heavy equipment operation, work with sharps, and tasks involving high levels of cognitive function."

In 2017, the U.S. Department of Health and Human Services (HHS) declared the opioid epidemic to be a public health emergency. Managing this epidemic requires forestalling dependence at the outset. This necessitates engaging in the pain management revolution set before us. The "National Pain Strategy," put forth by the HHS, advises clinicians to "take active measures to prevent the progression of acute to chronic pain and its associated disabilities. Treatment should involve high-quality, state-of-the-art, multimodal, evidence-based practices."

However, simply restricting opioids is not the solution in compassionately caring for injured workers. Therapeutic interventions are effective for alleviating acute pain, seen in posttraumatic workplace injuries. This can be said to reduce progression to or exacerbation of chronic pain by providing direct and localized relief and allowing for adequate participation in rehabilitation.

Opioids, with known risks of misuse, abuse, and addiction, also come with the adverse effects of sedation, dizziness, and impaired mental faculties. This can place workers at risk of further injury on the job, leading to more time off work, more claims, and higher economic costs. Interventions decrease utilization of opioids and, in some cases, avoid or delay surgical intervention.

For spine pain, comparatively, the risks of therapeutic injections (i.e. epidural injections, facet injections) are fairly low (less than one percent (1%) with infection, bleeding, or nerve injury), especially when combined with fluoroscopic or ultrasound image guidance.

Selective diagnostic blocks (i.e. medial branch blocks of inflamed spine joints called facets) can help determine which spine levels are the primary pain generators, for better predictive and targeted value of subsequent therapeutic procedures to provide the necessary clinical information for more successful, longer-term relief and restoration of function. There are numerous other minimally-invasive procedures in the arsenal of interventional pain management that can be utilized for comprehensive treatment plans.

In the best interest of the injured worker, the employer, and overarching society, prioritizing interventions can expeditiously progress patients to maximum medical improvement, increase return to work rates, and effectively reduce the need for long-term opioid use, helping to mitigate this epidemic.

Alliance Spine
AND PAIN CENTERS

Dr. Delille received her medical degree from Albany Medical College in Albany, New York. She is double board certified in Pain Medicine from the American Board of Physical Medicine and Rehabilitation and Interventional Pain Management from the American Council for Graduate Medical Education. She specializes in neuropathy, compression fractures, pelvic pain, non-surgical orthopaedic and spine management.

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Don't Let a Spinal Injury Be a Pain in the Neck

Jason W. Vélez, D.O.

Headache, neck, and shoulder pain are common symptoms following minor strains or motor vehicle accidents. Most neck pain is secondary to minor muscle injury and resolves in six to eight weeks. For some, the pain lasts longer, which may indicate other spinal structure injuries.

The facet joints, the most frequently injured structures in the neck, are responsible for causing prolonged symptoms. The ongoing pain may be a combination of unavoidable continuous head movement throughout the day along with poor body mechanics that don't give the structures adequate time to heal.

Basic Anatomy

In the neck, there seven main bones stacked on top of the other which hold your head up over your body. This section is known as the cervical spine or "c-spine." In the front half of the spine, the bones are set on cushions—intervertebral discs—so they do not rub each other. In the rear half of the spine, the bones are connected through a pair of facet joints which allows head movement in all directions. They are like other body joints which have a capsule around them keeping a small amount of lubrication or fluid within the joint.

Symptoms

A day or two after an injury, the neck may become stiff and one may experience an intense, deep, aching pain that may become worse—or sharp—when turning the head side to side. Other symptoms may include: shoulder and/or upper arm pain, daily headaches, pain behind the eye, and blurry vision. These symptoms have been associated with post-accident c-spine injury.

Evaluation

Your doctor will examine your neck by touching, turning, and pressing which may cause discomfort or pain. However, it is important in determining the source of your pain and the severity of your injury. Communication with your physician will help them identify your best initial treatment plan. Based on your history and physical exam, you may or may not have X-rays taken on your initial visit. X-rays and MRI studies are usually normal or they may show minimal changes that would not fully explain the severity of your pain.

Conservative Treatment Options

Whether the pain comes from the cervical spine musculature, facet joints, or disc, the most essential step is to begin working with a qualified physical therapist to correct any abnormal posture or body mechanics. Therapy is crucial for successful long-term treatment of this condition. A well-structured physical therapy program can strengthen muscles and improve posture to help support the weight of the head and have it better positioned over the spine to reduce stress on the inflamed structures. Since both are key components to successful treatment, soft cervical collars worn for more than a few days are not usually recommended for this type of injury. A collar allows neck muscles to rest too much, making them weaker, rather than stronger, and can also prolong recovery time.

Nonsteroidal anti-inflammatory medications (NSAIDs), such as Ibuprofen or Naproxen, are best to help control pain after a neck injury which is usually caused by an inflammatory response in and around the facet joint or disc. If you have stomach ulcers or active gastritis, inform your doctor so they can choose the best medication for you. Long-term daily use of most NSAIDs is generally not recommended. If you require Naproxen or Ibuprofen more than once or twice a day for more than a month, tell your doctor so they may consider other treatment options.

Options for Persistent Pain

For pain lasting longer than six or eight weeks which prevents participation in physical therapy or interferes with family life or work, a more aggressive diagnostic and therapeutic plan may be necessary. This could involve a variety of spinal injections or surgery. Options would be carefully considered by both patient and physician to do what's best for the patient's life and social situation. Again, talk with your doctor throughout treatment and report if the pain affects your sleeping habits, job performance, or your personal relationships which will make it necessary to change your treatment plan and more aggressively treat your condition.

Jason W. Vélez, D.O.

Dr. Velez specializes in Complex Reconstructive Spine Surgery, Minimally Invasive Spine Surgery, Cervical Spine Surgery, Kyphoplasty, and Artificial Disc Replacement.

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Impairment Ratings in Georgia Workers' Compensation

C. Todd Ross, Ross, Burriss & Handelman, LLC

Why is an impairment rating needed?

An injured worker is entitled to **permanent** partial disability benefits if he/she has a disability that is partial in character, but permanent in quality, resulting from the loss, loss of use, or partial loss of use of the body. However, an impairment rating is needed to calculate the benefits due.

The American Medical Association's (AMA) *Guides to Evaluation of Permanent Impairment, Fifth Edition* must be used by the physician to determine the amount of permanent loss to a body part. (O.C.G.A § 34-9-263).

Should every injured worker receive an impairment rating?

No. A rating should be performed only if there is an impairment related to the work injury (O.C.G.A § 34-9-263).

When should an employee get evaluated for a permanent impairment rating?

A rating typically follows a finding of Maximum Medical Improvement. If the authorized treating physician believes there is some permanent impairment, the physician assigns the rating. In many instances, the physician first refers the worker for a Functional Capacity Evaluation (FCE), then agrees or disagrees with the FCE and assigns a rating.

When the employee is no longer receiving temporary total or temporary partial benefits, and a rating has not already been issued, the employer has thirty (30) days to request from the authorized treating physician that the employee is rated.

When can an employee receive permanent partial disability benefits?

Once an injured worker stops receiving temporary total or temporary partial income benefits, he/she can receive permanent partial disability benefits, if entitled to same.

What impairments should get rated?

Previously rated impairments or prior, unrelated conditions should not be included in a new rating.

A work injury can include aggravation of a pre-existing condition, but only for so long as the aggravation continues to cause disability. Once the aggravation subsides, the work injury is no longer compensable, and an impairment rating is not appropriate. [O.C.G.A § 34-9-1(4)].

Please see the *Guides to Evaluation of Permanent Impairment, Fifth Edition*, for additional information regarding when, how, and why to evaluate a person's permanent impairment. As you will see in the *Guides*, not all injured workers are eligible for a rating, as some qualify for a rating of zero percent (0%). There are examples in each chapter of the *Guides* to help distinguish between the value of the ratings.

