Fall 2018 Edition

WH Workplace Health

On the Forefront of Medical Technology

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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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Misdiagnosis at Initial Injury - A Common Practice

Shalin Shah, M.D.

Pain management physicians are usually the last specialist to treat a patient from the time of their initial injury. Patients are typically referred to a pain management physician when no solution can be found for treatment other than chronic therapy with narcotics. Many times, the patient could have avoided unnecessary surgery or chronic narcotic treatment if they had seen a pain management doctor first.

Here is an example: Betty goes to the urgent care following a bus driving accident and is seen by a generalist for her initial diagnosis. She complains mostly of focal right shoulder pain. The pain can be so severe to the point where she is unable to tell if there is any radiation of the pain. After failing conservative therapy, Betty undergoes an MRI of the right shoulder. Keep in mind, at Betty's age of fifty-seven, degenerative changes will be found on her MRI. At this point, she'll be referred to a shoulder specialist.

The shoulder specialist finds bone spurring, partial degenerative rotator cuff tear, and possible old biceps tendon tear. Betty undergoes three right shoulder steroid injections without any relief. She tries various anti-inflammatories, which do not help her pain, either. The surgeon may then suggest a diagnostic and therapeutic shoulder arthroscopy.

Later, after repair of the arthritic changes are performed, Betty still complains of shoulder pain. She's advised that shoulder replacement may be an option. However, after undergoing this procedure, she still has no relief. Betty continues taking narcotics and is now classified as a "chronic pain" patient and referred to pain management.

Upon arriving to the pain management specialist, it is discovered that Betty has tingling and numbness in her right arm with some radiation toward her neck.

Despite attempts to order a cervical MRI to evaluate for cervical radiculopathy, the problem now occurs where the pain physician is only authorized to treat the right shoulder.

So, therein lies the problem. Initial referrals in cases like this are typically performed by a generalist who may not be properly trained to diagnosis the patient adequately, yet it often determines the patients' outcome. It wasn't clear at the initial visit whether Betty had a right shoulder issue or cervical radiculopathy, so she suffered through a series of misdiagnoses.

Cervical and lumbar radiculopathy often do not present with the classic neck/back pain with numbness and tingling in the upper or lower extremities. Even many spine surgeons and pain physicians are poorly trained to recognize the difference between orthopedic conditions and radiculopathy.

Matters can be further complicated when the patient has mixed pre-existing conditions such as a chronic rotator cuff tear and cervical radiculopathy. Spine surgery may be performed incorrectly for pain originating from an orthopedic injury.

An advantage of a well-trained pain specialist includes the ability to perform diagnostic joint injections and/or selective nerve root blocks (diagnostic and therapeutic epidural steroid injections) in the spine to help aid in the correct diagnosis, since a physical exam and medical history aren't always reliable when co-existing conditions occur. When a pain specialist performs diagnostic joint and spine injections, there is usually no potential conflict of interest, which in other cases may lead to costly and unnecessary surgery.

Shalin Shah D.O.
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Augusta, GA
American Board of Anesthesiology Certified Chronic Pain
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Minor Neck Pain: Recognizing and Treating

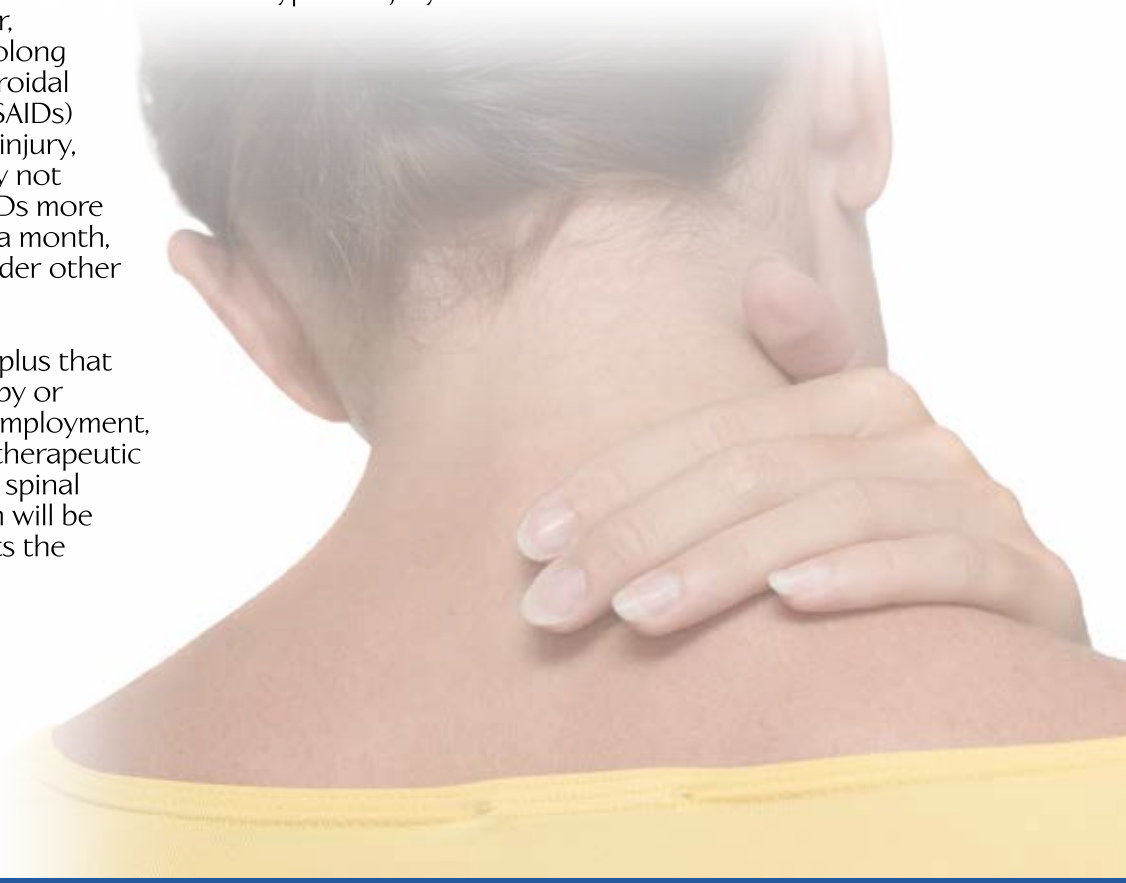
Christopher O. Blanchard, D.O.

Headache, neck, and shoulder pain are common symptoms following minor strains or a motor vehicle accident. Most neck pain is secondary to muscle injury and resolves itself in six to eight weeks. For some, the pain lasts longer, which may indicate other injuries to the spine. The facet joints—the most commonly injured neck structures—are responsible for causing prolonged symptoms. Ongoing pain may be a combination of head movement throughout the day along with poor body mechanics which don't give the structures time to heal.

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/sharp when turning the head from side-to-side. Other symptoms may include shoulder and/or upper arm pain, daily headaches, pain behind the eye, and blurry vision.

Your doctor will examine your neck by touching, turning, and pressing with the possibly of causing discomfort. They are merely trying to define the pain source and injury severity. It's important the patient communicate with the physician while being examined because this will help determine the best initial treatment plan. X-rays and MRI studies are usually normal or may show minimal changes not fully explain by the severity of your pain.

Following your diagnosis, it's important to start working with a qualified physical therapist to correct any abnormal posture or body mechanics. Therapy is vital for successful long-term treatment. 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. Soft cervical collars worn for more than one or two days are not usually recommended for this type of injury because it will allow the neck muscles to rest too much, they will become weaker, rather than stronger, and it will prolong the overall recovery time. Non-steroidal anti-inflammatory medications (NSAIDs) can help control pain after a neck injury, but long-term daily use is generally not recommended. If you require NSAIDs more than once or twice a day for over a month, tell your doctor so they may consider other treatment options.



For pain lasting six or eight weeks plus that prevents successful physical therapy or interferes with your family life or employment, a more aggressive diagnostic and therapeutic plan is necessary. This may involve spinal injections or surgery. These option will be discussed to see which one best fits the patient's life.

Always let your doctor know how treatment is affecting sleep, work performance, or relationships. These situations may make it necessary to change your treatment plan and more aggressively treat your condition.

Christopher O. Blanchard, D.O., specializes in Complex Reconstructive Spine Surgery, Minimally Invasive Spine Surgery, Cervical Spine Surgery, Kyphoplasty, and Artificial Disc Replacement. With 104 physicians, Resurgens Orthopaedics provides specialized expertise and broad experience in sports medicine, joint replacement, neck and back surgery, foot and ankle surgery, shoulder and elbow surgery, non-operative spine care, hand surgery, arthroscopic surgery, epidural steroid injection, general orthopaedics, and trauma care.

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Causation in Workers' Compensation

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

In Georgia, employers and adjusters must determine causation of injuries alleged by employees. If they are unable to do so, the final arbiter of causation requires a judicial determination. However, prior to litigation, the employer and adjuster can evaluate causation in the following manners:

- Factually,
- Medically, and
- Reasonable inference

Factual proof of causation can occur many different ways. Under evidentiary law in Georgia, the testimony of one witness is enough to establish a single fact. However, what other circumstances may prove causation beyond the allegations of the injured worker? Certainly, if the injury is witnessed by others, you can comfortably accept causation. Additionally, video surveillance, which captures the injury, is powerful and allows an employer to accept compensability of the injury. Causation of injuries by employees working offsite can be documented by the written report of neutral third party entities. Specifically, a written report from the police, an ambulance service, or even the fire department can go a long way to confirm causation as alleged by the injured worker. Other factual proof of causation may include the damage to an employer's own vehicle when an employee alleges they were injured in an automobile accident. Likewise, the absence of the aforementioned should heighten reservations against claim acceptance.

Medical proof of causation remains the most common method in an overall investigation. Objective medical evidence is multifaceted. What is documented in the medical records? Are there objective notations of bruising? Is the injured worker in obvious pain? What did the diagnostic test results show? Was a drug *and* alcohol test timely performed? What were the results? In the event of death, what does the autopsy report reveal? Ultimately, the independent opinions of medical experts who opine based upon the facts as they know them, combined with the objective medical evidence before them, is the highest regarded medical proof of causation.