For instance, according to the *Guides*, if the impairment is resolving, changing, unstable, or expected to change significantly with or without medical treatment within twelve (12) months, it is not considered a permanent (stable) impairment and should not be rated under the Guides criteria.

C. Todd Ross serves on the Legal Committee for the Georgia State Board of Workers' Compensation's Steering Committee. He has presented on workers' compensation topics to numerous claims associations, TPA's, employers, insurers, self-insureds, and at State Bar of Georgia seminars. He is also active with the Georgia Association of Manufacturers. Ross, Burriss & Handelman provides workers' compensation legal defense throughout Georgia for insurers, TPA's and employers. The firm strives to provide the best legal advice and court room defense available.

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Pictured: Derek Moore, M.D., board-certified orthopedic surgeon

Proper DVT Screening and Treatment Can Prevent Dangerous Complications

Dev Mangalat, M.D.

Venous thromboembolism (VTE) is a common disease process that involves both deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT results when a blood clot occurs in the veins (the vessels that take the blood back to the heart). A pulmonary embolism is when some of the clot breaks off and migrates to the lung blood vessels. Almost fifty percent (50%) of all untreated deep vein thrombosis is complicated by pulmonary embolism, which can be fatal.

Risk factors

VTE has numerous risk factors, which include, but are not limited to, major surgery, hospitalization, immobilization, trauma, advancing age, smoking, obesity, neurological deficit, malignancy, family history of VTE, and inherited blood clotting disorder.

Symptoms/Signs

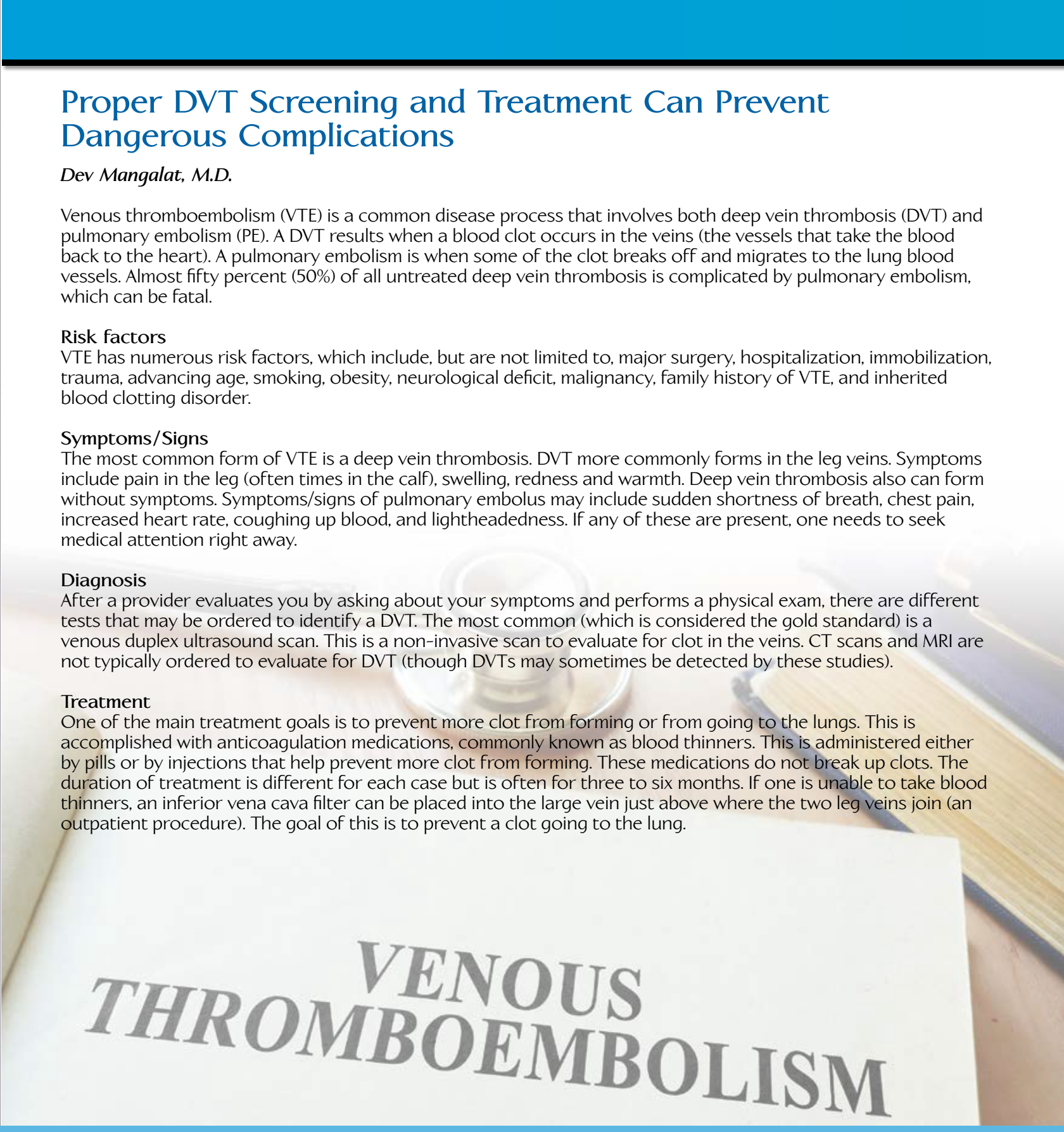
The most common form of VTE is a deep vein thrombosis. DVT more commonly forms in the leg veins. Symptoms include pain in the leg (often times in the calf), swelling, redness and warmth. Deep vein thrombosis also can form without symptoms. Symptoms/signs of pulmonary embolus may include sudden shortness of breath, chest pain, increased heart rate, coughing up blood, and lightheadedness. If any of these are present, one needs to seek medical attention right away.

Diagnosis

After a provider evaluates you by asking about your symptoms and performs a physical exam, there are different tests that may be ordered to identify a DVT. The most common (which is considered the gold standard) is a venous duplex ultrasound scan. This is a non-invasive scan to evaluate for clot in the veins. CT scans and MRI are not typically ordered to evaluate for DVT (though DVTs may sometimes be detected by these studies).

Treatment

One of the main treatment goals is to prevent more clot from forming or from going to the lungs. This is accomplished with anticoagulation medications, commonly known as blood thinners. This is administered either by pills or by injections that help prevent more clot from forming. These medications do not break up clots. The duration of treatment is different for each case but is often for three to six months. If one is unable to take blood thinners, an inferior vena cava filter can be placed into the large vein just above where the two leg veins join (an outpatient procedure). The goal of this is to prevent a clot going to the lung.



Dev Mangalat, M.D., is a board-certified, fellowship-trained vascular surgeon at Longstreet Clinic. A multi-specialty practice with nine locations across North Georgia, Longstreet Clinic's 200 providers deliver personalized and comprehensive care to patients of all ages at all stages of life. Workers' Compensation services span specialties including vascular surgery, general surgery (hernias), orthopedics, neurosurgery, physical medicine & rehabilitation, neurology and more.

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Continued Challenges of Carpal Tunnel Syndrome

Tedman L. Vance, M.D.

What do a violinist, butcher, and dental hygienist have in common? They all work in occupations predisposed to causing carpal tunnel syndrome.

Prolonged and repetitive hand motions, strong gripping, and vibration have all been associated with an increased risk of carpal tunnel syndrome and can cause significant functional limitation that can affect both work productivity as well as recreational activities.

According to The National Institute of Neurological Disorders and Stroke, carpal tunnel syndrome is the result of a combination of factors which increase pressure on the median nerve as it passes through the carpal tunnel passageway in the wrist. When the tunnel becomes narrowed or when swelling occurs around the tissues surrounding tendons, it can result in severe pain for the patient.

Symptoms of carpal tunnel syndrome include:

- Numbness, tingling, burning, and pain in the thumb and fingers
- Pain or tingling feeling traveling up the forearm
- Hand weakness and clumsiness making it difficult to perform basic, everyday movements (buttoning clothes, writing, typing, etc.)

There are many reasons to see a doctor sooner rather than later if signs of carpal tunnel syndrome occur. Primarily, symptoms tend to start gradually and increase in severity over time. If caught early enough, there is a greater chance simple treatments like wearing a splint, stretching the affected area, or avoiding certain activities will slow or stop the progression. An early diagnosis can also reduce the risk of permanent nerve damage.

To confirm carpal tunnel syndrome, doctors perform an examination of the hand and wrist by tapping along the median nerve to see if it causes numbness, sensitivity, or tingling in the patient's fingers. Atrophy in the hand muscles will also be tested. The doctor asks pertinent questions about everyday tasks performed at work and a home to assess the severity of the patient's condition.

The doctor can do electrophysiological tests to measure how well the median nerve works and whether there is too much pressure on the nerve. These tests can help rule out other conditions, such as neuropathy, and will assist in formulating a treatment plan.

Non-surgical treatments may include:

- Splinting
- Non-steroidal anti-inflammatory drugs, like ibuprofen
- Nerve gliding exercises
- Steroid injections

If non-surgical treatments fail to provide relief, carpal tunnel release surgery increases the size of the tunnel and relieves pressure on the median nerve. The surgery is performed under general or local anesthesia on an out-patient basis. Recovering varies per patient, but can be as soon as two months and as long as twelve. With respect to alleviation of symptoms, an up to ninety percent (90%) success is reported. The success rate, however, depends on many factors, including participation in hand therapy after surgery to achieve optimal functioning; a willingness to do therapeutic exercises independently to improve nerve healing, increase range of motion, and reduce scar tissue, and, finally, as with any surgery, patience and endurance will ensure the time to heal properly.

Tedman L. Vance, M.D., is a board certified orthopaedic surgeon, fellowship-trained in orthopaedic hand and upper extremity surgery and certified by the American Board of Orthopaedic Surgery. He earned his doctorate of medicine from Louisiana State University and completed his residency at the University of New Mexico. He served in the United States Navy and Navy Reserves. Dr. Vance joined Perimeter Orthopaedics in 2009 and has performed more than 1,000 carpal tunnel release surgeries.

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Telemedicine in the Workplace

Mark K. Soliman, M.D., FACS, FASCRS

Nearly 90,000 hours of the average American's life are spent in the workplace, which affords ample opportunity for, not only health education and disease prevention, but also for on-site injury or illness.

As reported by the United States Bureau of Labor Statistics, there were approximately 2.9 million preventable non-fatal workplace injuries and illnesses reported by private industry employers in 2016, which occurred at a rate of 2.9 cases per one hundred full-time equivalent workers.

Although these numbers are durably at a steady decline from years past, cases resulting in lost days of work have not dropped. This is due in part to injuries or illnesses severe enough to legitimately require time off for recovery. More often, time off is commonly required even in the most minor of injuries to allow competent medical personnel the opportunity to examine and release workers back to their trade.

While the need for emergent access to medical personnel for major injuries will never disappear, immediate access to physicians for minor injuries continues to pose an obstacle for patients and business owners alike. The vast majority of injuries, whether minor or major, commonly result in a trip to a hospital emergency room.

Obviously, this level of care is appropriate for some patients, but certainly not all. In fact, seventy-one percent (71%) of all emergency department (ED) admissions are attributed to conditions that could have easily been managed in an outpatient setting. These unnecessary ED visits very rapidly contribute to lost time and increased health care cost.

In recent years, innovation in healthcare delivery methods has cultivated the practice of telemedicine. Telemedicine is the use of telecommunication and information technologies to provide clinical health care via phone or internet. It helps eliminate time and distance barriers as well as improving access to medical services that would often not be consistently available in rural communities or would otherwise be cost-prohibitive to have highly-specialized medical personnel on staff. By introducing telemedicine into the workplace, many of the aforementioned obstacles are overcome, challenges solved, and gaps in access are closed.

Telemedicine practices (such as kloudMD.com) offer patients and employers modern telecommunications technology to provide remote and interactive healthcare services by board certified and highly-specialized physicians. A worker may use his/her mobile device or desktop computer to facilitate the physician's interview and exam, where oftentimes definitive care is rendered without the need for emergency room visits or lost days of work. These services are performed using Health Insurance Portability and Accountability Act (HIPAA) compliant encrypted services and are available no matter the location, only limited by the availability and license of the providers.

As employers look for innovative ways to supply cost efficient, timely, and high-quality workplace health to their workforce, telemedicine is surely to be a modality that cannot be ignored.

Mark K. Soliman, M.D., FACS, FASCRS, is a managing partner with kloudMD.com. He is also the Chairman of Surgery, Florida Hospital Altamonte, an Assistant Professor of Surgery, University of Central Florida, Program Director, Minimally Invasive Colorectal Surgical Fellowship, Associate Program Director, Colon and Rectal Surgical Residency and Colon and Rectal Clinic of Orlando.

2018 Upcoming Educational Events
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APRIL
13 – SBWC – Alpharetta, GA
15-17 – Georgia Employers Association – Savannah, GA
20-22 – Georgia Society of Interventional Pain Physicians – Greensboro, GA
25-27 – Georgia PRIMA Educational Series – Savannah, GA
26 – SBWC – Warner Robins, GA

MAY
2 – SBWC – Augusta, GA
2-3 – Alabama Self Insured Seminar – Hoover, AL
4 – Society of Human Resource Management – Legal Summit – Savannah. GA
9 – SBWC – Savannah, GA
9-10 – Alabama Workers' Compensation Organization Spring Conference – Birmingham, AL

JUNE
5-8 – GWCA Summer Conference – Jekyll Island, GA
14 – Moore Ingram Johnson & Steele Adjuster Seminar – Atlanta, GA
20 – Alabama Self Insured Seminar – Birmingham, AL

JULY
19 – Workplace Health/SHRM Georgia Day Conference, Flowery Branch, GA
23-27 – 70th Annual SAWCA Conference, Middleburg, VA

AUGUST
6-8 – Alabama Self Insured Annual Conference – Miramar Beach, FL
19-22 – WCI Florida WC/Safety Annual Conference – Orlando, FL
27-29 – Georgia State Board of Workers' Compensation Annual Conference – Atlanta, GA

SEPTEMBER
5-7 – Georgia Safety and Society of Human Resource Management Annual Conference – Savannah, GA
6-8 – Georgia Association of Occupational Health Nurses Annual Conference – Savannah, GA

OCTOBER
26 – 4th Annual Boo Bash – Savannah, GA

NOVEMBER
7-9 – Georgia Association of School Business Officials (GASBO) Annual Conference – Augusta, GA

DECEMBER
4-7 – National Workers' Compensation Conference – Las Vegas, NV

Pain Management: Topical Pain Formulations

The management of acute and chronic pain commonly includes the prescribing of oral opioids, and/or nonsteroidal anti-inflammatory drugs (NSAIDs). Although potentially effective in providing significant pain relief, these oral medications are often discontinued due to the significant adverse effects (AEs), that include but are not limited to physical dependence, tolerance, nausea, constipation, vomiting, gastrointestinal distress, respiratory depression, and more. Opioid medications also carry the serious risk of abuse or addiction.

As the physiological processes that block the nociceptive and neuropathic pain are more thoroughly researched and better understood, new drug delivery routes have been developed that maximize the drug mechanisms while minimizing the adverse effects. Topical medication formulations are the result of such research.

According to the Journal of Pain Research, "evidence based on empirical practice has suggested that topically applied medications can be almost as effective as those taken orally, with a good safety profile in terms of adverse effects."[1] Given that pain is remarkably complex and multifaceted, the management of this disease state involves a multimodal approach.

Topical Agents for Acute and Chronic Pain

As a NMDA-Antagonist, **Topical Lidocaine** is a local anesthetic that relieves burning and pain associated with inflammation by blocking nerve conduction to decrease synaptic efficiency. Topical Lidocaine is recommended as a first-line treatment for the management of neuropathic pain.[2] Additional applications of usage include postherpetic neuralgia, as a complication of shingles, acute pain, plantar fasciitis, & diabetic neuropathy.