Finally, the attributes of a reasonable inference can determine causation. Two common examples illustrate this:

1. An employee who departs the job site at the end of their shift at 5:00 p.m. on Friday with no reports of injury seems typical. However, when they return to work at 8:00 a.m. Monday morning—following a two day weekend interval of no work—and report they were injured at the end of their shift on Friday, it's a reasonable inference that something occurred over the weekend.

2. An employee who begins their shift without any sign of injury is later observed limping or complaining of back pain. This demonstrates a likelihood that something happened during their work shift. Remember to always think critically. Carefully evaluate the evidence. Then, ask: *"What caused this injury?"*

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, TPAs, 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, TPAs and employers. The firm strives to provide the best legal advice and court room defense available.

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Pictured: Betsy Grunch, M.D., board-certified neurosurgeon.

Multiple Options for Treating Degenerative Disc Disease

Betsy Grunch, M.D.

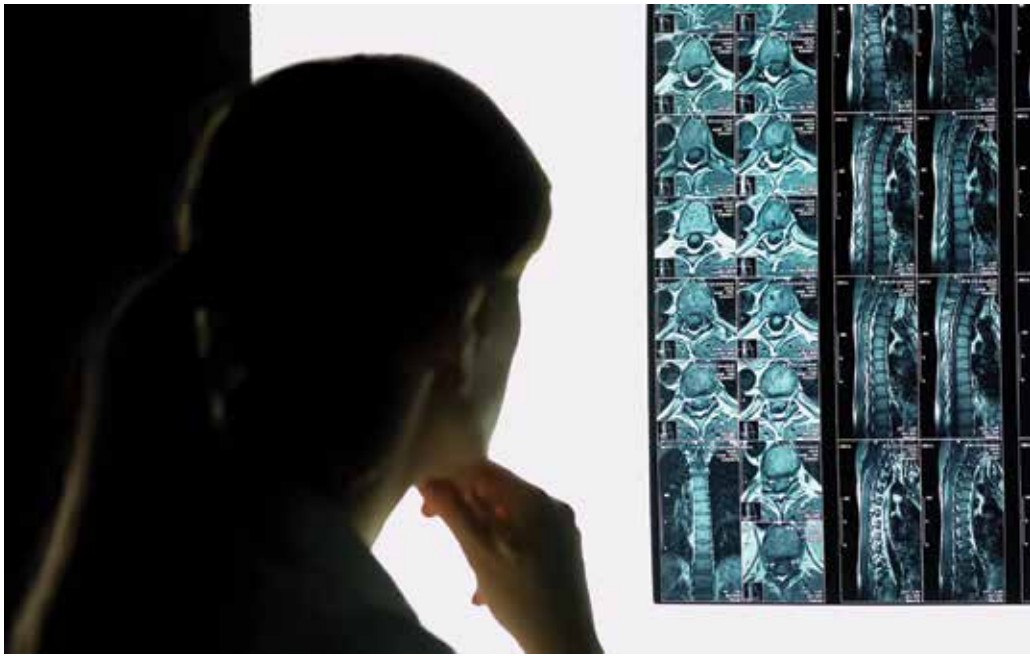
Lumbar Degenerative Disc Disease (DDD), one of the leading causes of lost work time in the US, occurs when a spinal disc no longer functions normally due to aging, wear, or injury. In a healthy spine, discs serve as cushions between vertebral segments to minimize the impact of movement on the spinal column. DDD may cause a disc to shrink, leading to pain or making the spinal joint unstable.

Symptoms:
DDD primary symptoms are lower back and leg pain, numbness, and tingling. Disc problems may cause the spine to become unstable, making the patient feel like they're "giving out." A worn-out disc or spinal joint can press on nerves branching out from the spinal cord. This may cause leg or back pain when a patient moves certain ways which could reduce mobility. Patients may find relief when they change position from sitting to standing to walking.

Diagnosis:
The physician will review a patient's medical history to determine whether the low back pain was triggered by an injury or occurred over time. A physical exam is necessary to properly diagnose DDD by assessing the range of motion and strength and to determine where the pain originates in the spine. A definitive diagnosis for DDD may require radiographs, such as MRI and x-ray, to rule out other sources of pain.

Conservative Treatment:
DDD can be treated non-surgically with over-the-counter and prescription medications, physical therapy, spinal injections, chiropractic care, braces, exercise programs, or even rest. However, in some cases, the symptoms may not improve or even get worse. Such unresolved pain continuing more than six months is considered chronic low back pain, meaning patients typically become surgical candidates.

Surgical Treatment:
Fusion Option: In spinal fusion surgery, the unhealthy disc is removed, a bone graft or a plastic spacer is placed in the area, and medical implants (rods, screws, or plates) are used to hold the bones in position until stable. The goal is to permanently fuse the vertebrae together so they move as a single unit, therefore reducing the movement of that part of the spine. Fusion surgery may alleviate pain, but it significantly alters the way the spine functions, possibly accelerating DDD at other spine levels.