Originally developed as an anti-seizure drug, **Topical Gabapentin** is an analgesic used to treat neuropathic hyperexcitability at pain receptor sites. It may also block glutamate at NMDA receptors. For various types of neuropathic pain, topical Gabapentin is considered a first-line medication. Acute pain, carpal tunnel syndrome, plantar fasciitis, and postherpetic neuralgia are also indications for topical Gabapentin.

Topical Diclofenac is a nonsteroidal NSAID that decreases pain receptor sensitivity by blocking the production of prostaglandins. It is used to reduce inflammation and pain with its anti-inflammatory, antipyretic and analgesic properties. Research shows its benefits in the management of acute soft tissue injuries and chronic joint-related conditions.[3] It has been studied for pain relief in osteoarthritis for the knees and hands, and was found to be as effective as oral NSAIDS.[4] Foot pain, musculoskeletal pain, rheumatoid arthritis, fibromyalgia and tennis elbow are further applications.

As a GABA-agonist, **Topical Baclofen** is a muscle relaxer and antispastic agent that produces neuron inhibitory effects. It is highly effective in relaxing muscle tissues at the site of pain and appears to have peripheral analgesic properties. Baclofen has been studied as a single agent for chemotherapy-induced painful neuropathy[5] as well as for neuropathic pain, fibromyalgia and TMJ pain.

Associated Benefits

Topical pain formulations offer benefits over oral opioids and NSAID's that range from a lowered total systemic daily dose pain relief to be achieved, to site specific drug delivery, as well as an overall reduction in the side effect profile. Further advantages of topical pain formulations include:

- Reduction in gastrointestinal distress through site application
- Overall decrease in major drug interactions
- Decreased gastrointestinal, renal, and/or hepatic exposure
- Diminished usage of oral pain medications needed
- Non-addictive
- Negligible systemic absorption
- No constipation
- Avoidance of first pass effect

Adverse Effects

The most common adverse effect with a topical pain delivery is an application site reaction. A minor rash could develop if skin is exposed to the sun after application. In addition, if there is an allergy to one of the drugs used in the formulation, a minor rash may develop. As the systemic absorption of the topical formulation is negligible, the chance of systemic effects is significantly lower in comparison to a patient on the same prescription with an oral formula.

Additional Considerations

As with the majority of medications, patient compliance to the prescribed topical treatment remains a challenge. This is particularly true with patients who possess chronic painful conditions. By providing an alternative to an oral medication and reducing the associated adverse reactions, patients have an enhanced strategy for adherence.

1 Jorge LL, Feres, CC. ,Teles, VE. "Topical preparation for pain relief: efficacy and patient adherence." Journal of Pain Research. 2011; 4: 11-24.
2 Dworkin RH, O'Conner AB, Backonja M, et al. "Pharmacologic management of neuropathic pain: evidence-based recommendations." Pain. 2007;132: 237-51.
3 Argoff CE. "Topical analgesics in the management of acute and chronic pain" Mayo Clinic Proceedings. 2013; 88(2): 195-205.
4 Derry S, Moore RA, Rabbie R. "Topical NSAIDs for chronic musculoskeletal pain in adults" Cochrane Database of Systemic Reviews. 2012; 9.
5 Barton DL, Wos EJ, Qin R, et al. "A double-blind, placebo-controlled trial of a topical treatment for chemotherapy-induced peripheral neuropathy" Support Care Cancer. 2011; 19:833-841.

A Word from the Chairman

Frank R. McKay, Chairman and Chief Appellate Court Judge, SBWC New Director and Appellate Court Judge

We are pleased to say 2018 will be a good year for the Georgia State Board of Workers' Compensation (SBWC) and our Workers' Compensation system.

Georgia continues to experience population growth and is now the eighth most populous state in the nation with over 10.4 million citizens. Among the ten most populous states, Georgia is one of five to have above average employment growth. As this year started, unemployment stood at just 4.3 percent with more than 675,000 new private sector jobs added to Georgia's economy in the last seven years. Georgia continues to be recognized as the number one state in the nation in which to do business.

With all this economic growth and expansion of business, it is imperative we continue to have an efficient, fair, and balanced Workers' Compensation system to take care of our most valuable resource – our employee work force. Accidents and injuries do and will happen in a booming economy. Fortunately, Georgia employers have some of the best accident prevention and safety programs in the nation. With an emphasis on prompt medical care and returning to work as soon as possible following a work-related injury, both the injured employee and their employer experience a far greater successful outcome from the unfortunate accident and injury.

As the SBWA starts 2018, we welcome Judge Brian Mallow, who joined us January 1, 2018. Judge Mallow is in our Albany office and will hear cases in the southwest Georgia area. Judge Mallow comes to the Board from private practice where he handled workers' compensation cases for over fifteen years. We are excited to have Judge Mallow and his experience at the Board.

On July 1, 2017, the Board changed Board Rule 205 and implemented a new procedure and Board form WC-PMT to address the delay problems of an injured employee receiving authorized medical treatment as recommended by an authorized treating physician for a compensable injury or condition. The Petition for Medical Treatment (PMT) is simple and easy to file and will trigger a show cause telephonic conference before an administrative law judge within five (5) business days with the employer/insurer for them to show cause why the recommended medical treatment/testing should not be authorized. As of the middle of January 2018, 521 WC-PMTs were filed with telephone conferences scheduled and eighty-one (81%) percent of those were resolved between the parties prior to the teleconference, which resulted in the teleconference being canceled. The remaining nineteen (19%) percent, in which a teleconference was conducted, led to a mixture of orders being issued directing authorization of the treatment or there was authorization by agreement of the parties, WC-3 controverts being filed, or withdrawal of the WC-PMT by the petitioner. This new process has been highly successful in accomplishing the goals and intentions of the Workers' Compensation Act.

Georgia is the eleventh leading state in the nation for fatal opioid overdoses which points even more toward the immediate concern that we must reduce the reliance upon opioid drug prescriptions. All players in the Workers' Comp system from prescribers, caregivers, adjusters, policy makers, employers, and injured workers have a role in helping to reduce the misuse of opioids. Prescribers, especially, should be asking whether opioids are the most appropriate choice to alleviate the individual's pain and return the patient to function, and whether an alternative could work as well or better.

In a poll from the National Safety Council, it was shown that three quarters of doctors erroneously believed morphine and oxycodone were more effective than acetaminophen and ibuprofen. Therefore, more education is needed for the individuals taking prescription opioids. According to a separate National Safety Council survey, roughly nine in ten patients taking opioids were not concerned about addiction. In Georgia, our State Board of Workers' Compensation Advisory Council's Medical Committee has recommended the Board adopt a drug formulary on opioids and the Medical Committee has now moved into the initial implementation stage.

Data received from the National Council on Compensation Insurance (NCCI) shows the total amount of workers' compensation premiums paid continues to increase in Georgia due to the expanding payroll and economic development. NCCI has also recommended to the Department of Insurance an 8.7 percent rate decrease in workers' compensation insurance policy premium charged to employers. This data reflects a good, healthy, and stable workers' comp system in Georgia.

In 2018, the SBWC plans to greatly expand the number of users to access and file Board forms on ICMS. We anticipate adding over 2,500 additional users which will include adjusters and claims handling professionals.

And, finally, SBWC is excited about a five-city tour for regional educational seminars this spring:

Rome - March 28
Alpharetta - April 13
Warner Robins - April 26
Augusta – May 2
Savannah - May 9

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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Exciting news for 2018!

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- **Pain Management Issues**
- **Georgia Workers' Comp Update for 2018**

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Georgia Employers' Association Spring Conference Targets Opportunities for Georgia Business

Mike McCurdy, Executive Director

The theme for the Georgia Employers' Association (GEA) 2018 Spring Conference is *Strategies for a Better Business Environment.* This year's event will focus on opportunities and challenges for Georgia businesses in today's expanding economic climate. Attendees will hear from business leaders, healthcare experts, and Georgia government representatives in order to gain valuable perspectives to help improve and grow their organizations. The event is scheduled for April 15 - 17 at The Westin Savannah Harbor Golf Resort & Spa.

"Today's growing economy is providing some real opportunities for business growth," comments GEA Executive Director, Mike McCurdy. "At the same time, businesses are facing a tight labor pool, healthcare and insurance challenges, and tough issues like workplace sexual harassment. This year's conference is on point with excellent speakers and valuable and relevant content."

Key speakers for the event include Georgia Labor Commissioner, Mark Butler, who will provide information about the Department of Labor's efforts to assist employers when hiring is difficult. Navicent Health CEO, Dr. Ninfa Saunders, will address opportunities for cooperation between businesses and the medical community. Bart Gobeil, Senior Director of the Georgia Port Authority, will discuss progress at Georgia ports and the direct benefit to businesses in the state.

Other featured speakers for the event include Stuart Countess of Kia Motors, Judge Elizabeth Gobeil, Dr. Layne Meyers, and Jody Jernigan, Southeast CEO of the National Safety Council. Presentations include workplace health and wellness, problem-solving techniques, and a panel discussion on the effects of Opioids in the Workplace.

The GEA Spring Conference is designed for proactive business leaders and HR professionals. Attendees will leave with new ideas and directions to help their companies become more efficient, productive, and profitable.

Since 1981, the Georgia Employers' Association has provided a valuable resource that helps Georgia businesses manage risk, develop leadership capabilities, and build an engaged workforce. GEA is a single source for training, consulting services, legal resources and other products, and professional services members need to succeed.

A full list of topics and speakers for the Georgia Employers' Association Spring Conference is available on the GEA website at georgiaemployers.org/2018-spring-conference/. For more information about the event or Georgia Employers' Association, please contact: Mike McCurdy, Executive Director; phone: 478-722-8282; email: mike@georgiaemployers.org.

Pain Management: It Just Makes Sense

Michael Schurdell, M.D.

Recently, I attended a Workers' Compensation conference where there was a discussion regarding which physician specialties should be included on a company's Workers' Compensation panel. Specifically, they discussed the benefits of incorporating an interventional pain management physician on the panel of providers.

The reaction of many led me to realize that there is some trepidation when considering sending a patient for pain management. I believe this arises from the misconception that pain management is a "last resort" for a patient, accompanied by uncontrolled spending and no measurable improvement – That is the farthest from the truth.

Amidst a national opioid epidemic, it has never been more important to get an injured worker to the right pain physician early in the recovery process to prevent opioid (or other) addiction, decrease the risk of acute pain transitioning into chronic pain, and lower the ballooning costs of treating the injured worker. Although we are experts in dealing with difficult and oftentimes drawn out cases, our pain management services can be most cost-effective when the patient is seen within weeks of the initial injury.

Studies have shown that acute pain, if not properly managed, has a much higher risk of becoming chronic pain. Higher pain intensity is a predictor of a longer and/or more expensive claim. The temptation of the under trained physicians is to treat pain with high doses of opioids with no stop date in mind.

In injuries outside of work, fifty percent (50%) of patients taking opioids for three (3) months are still on opioids five (5) years later. This percentage is likely higher in the population of injured workers. Having a physician willing to judiciously administer and appropriately wean opioids early on will decrease complications and control costs.

A trial in the United States Department of Veterans Affairs (VA) health system compared liberally escalating doses of opioids with a "hold the line" dosing strategy. Surprisingly, there was no significant improvement in a patient's function with the higher opioid-using group. If a physician is not following the widely-accepted national guidelines on opioid prescribing, the onus is then on the payer to remove that physician from the treatment picture and to provide the injured worker with safer care from a more conservative physician. Such a change will benefit the worker and help decrease long-term costs.

Workers' Compensation management may sometimes delay treatment by a pain physician because of the legitimate concerns over containing monthly costs. However, the real key to sustainable reduced medical expenses is directing the injured worker to the right pain physician early on while in the acute phase of the injury. Allowing such a physician to triage the patient from the initial occurrence will prevent the unneeded use of expensive name brand medications, curb the escalating doses of addictive opioid medications, avoid unnecessary invasive surgery, and appropriately designate only the necessary conservative specialty services to promptly treat the injury. This approach requires finding the right strategic partner to help navigate the dangerous waters of overly-aggressive and unproductive medical care.

Michael S. Schurdell, M.D. – The Physicians - Spine and Rehabilitation Specialists
Dr. Michael Schurdell is a board certified anesthesiologist with a subspecialty certification in pain Management with The Physicians – Spine & Rehabilitation Specialists in Rome, GA. Dr. Schurdell received his medical degree at University of Texas Medical School/Houston. He completed his residency in Anesthesiology at Emory University School of Medicine and his subspecialty training in interventional pain management at Wake Forest School of Medicine.

Platelet-Rich Plasma: Stimulating the Healing Response

Spencer M. Wheeler, M.D.

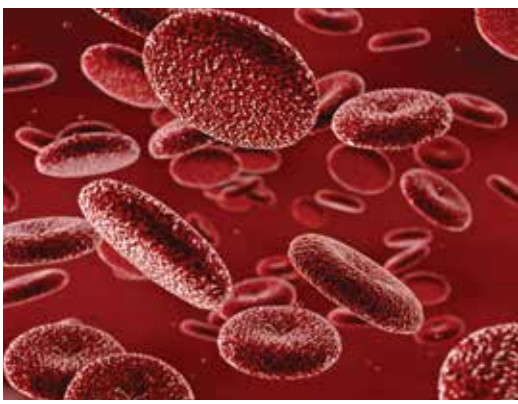
Many advances have been made in the treatment of musculoskeletal disorders resulting in improvements in surgical techniques and diagnostic imaging. While it is possible to reliably repair soft tissues during surgery, the long-term outcomes are not always as successful as immediate surgical result. One of the reasons for long-term suboptimal outcomes is the eventual failure of surgical fixation (sutures, screws, anchors) when repaired structures do not heal themselves and regain their strength.

New focus is underway on optimizing the healing environment biology to stimulate the body's natural restorative process and improve long-term outcomes. Many structures we try to repair in orthopaedic surgery (menisci, rotator cuff, etc.) have poor blood flow with a limited capacity to heal. New methods are available to improve the biologic environment at these soft tissue repair sites. One such method involves the use of platelet-rich plasma which can be used in both operative and non-operative settings to improve/stimulate the healing response.

Platelet-rich plasma has been processed to contain a high concentration of platelets and growth factors derived from the patient's whole blood which is spun down in a centrifuge allowing the platelet-rich layer to be extracted. This plasma can then be activated with the use of thrombin or calcium chloride which causes the release of the platelets growth factors. Inactivated platelet-rich plasma can also be injected to be activated once it is in the body.

There are different commercial systems to create platelet-rich plasma that contain specific growth factors. These include: transforming growth factor beta (TGF-B), platelet-derived growth factor (PDGF), insulin-like growth factor (IGF), vascular endothelial growth factor (VEGF), epidermal growth factor (EGF), and fibroblast growth factor-2 (FGF-2). Many of these factors have been shown to enhance one or more phases of soft tissue and bone healing.

In order to understand the action mechanism of platelet-rich plasma, it is necessary to review the normal healing process of musculoskeletal tissue. The repair response starts with the formation of a blood clot and degranulation of platelets which releases growth factors and cytokines into the local environment. This, in turn, results in chemotaxis of inflammatory cells as well as the activation and proliferation of local progenitor cells. Platelet-rich plasma can augment or stimulate healing by turning on the same process which normally occurs after musculoskeletal injury. In vitro studies have demonstrated that platelet-rich plasma can enhance the proliferation of stem cells and fibroblasts.