Motion Preservation Option: This surgery uses an artificial disc replacement device which was developed to provide pain relief while still allowing motion in the low back. The unhealthy disc is removed and replaced with a motion-bearing device that attempts to mimic the natural mechanics of a healthy spine. This surgery is for select patients and, when appropriately utilized, can provide patients with benefits over a fusion procedure.

Betsy H. Grunch, M.D., FAANS, FACS, is a board-certified, fellowship trained neurosurgeon at Longstreet Clinic which delivers personalized and comprehensive care to patients of all ages at every stage of life. Workers' Compensation services specialties including vascular surgery, general surgery (hernias), orthopedics, neurosurgery, physical medicine and rehabilitation, neurology, and more. Visit longstreetclinic.com to learn more.

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Stand Much? Plantar Fasciitis and Other Conditions

Paul V. Spiegl, M.D.

Many occupations require standing for prolonged periods which can cause both discomfort and pain. Evidence shows extended standing at work leads to adverse health outcomes. The effects of being on your feet all day can accelerate health problems and soft tissue injuries. For example, standing all day on your feet can result in:

- Varicose veins
- Plantar fasciitis
- Low back pain
- High blood pressure
- Knee or hip arthritis
- Bunions
- Pregnancy complications
- Neck and shoulder stiffness
- Chronic heart and circulatory disorders
- Knee problems
- Stretched Achilles tendon (tendonitis)
- Joint damage
- Poor circulation and swelling in feet and legs

Industrial workers, restaurant servers, medical staff, teachers, police officers, and military personnel are among those experiencing conditions resulting from extensive standing.

Pain spreading from the heel could be caused by a medical problem called plantar fasciitis, an irritation or inflammation of the band of tough tissue that connects the heel bone to the toes. The condition occurs when the strong band of ligaments supporting the foot's arch becomes irritated and swollen.

The plantar fascia is designed to absorb the weight, high stresses, and strains on our feet. But, sometimes, too much pressure damages or tears the tissue. The body's natural response to injury is inflammation which results in heel pain and stiffness of plantar fasciitis. In addition to prolonged standing and walking, other risk factors can predispose one to this condition, including:

- Tighter calf muscles
- Obesity
- Very high arch
- Repetitive impact activity (running)
- New or increased activity

An orthopedic physician will perform an exam, take x-rays, or order other imaging tests to help diagnose the condition. These tests help rule out possible causes of heel pain, like fractures or arthritis. Many patients will improve within months of starting simple, at-home treatments, like rest, ice, and anti-inflammatory medications.

There are simple things to be done independently, such as:

- Calf stretches
- Plantar fascia stretches
- Support shoes and orthotic inserts
- Night splints
- Buying the right shoes for your occupation
- Compression socks

Companies can also assist workers in avoiding the onset of plantar fasciitis or alleviating symptoms from extensive standing. Such interventions include the use of special floor mats and sit-stand work stations. However, if pain persists, it's time to consult a doctor. While plantar fasciitis treatment varies, some common therapies include:

- Cortisone injections
- Special prescription orthotics
- Physical therapy
- Extracorporeal shockwave therapy
- Surgery after twelve months of aggressive, nonsurgical treatment

Research has shown shoe inserts significantly improve the quality of life for sufferers of plantar fasciitis. Studies also indicate that extended standing—even for an hour without rest—affected patients negatively and should be avoided. Use of the suggested interventions and guidelines from governmental and professional organizations should assist in reducing the health risks associated with prolonged standing.

Paul V. Spiegl, M.D., is a Board Certified and fellowship trained in orthopaedic foot and ankle surgery who founded Perimeter Orthopaedics in 1983. He earned his medical degree from the University of Wisconsin, and completed his residency at Duke University. His residency training includes foot and ankle reconstructive surgery. Dr. Spiegl has served as a clinical instructor at Emory University and Grady Memorial Hospital. He specializes in reconstructive foot and ankle, total ankle replacement, and diabetic foot.

An Introduction to Georgia PRIMA

Georgia PRIMA is one of twenty-seven state chapters of the National Public Risk Management Association (PRIMA), a non-profit association offering educational programs and publications for employees who have public sector responsibilities. There are more than 2,200 PRIMA member entities who realize membership provides the necessary tools needed in today's complex and changing risk management environment.

Our mission is to enhance the skills of our members through:

- Quarterly meetings with topics and speakers related to the risk management profession
- Increasing the proficiency of risk and insurance management in governmental agencies at the state and local level
- Networking opportunities allowing members to share and exchange ideas and solutions with their colleagues and enhance the knowledge and skills of individuals who carry out the risk management function in the public sector

We have two categories of membership:

Public Sector Members: This includes employees of governmental entities who are responsible for risk management, human resources, finance, police, fire, legal counsel, and other governmental staff members responsible for workers' compensation, benefits, employee safety, casualty and property, regulatory compliance, and other related areas.

Affiliate Members: This includes brokers, agents, law firms, insurance/safety consultants, insurance pool administrators, third party administrators, occupational medicine and medical facilities, and others who offer risk management related services and products to the public sector.