While clinical tests still continue, platelet-rich plasma has been successfully used to treat lateral epicondylitis (tennis elbow), Achilles tendonitis, plantar fasciitis, patella tendonitis, and soft tissue injuries in elite athletes. The simple—and minimally painful—process is easily done in an office setting, taking less than thirty minutes and is repeated three to four times in a chronic condition on a weekly basis; three to four times every four to five days for an acute injury.

The technology of platelet-rich plasma may prove to have numerous applications in the treatment of musculoskeletal injuries.

Spencer M. Wheeler, M.D., specializes in arthroscopy of the knee and shoulder, as well as treating general orthopaedic problems. He received his medical degree from Medical College of Georgia in Augusta and completed both his internship and residency at the University of Florida in Jacksonville. Dr. Wheeler has been involved in local, state, national, and international Sports Medicine, including the 1996 Olympic Games and seven World Championship events. He is Board Certified by the American Board of Orthopaedic Surgery and maintains an active appointment as a faculty member at Mercer University School of Medicine.

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Pain Institute of Georgia is a leader in diagnosing and treating work-related injuries.

Our physicians:

CARLOS J. GIRON, M.D.

- Interventional Pain Management Physician and founder, Pain Institute of Georgia
- IME Training: ABIME, SEAK, 5th & 6th Ed. AMA Guidelines
- IME Certifications: CIME, Georgia MPWCP
- Founder & Executive Director of Georgia Society of Interventional Pain Physicians
- Co-author ASIPP Interventional Pain Management Clinical Practice Guidelines 2.0
- Member of Georgia State Board Workers' Compensation Medical Committee

PRESTON C. DELAPERRIERE, M.D.

- Interventional Pain Management Physician, Pain Institute of Georgia
- Medical Director, Sweet Dreams Anesthesia 2013 to Present
- State of Georgia Medical MPWCP
- ACLS/BLS Certified
- Bibb County Medical Society
- American Society of Anesthesiologists
- Georgia Society of Anesthesiologists
- American Society of Interventional Pain Physicians
- Georgia Society of Interventional Pain Physicians

JULIAN M. EARLS, JR., M.D.

- Chief Neurologist, Pain Institute of Georgia
- President, Middle Georgia Medical Society
- American Academy of Pain Management
- Georgia Society of Interventional Pain Physicians
- American Society of Interventional Pain Physicians
- Georgia State Medical Association
- National Forum of Independent Pain Clinicians
- National Headache Foundation

Pain Institute of Georgia is a multi-disciplinary comprehensive Pain Management medical practice. It is our goal to make the treatment process as smooth as possible. **We are devoted to providing the safest and most appropriate care for the injured worker.** We understand the Georgia Workers' Compensation system, and our treatment plans focus on achieving maximum medical improvement (MMI) as quickly as possible.

The goals of our Workers' Compensation program:

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Prescribed Motion to Improve Function

Carlos Giron, M.D.

Many patients often ask about the most effective treatments for pain. The most consistently proven treatment I prescribe is movement.

As simplistic as it sounds, simple movement works and helps to relieve pain, prevent further dysfunction, and is much safer than opioid medications.

Human nature dictates when something hurts, you avoid moving or using that body part. Restricted mobility, loss of function, and scar tissue formation all hinder recovery from injuries. The best outcomes are achieved by early mobilization and maintenance of an exercise regimen. This is a staple of post-surgical recovery as well as in the prevention of chronic pain. Thankfully, the days of bed rest are in the past.

Scientific studies have arrived at the same conclusion. Evidence-based medicine shows strong evidence for the incorporation of exercise in aiding in the recovery from most injuries. In my medical opinion, exercise accomplishes much more than any prescription medication could ever provide.

When a patient is experiencing pain, one must be compassionate and understand that the pain must be adequately treated to facilitate movement. Often, a patient will require interventional Pain Management injection procedures to control their pain. Physical therapy can be effective and begin the cascade of improving a patient's motion and function.

Aquatic therapy is an effective modality that allows an injured patient to move more comfortably. Working against the resistance of the water in a buoyant environment affords less strain on joints, including those of the spine. It is a mainstay of our *Return to Function* program and engages the patient to maintain the gains made by continuing a tailored exercise program after formal therapy has ended. We always encourage our patients to become their own physical therapists.

An engaged, accountable, participating patient will recover and return to a productive life quicker.

Dr. Carlos Giron is an experienced Interventional Pain Management physician with a demonstrated history of treating Workers' Compensation patients as well as those involved in personal injury cases. Skilled in Opioid Management and Tapering strategies, Healthcare Consulting, Medical Treatment Plans, Evaluations, Medical Case Management, Ambulatory Surgery, Physical Therapy, and Comprehensive Spine care.

Fake HR: What is the real story?

Rushe Hudzinski, Director, Georgia State Council of the Society of Human Resource Management

Multiple times a day we are bombarded with the accusation and proliferation of something being labeled "fake news." What does this really mean?

Wikipedia defines "fake news" as *"A type of journalism consisting of deliberate misinformation. Fake news is written and published with the intent to mislead… [it] also undermines serious media coverage and makes it more difficult to cover significant news stories."*

Now, the question is posed: Is your organization perpetuating Fake HR?

That is, is your organization misleading themselves deliberately by saying the traditional HR administrative function, personnel processing, and acting as the company's policy police are the only full human resources functions? If so, then Fake HR is hard at work.

Many organizations, both large and small, are not using the human resources function to its full potential. The traditional functions of recruitment, policy implementation and interpretation, and managing employees' benefits still exist, however those are only parts of the evolving function of HR management.

HR professionals in true form are enhancing organizational profitability and are becoming strategic partners to the overall company picture. Employees are shifting into an even more integral part for the achievement of the organizational mission and goals. HR professionals understand finance, accounting, and provide cost saving and efficient models of business not only at the core, but at executive level, as well. An organization making the HR function secondary or combining HR with other job functions, such as safety or finance, undermines the success of potential revenue achievement. It is directly supporting Fake HR.

To avoid this pitfall, aligning the strategic HR function with true business initiatives impacts position design, talent management, compensation, and corporate succession planning and development. The lesson learned is not making organizational objectives less significant. Let true HR pave the way for future forward-thinking and support of paralleled business initiatives.

Rushe Hudzinski, MBA, GPHR, SHRM-SCP, GA-PPT, is a Professor of Business Management for Savannah Technical College and Director of SHRM Georgia. Before coming to the college she served as the Human Resources Director for Effingham County, Training and Development Coordinator at Savannah College of Art and Design and a District Recruiting Specialist for Eddie Bauer. She has been an elected participant for the SHRM Executive Summits at Harvard and University of Pennsylvania. Two community projects for Human Resources (Preserving Human Capital – An Active Shooter Response and the Community HR Collaboration Project) have been recipients of the SHRM National Pinnacle Award.

Join Us! Registration Open!

SHRM Georgia HR Legal Summit

SHRM Georgia and the Savannah Area Chapter welcomes Lilly Ledbetter

Lilly's historic discrimination case against Goodyear highlighted her fight for equal rights and pay in the workplace. The case inspired the passing of the federal law: Lilly Ledbetter Fair Pay Restoration Act in 2009. She is also the author of Grace and Grit: My Fight for Equal Pay and Fairness at Goodyear and Beyond.

WHEN: May 4th, 2018

WHERE: Savannah International Trade and Convention Center
1 International Dr, Savannah, GA 31421

7:30 am	Check In/ Breakfast
8:15 am	HR Legal Summit
12:30 pm	Keynote Luncheon welcoming Lilly Ledbetter
2:15 pm	Book Signing

SHRM/PDC and HRCI credit available
Registration Link: https://savannah.shrm.org/

Costs:

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Table for 8: $350.00

Guest:
Conference / Lunch: $125
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Workers' Comp Best Practices

Steve Heinen, Risk Advisor

One of the beauties of the Georgia Workers' Comp System is its stability over the past twenty years, which is a credit to the leadership at the State Board of Workers' Compensation.