Our Annual Educational Series Conference, generally held in April, is an intensive three-day event where members learn, network, and meet with fellow public entity members, as well as companies which offer risk management services to our members. We also recognize and award the Public Risk Manager of the Year and the Public Entity Achievement Award.

We just completed our Annual Education Series Conference held April 25-27, in Savannah, Georgia, which included a wide variety of presentations on topics of interest to our members.

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The Effective Choice: Chiropractic Instead of Pills

Leana Kart, B.S., D.C., Chiropractor

Prescription opioids have created a crisis for patients and doctors. Opioid overdose deaths have quadrupled since 1999 and, now, ninety-one Americans die from opioid overdose every day, according to the Center for Disease Control (CDC). Another forty-three million Americans are addicted to opioids.

Chiropractic care is a proven method of treating patients who have injuries and conditions that have been routinely prescribed pills. In the area of Workers' Compensation, it is critical to attend to these injuries in a way that avoids addiction and enables the patient to return to work quickly, in better health, and can even help prevent injury.

Backed by several medical studies, including one of more than 40,000 Workers' Comp cases, chiropractic treatment has shown highly effective results with no negative side effects. Making chiropractic treatment part of the usual and customary therapies offered would go a long way to help patients resume normal and productive lives. Rather than *prescribe, prescribe, prescribe*, practitioners can recommend chiropractic care as a safe and effective alternative. Referring patients with muscular skeletal pain to a chiropractor often reduces the need for opioids and surgery. Further, chiropractic care treats the root cause of the pain, making a return to work possible sooner with healing of the injury, rather than masking the pain symptoms.

"Clinicians and patients should select non-pharmacological treatment as the first-line approach to treating back pain such as spinal manipulative therapy."

~ American College of Physicians

A 2013 study found patients who saw a chiropractor for back injuries were 1.5% likely to have surgery while patients who saw a surgeon were 42.7% likely to have surgery.

Many musculoskeletal injuries of the low back occur in the workplace; therefore, faced with huge costs, human resources departments, insurance carriers, and physicians are utilizing chiropractic manipulative therapy more to significantly decrease pain and improve physical function without the use of drugs or surgery. For example, a North Carolina study of 43,000+ Workers' Comp claims over nineteen years showed a drastic difference in the average cost of treatment, number of days spent in a hospital, and compensation payments among patients treated by a chiropractor. The average chiropractic cost was almost $2,900 less. And, the injured workers were able to return to work almost six times faster.

Telemedicine Combined with Chiropractic Care

Chiropractic care is a solution to dangerous side effects. Georgia ranks among the Top 11 states with the most prescription opioid deaths. With twenty-five percent (25%) of all Workers' Comp costs related to opioid use, the costs to the workplace are staggering. Chiropractors are one of the largest groups of drugless doctor-level healthcare providers and are part of the solution to the opioid epidemic.

Dr. Leana Kart, B.S., D.C. has been practicing in Atlanta Chiropractic care for the past thirty-two years and was named Chiropractor of the Year in 2016. She is a wellness consultant and expert in workplace settings for both safety and injury prevention. She is also the President of the Georgia Chiropractic Association. Dr. Kart can be found at Northwest Chiropractic, 1526 Howell Mill Road, Atlanta, Georgia. For more information, visit www.atlantpainrelief.com.

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Georgia's Prescription Drug Monitoring Program

Carlos J. Giron, M.D.

The Prescription Drug Monitoring Program (PDMP) database is a valuable tool for Georgia physicians. Effective July 1, 2018, all licensed Georgia physicians are required to register for the PDMP and use it according to Georgia Law.

The Georgia PDMP was created legislatively in 2011 and administered by the Georgia Drug and Narcotics Agency until 2017 when control moved to the Department of Community Health (DCH). The widespread use of this database was slow at first, but its value has become quite evident amid the opioid epidemic, something I have personally invested significant time and work in helping to combat for over twenty years.

The long road to Georgia's PDMP began in Kentucky in the late 1990s with an escalation of opioid use and abuse in that state. Many people received prescriptions for opioids from multiple physicians and crossed state lines to illegally obtain those drugs either for personal abuse or criminal diversion. A successful effort in Kentucky was led by concerned, responsible Pain Management physicians to educate and lobby their state legislature to pass KASPER, the Kentucky All Schedules Prescription Electronic Reporting Act. It created a database to help identify illicit use and abuse of prescription medications. It was so successful that the American Society of Interventional Pain Physicians began lobbying on Capitol Hill in Washington, D.C. for a similar national program.

I became involved in this effort in 1998. After many visits with congressional leaders, we reached a breakthrough in 2005 when NASPER, the national version, was passed and signed into law by President George W. Bush authorizing state programs with inter-state communication to stem the problem.

It took another six years of lobbying and intensive advocacy in Atlanta by the Georgia Society of Interventional Pain Physicians and the Medical Association of Georgia to achieve the goal of a PDMP for our state. The delays were largely due to privacy concerns and data security.

Today, state PDMPs have helped accomplish the following objectives:

- Assisted in reducing overprescribing and abuse of controlled substances;
- Promoted proper treatment of pain and terminal illness with fewer opioids;
- Curtailed doctor shopping, duplicate prescriptions, and obtaining of controlled substances in multiple states.

Georgia PDMP achieves these purposes by giving complete and current information to doctors and pharmacists about prescriptions dispensed to their patients over a two-year timeframe. Data entry is required within twenty-four hours of a prescription being filled by the dispensing entity, typically a pharmacy. The PDMP user must be approved by the DCH and have a legitimate medical purpose for accessing the database or may face criminal charges for misuse of personal health information.

It is now the standard of care that the PDMP be reviewed before prescribing controlled substances. I am proud to have played an instrumental role in helping create this vital, successful program for patient safety in Georgia.

Dr. Carlos J. 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. He is skilled in Opioid Management and Tapering strategies, Healthcare Consulting, Medical Treatment Plans, Evaluations, Medical Case Management, Ambulatory Surgery, Physical Therapy, and Comprehensive Spine care.

A Word from the Chairman

Frank R. McKay, Chairman, State Board of Workers' Compensation

Annual Conference

The State Board of Workers' Compensation's 2018 Annual Workers' Compensation Conference will be held August 27-29 at the Hyatt Regency Hotel in Atlanta, Georgia. This year's theme is *Broadway Showcase Spotlight on Workers' Compensation*. This theme should provide our exhibitors with a host of ideas for festive attire and booth decoration from the many fabulous shows that have run on Broadway over the years.

In keeping with the show business theme, our keynote speaker will be television judge from *The Verdict*, The Honorable Glenda Hatchett. Prior to presiding over a televised courtroom, Judge Hatchett served as corporate counsel for Delta Airlines and as Chief Presiding Judge of the Fulton County Juvenile Court. Judge Hatchett will present on the topic of professional ethics and her varied experiences should make for interesting ethical insight.

The 2018 Annual Conference will also include a special session on how to minimize workplace violence as well as our typical legal, medical, rehabilitation, and licensure sessions that will incorporate case and statutory law updates, presentations on state-of-the-art medical treatment for workplace injuries, and the current best practices for handling workers' compensation claims.

As any recent attendee knows, the Board's Annual Conference is the preeminent opportunity for both education and networking with stakeholders involved in all aspects of the Georgia workers' compensation system. We hope you will put this event on your calendar and plan to attend. The SBWC thanks the Steering Committee for their hard work in the development of this outstanding program.

ICMS 2

In 2016, after roughly three years of non-stop dedicated work, the Board successfully implemented our new electronic ICMS 2 system, a more robust and stable system than the former claims management system that the Board had been using since 2005. This new, updated on-line system was designed to allow many more users to view and file documents electronically with the Board.

We are pleased to announce we are now implementing our next phase of ICMS 2 by expanding our electronic user base to self-insured employers, insurers, and claims handlers who will now, for the first time, be able to view and file documents electronically with the Board. We will be contacting self-insured employers, insurers, and claims offices concerning this new upgrade to our ICMS 2 system. For more information, please visit our website at www.sbwc.georgia.gov.

In addition to our exciting new expansion of the ICMS 2 system, we are moving toward the following future goals: 1) Discontinuing the use of social security numbers in files and on documents to protect the privacy of injured workers; and 2) Requiring Form WC-1s to be filed with the Board in all claims, including medical only claims. The filing of WC-1s in all claims has always been required by O.C.G.A. § 34-9-12(a) but in the past, the Board has not enforced this requirement due to the inability of our prior systems to handle the volume of such filings. However, with our new ICMS 2 system, we now have the capability to handle these filings. This update will assist the Board in capturing better and more accurate information in claims. The SBWC recommends all filers start now filing a WC-1 in all claims.

Opioid Update

In a recent groundbreaking study, orthopedic surgeons in North Carolina found that a non-opioid strategy was as effective as opioids in relieving pain in patients undergoing shoulder replacement surgery. The findings have not yet been published in a peer-reviewed medical journal, but the research was featured in the May edition of the American Academy of Orthopaedic Surgeons' magazine, *AAOS Now*. Dr. Daniel Leas, one of the study's authors,

told *AAOS Now*, "Our study firmly supports the idea that we should be exploring ways to eliminate opioids as 'standard of care' for pain in the medical community." *Orthopedic Surgery Without Opioids Is Possible, Researchers Say*, Elaine Goodman, *Workcompcentral*, May 4, 2018.

Last May, the SBWC Board concluded a five city Regional Educational Series on many of the hot topics and issues in our workers' compensation system. The Board's Public Education Committee did a fantastic job designing, writing, and presenting a seminar based on the hit TV show, *Seinfeld*, and its cast of characters, concluding with the highly educational and entertaining, "Mock Trial of George Costanza."