There is a low incident rate of lost time claims, but when there is a lost time claim in Georgia, the indemnity costs and the litigation rate are both high. Therefore, it is critical to understand the cost drivers in Georgia by knowing and enacting these best practices.

Have a valid panel of physicians with quality doctors:

The physicians' panel is a two-prong test. First, you must have a valid panel posted of at least six doctors with a minority doctor, an orthopedist, and no more than two industrial clinics. The second part of the requirement is you must have documentation showing you explained the panel to the employee and gave them the right to choose the doctor. Often, this is where employers stumble. Finally, while it is not a Board requirement, it is extremely important to have good physicians on your panel. A good doctor will be objective with the injured employee and will communicate properly on a timely basis. The physicians' panel is the first line of attack for a claimant attorney. If the claimant attorney can invalidate the panel, then they get to pick the doctor, which increases costs significantly.

Report the claim timely:

Every day someone waits to report the injury claim adds three percent (3%) to the cost of the claim and the chances of litigation increase. A delay in reporting/filing a claim can also result in losing a drug/alcohol defense.

Return to Work:

Georgia is a return to work state which means the employer is on the hook for indemnity benefits for 350 or 400 weeks (in a non-catastrophic case) unless the employee returns to their regular job. This is why it is critical to have a return to work program in place. Employers need to initiate the return to work quickly to increase the odds of a successful return to work and to decrease the chances of attorney involvement. A return to work program will reduce costs.

If you utilize the above best practices you will significantly lower your workers' compensation costs and take care of your most important asset which is your employees.

Steve Heinen is a Risk Advisor at Pritchard and Jerden. He also has administered the Certified Workers' Compensation Professional Program since its inception in 1999. Over 200 Self-insureds, Insurance Carriers, and TPA's participate in the program. To learn more about the CWCP program, visit www.cwcp.net.

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ATTORNEY TROY LANCE GREENE ANNOUNCES THE NAME OF HIS NEW FIRM

Troy Lance Greene of Vidalia announces the opening of his practice Troy Lance Greene, P.C. Mr. Greene is a Magna Cum Laude graduate of Mercer University and the Walter F. George School of Law. He is a former member of the Board of Directors of the Georgia Defense Lawyers Association and a member of the Defense Research Institute. He is involved in several committees and organizations involving workers' compensation matters. He is a member of the National Eagle Scouts Association and the Toombs County Bar Association.

Mr. Greene was a law clerk for the judges of the Middle Judicial Circuit. He also served as juvenile court associate judge in the Middle Judicial Circuit. He was formerly employed with Allen, Brown, and Edenfield in Statesboro. He has been a member and partner of the firm of McNatt, Greene and Peterson for over 26 years.

Mr. Greene represents several insurance companies and self-insurers in Georgia and has been in practice for over 26 years in the field of insurance and workers' compensation defense. Mr. Greene is well versed in property and casualty matters, premise liability and electrical contact cases. In this regard, he has represented utilities in the state for several years. He has tried a great number of workers' compensation hearings before administrative law judges in the state. He has significant trial experience and has tried many jury trials to verdict. He has been involved in four jury trials in the last eighteen months. He continues to represent insurers and self-insurers in his new practice.

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Pitcher's Elbow

Elliot P. Robinson, M.D.

Baseball is America's pastime with a strong tradition in Georgia. However, perhaps no other sport places the athlete's elbow at more risk. This has been magnified as athletes specialize earlier, throw harder, play year-round, and, in general, "put more miles on their elbow" at a young age. Unfortunately, a broad range of elbow injuries in the throwing athlete can have career-ending implications if not addressed in a timely fashion.

In 1974, major league pitcher, Tommy John, tore the medial ulnar collateral ligament, the supporting ligament on the inside of his elbow, which was thought to be a career-ending injury. He sought the care of orthopedic surgeon Frank Jobe who came up with an untested, but promising, technique to restore stability to Tommy's elbow. He borrowed a tendon from Tommy's forearm to reconstruct the medial collateral ligament. Tommy made an unprecedented recovery and went on to win 164 games for the Dodgers and Yankees after his surgery. The procedure was named after Tommy John and variations have been used to save countless throwing careers.

There are several pathologies other than ulnar collateral ligament tear the elbow surgeon sees in throwing athletes which are due to "valgus extension overload" mechanics. This refers to the torque placed on the elbow as energy generated in the legs and trunk is transmitted to the ball with the elbow acting as a fulcrum.

Tremendous tension is placed on the inside structures of the elbow which can lead to tearing of the ulnar collateral ligament. In a young athlete, however, the growth plate on the inside of the elbow is weaker than the ligament. Instead of a ligament tear, the bone can be pulled apart little by little or as an acute break. These injuries need rest, casting, or surgery depending on the severity. Another tension problem is ulnar nerve irritation, which presents as elbow pain, little finger numbness, and sometimes hand weakness.

When there is tension on one side, there is compression on the other. This is particularly important in growing athletes. The immature skeleton is relatively soft and susceptible to repeated microtrauma. Excess compression on the capitellum on the outside of the elbow can weaken it leading to osteochondritis dissecans. In the same way a pothole develops from loose gravel on the road surface, the bone supporting the joint cartilage softens. X-rays in the early stage are frequently negative, but if the lesion is not able to heal, a "pothole" develops. The resulting loose bodies can get stuck in the joint, leading to painful catching and decreased range of motion. This can often be treated with arthroscopy to remove the fragment and clean up the defect. On occasion, a cartilage and bone plug is harvested from the knee to fill the defect.

The Tommy John story is a great example of will and skill overcoming a difficult situation. Perhaps knowing there is a fix gives athletes and coaches excess confidence. In fact, there is an ever-increasing rate of Tommy John surgery being performed. According to one survey, one in nine major league pitchers undergoes this surgery. Additionally, while the surgery used to be performed almost exclusively in mature professional pitchers, the majority of are now done on college and late teenage athletes. The downsides are Tommy John surgery offers no guarantee of successful return to competition and the rehabilitation process is an arduous year-plus process.

Clearly, prevention of elbow injuries deserves at least as much publicity as Frank Jobe's ingenuity and Tommy John's remarkable recovery.

Elliot P. Robinson, M.D., earned a Bachelor's of Arts in Biology from Brown University in Providence, Rhode Island and received a Doctor of Medicine at the University of Virginia School of Medicine in Charlottesville, Virginia. Robinson is a board certified orthopaedic surgeon by the American Board of Orthopaedic Surgery and holds a Certificate of Added Qualification in Surgery of the Hand and is a partner of OrthoGeorgia.

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Beware of the Weinstein Tax: How the New Tax Bill Affects Sexual Harassment Settlements

Robert A. Luskin and Joshua Y. Joel, Attorneys, Goodman McGuffey LLP

In a nod to the #metoo movement and increased awareness of workplace sexual harassment and issues of sexual abuse, the recently passed Tax Cuts and Jobs Act includes what has become known as the "Weinstein Tax." The Weinstein Tax, originally proposed by Senator Bob Menandez (D-New Jersey), is not a tax at all. Rather, Section 13307 of the Act prohibits settlement funds or attorneys' fees paid out pursuant to confidential settlement agreements from being deducted from taxes. In an effort to curb the use of settlement agreements that muzzle those who raise claims of sexual harassment or abuse, the provision was intended to protect the victims and incentivize employers not to demand confidentiality. Specifically, Section 13307 states:

> PAYMENTS RELATED TO SEXUAL HARASSMENT AND SEXUAL ABUSE.
> No deduction shall be allowed under this chapter for—
> (1) any settlement or payment related to sexual harassment or sexual abuse if such settlement or payment is subject to a nondisclosure agreement, or
> (2) attorney's fees related to such a settlement or payment.