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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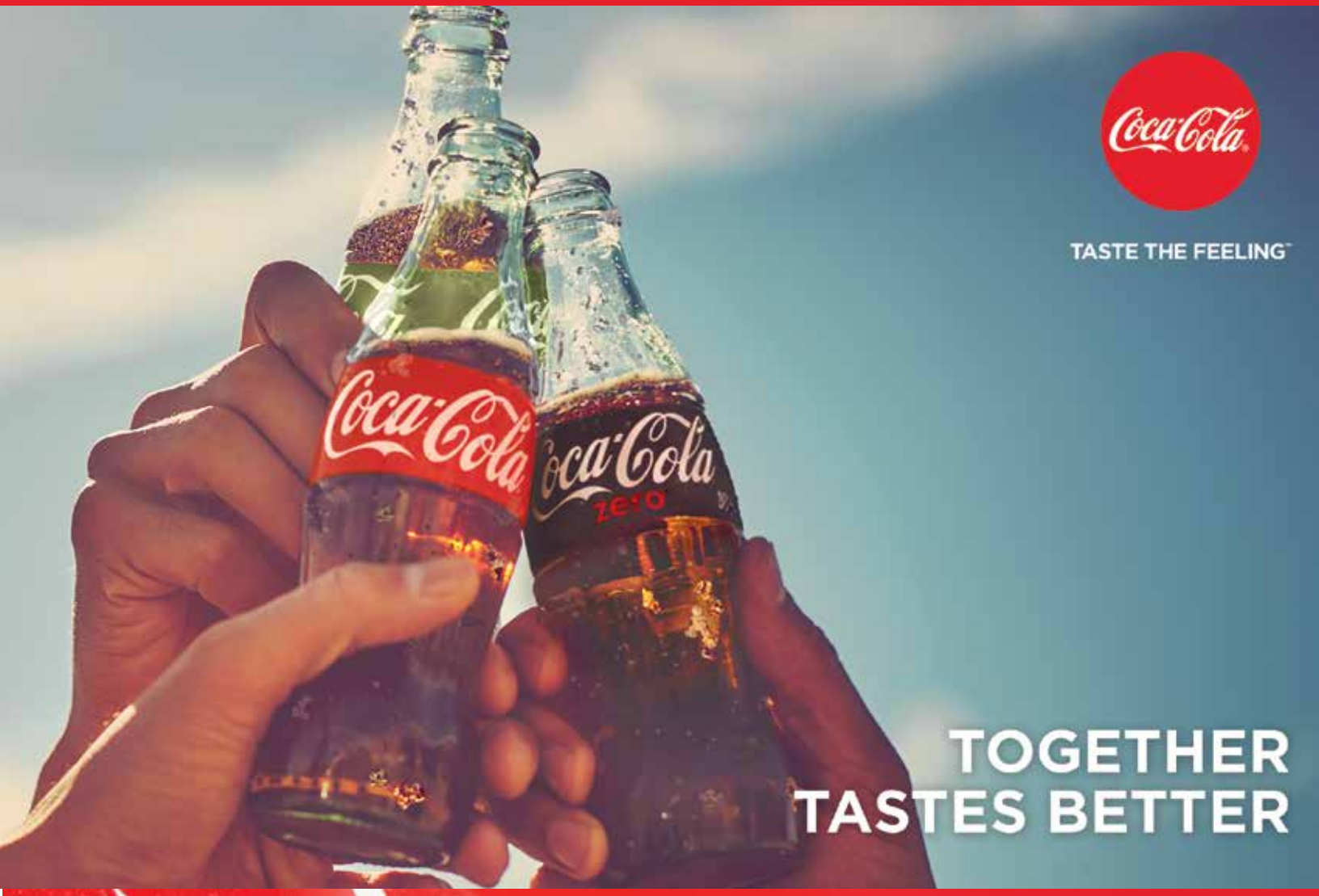

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Prescribing Decisions Based on Biochemical Profile

Randy F. Rizor, M.D.

A patient with chronic back pain receiving years of treatment with a fentanyl patch is referred to a pain management specialist for opioid tapering. Out of safety concerns, and to facilitate weaning from the drug, the physician switches the patient from fentanyl to an equivalent dose of oral hydrocodone. Shortly thereafter, the patient reports marked increase in pain, has withdrawal symptoms, and demands to be put back on fentanyl. The physician suspects the patient is not taking the hydrocodone as prescribed. What is really going on?

Many previously unexplained responses to medications are now known to be caused by inherited variations in the body's proteins responsible for drug metabolism. Therapeutic mishaps—including over-dosage, under-dosage, unwanted side effects, and dangerous drug-to-drug interactions—can be avoided by the data gathered from a one-time test analyzing the DNA of a tissue sample obtained from a simple cheek swab.

The test results show genetic variations in seven (7) proteins responsible for metabolizing over eighty percent (80%) of all prescribed drugs. These proteins belong to a family known as Cytochrome P-450 enzymes. These enzymes regulate chemical reactions that alter the molecules of administered drugs once they reach the bloodstream. In some cases, these reactions break down and eliminate the drug. In other cases, the reactions are necessary for the drug to achieve its desired effect.