When faced with a sexual harassment claim—whether meritorious or not—employers must now consider the tax implications of contemplating settlement. For many, if not most sexual harassment claims, the potential risks of not including a non-disclosure provision will outweigh any tax benefits. This is especially true in cases that do not involve significant settlement payment amounts, as it is usually far more beneficial to keep any claims confidential than to receive the deduction. Therefore, the provisions effect on these agreements is questionable.

However, interestingly, the new law, while apparently intended to target only employers, is written broadly enough that it may prohibit plaintiffs from deducting their settlement payments as well. In fact, under the Act as written, victims of sexual harassment or abuse may need to pay taxes on the full amount of settlement payments and even their attorneys' fees. This may result in a lower settlement for plaintiffs and create the opposite effect from what was intended.

It remains to be seen how the Internal Revenue Service (IRS) will interpret the law or whether Congress will issue technical corrections. Meanwhile, employers should be aware of this new development. If you find yourself in the unfortunate situation of defending a sexual harassment claim, consider involving your company's tax professional or, at the very least, consider the tax implications.

Robert A. Luskin is a partner with Goodman McGuffey and is an experienced trial lawyer who represents clients in a wide range of insurance matters and employment litigation in Federal and State Courts across Georgia and the Southeast. He holds a Bachelors of Arts from Centre College and a Juris Doctorate from Mercer University. He is active in the Atlanta Bar Association (Litigation Section); the International Association of Defense Counsel; State Bar of Georgia; the Tennessee State Bar, and the Atlanta Volunteer Lawyers' Foundation. Robert is a founding member of Georgia's National Society of Professional Insurance Investigators chapter and serves on its Executive Board. He has also been recognized by Atlanta Magazine as a Georgia "Rising Star Super Lawyer."

Joshua Y. Joel is an Atlanta native who graduated magna cum laude with a Bachelor in Liberal Arts from Excelsior College, a Bachelor in Talmudic Literature from Yeshiva Beis Yisroel in Jerusalem, and a Juris Doctorate from Georgia State University College of Law where he also served as the legislation editor of the Georgia State University Law Review. He joined Goodman McGuffey as an employment litigation associate after having served as a staff attorney with the United States Court of Appeals for the Eleventh Circuit.

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Wide Awake Hand Surgery

David I. Katz, MD
Hand, Wrist & Upper Extremity

Hand surgeons have the ability to perform surgery without general anesthesia, sedation, or the need for a tourniquet on the arm. Local anesthetic is gently injected into the affected area of the wrist, hand or fingers. During surgery, patients remain alert and comfortable, while afterwards they can get up and return home without any of the side effects of sedation. This form of surgery has come to be known by its acronym, WALANT, which stands for: Wide Awake Local Anesthesia No Tourniquet.

WALANT offers significant advantages for patients. While modern anesthesia is one of the safest areas of medicine, there are always potential side effects and risks with sedation and general anesthesia. This is especially true for individuals with multiple medical problems. Less sedation is safer than more sedation - and the safest sedation is no sedation at all.

Before surgery involving anesthesia, many patients are required to go to the hospital or surgery center for tests and/or lab work. With WALANT, there is no need for preoperative testing since patients do not receive sedation. This eliminates the need to take even more time off work before surgery.

The night before surgery typically means having nothing to eat or drink after midnight, including the morning of the procedure. However, with WALANT, patients can eat and drink normally the morning of surgery, as they will not receive any of the typical anesthesia medicines. This is particularly helpful for diabetic patients as they can follow their typical diet and medication regimens around the time of surgery.

During the procedure, patients who are awake and alert have the added advantage of being able to ask their surgeon questions. At times patients may even be able to see their anatomy which can help with their recovery. None of this is possible when asleep or sedated during a typical operation.

"Less sedation is safer than more sedation - and the safest sedation is no sedation at all."

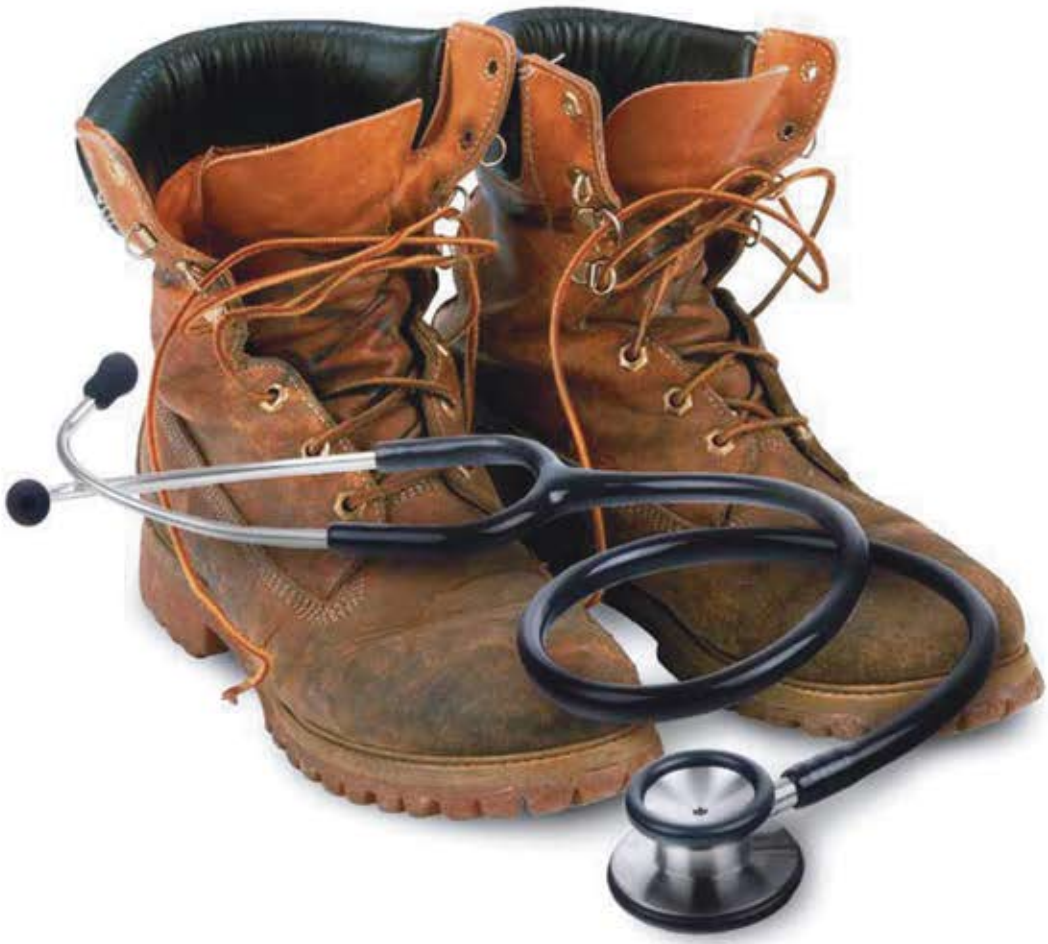
Without sedation, patients avoid many of the possible undesirable side affects associated with anesthesia and opiates. After wide awake hand surgery, there is no nausea, vomiting, urinary retention, or constipation. Most patients are able to simply get up and go home after WALANT.

Wide awake hand surgery has meant greater convenience, less expense, and lower risk for many patients. While WALANT is possible for a variety of procedures, it is not feasible for all surgeries. Additionally, some patients may not be suitable candidates to undergo wide awake hand surgery - and other individuals may simply choose to have anesthesia for their operation. There are many different factors that go into the decision to have wide awake hand surgery. If interested, feel free to ask your surgeon if it is a good option for you!

Director of Workers' Compensation, Alexis Hill, CWCP

I am honored and excited to serve in my new role as Director of Workers' Compensation. Having been a part of AOC's team for the past four years, I look forward to providing the same quality of health care to our patients and continuing to communicate with nurse case managers, adjusters, and employers in a timely and constructive manner.

Please feel free to contact me by phone at (706) 433-4028 or email at ahill@AthensOrthopedicClinic.com, should you have questions or concerns. I look forward to working with you!



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