In the example above, hydrocodone, although often thought of as a strong opioid, has very little influence on its own. Its effects are achieved when it is acted upon by an enzyme named CYP2D6 that converts it to the highly potent drug, hydromorphone. About ten percent (10%) of Caucasians and up to thirty percent (30%) of some African ethnic groups have genetic variations in CYP2D6 that reduce its activity, resulting in little or no hydrocodone being converted to its active form.

CYP2D6 is also the primary enzyme responsible for breaking down many common antidepressants. Therefore, a person with low CYP2D6 activity may not show results from high doses of hydrocodone, but display signs of antidepressant overdose when given a typical dosage of Prozac.

A full pharmacogenetic profile analyzes the activity levels of enzymes regulating the metabolism of virtually all opioid and non-opioid pain medications, antidepressants, anti-seizure drugs, and anti-inflammatory drugs. This information allows the clinician to predict the patient's sensitivity to a drug, the probability of side effects, and whether there is a risk of adverse effects arising when certain drugs are used in combination. Making prescribing decisions based on an individual's unique genetic profile eliminates the trial and error approach to prescribing, saving money, and improving patient satisfaction and compliance.

Randy F. Rizor, M.D., is a founding partner and Medical Director of The Physicians in Sandy Springs, Georgia. He graduated Phi Beta Kappa from Bates College and received his Doctor of Medicine Degree from the University of Toledo School of Medicine in 1976. He completed a residency in Anesthesiology at Dartmouth-Hitchcock Medical Center. Dr. Rizor was certified by the American Board of Anesthesiology in 1981 and received subspecialty certification in Pain Management from the American Board of Anesthesiology in 1993; recertification in 2005. To learn more, please visit: ThePhysicians.com

The Idiopathic Quagmire: Attempting to Define Injuries

Laura Ogg, Senior Counsel, Eraclides Gelman

Since 2004, the idiopathic law has been applied inconsistently resulting in different outcomes for cases with similar facts. This is a struggle for Employers/Insurers trying to determine what to accept and what to deny.

In March 2018, the Court of Appeals (CoA) decided on Cartersville City Schools v. Johnson tackling an issue considered a "quagmire" where even the Appellate Division (AD) "fell prey to the confusion that our case law has sown."

In Cartersville City Schools v. Johnson, the Claimant, a teacher, walked from her desk to the front of the classroom when she fell and injured her knee from weaving through a tight classroom configuration at a rapid pace. However, the AD found nothing particular about the classroom that caused her fall. Reversing the Administrative Law Judge, the AD determined the act of turning and walking is not a risk unique to the Claimant's employment. The AD said these motions are risks she would have been exposed to outside of employment; therefore, the injury is not compensable.

The Claimant appealed and the Superior Court reversed the decision, finding the AD applied an incorrect legal standard with no evidence indicating the fall was idiopathic since the injury arose out of the Claimant's performance of her teacher duties. It went on to note "a risk is incident to the employment when it belongs to, or is connected with, what a workman has to do in fulfilling his contract of service."

The Employer/Insurer appealed to the CoA who found the AD erred in its analysis of the legal framework because the AD overlooked the proximate cause requirement and held that, in order to be compensable, the injury must either be caused by activity the employee engaged in as part of the job or the injury must result from some "special danger of the employment." It defined an idiopathic injury as "one having no causal connection to workplace activity." The undisputed facts showed the Claimant was actively engaged in movements and behaviors required as a teacher when she was injured; therefore, this is a compensable injury.

This decision contrasts with St. Joseph's Hospital v. Ward where a nurse injured her knee while turning to get a patient water. The CoA denied her claim saying standing/turning were not risks unique to her employment. They also said an activity is not compensable where an employee could have engaged in it giving rise to the injury outside work. In Johnson, the CoA discussed overturning Ward because, in this CoA's opinion, Ward applied an incorrect legal standard by not addressing proximate cause. Although the CoA ultimately did not overturn Ward, it applies a more liberal standard in Johnson, shifting the compensability analysis in favor of the Claimant.

Laura Ogg is Senior Counsel at Eraclides Gelman in Lawrenceville, Georgia. She graduated cum laude the University of Georgia with a Bachelor of Music and a Juris Doctorate from the University of Georgia School of Law. Laura specializes in workers' compensation defense.

The Continuing Challenge of Treating Knee Arthritis

Robert Hoffman, M.D.

Osteoarthritis (OA) is a condition that results when the smooth cartilage on the ends of the femur (thigh bone) and tibia (shin bone) wear down. Nearly a quarter of the US population suffers from this chronic disease and it is one of the most common causes of pain and disability, especially as we age.

Treatment of OA can be challenging in younger patients and those employed in physically demanding occupations. Knee replacement surgery, a standard procedure for patients with severe symptoms, does not seem to be as effective and has a higher rate of revision surgery in younger patients compared to older patients. As a result, non-surgical treatments are encourage, including activity modification, weight loss, physical therapy, and oral anti-inflammatory non-steroidal anti-inflammatory (NSAIDs) such as ibuprofen, naproxen, meloxicam, etc. Studies have proven these non-surgical treatments to benefit many OA patients.

Patients who do not respond to such treatments often seek alternative non-surgical options. Physicians often suggest an intra-articular corticosteroid injection. These have been used for pain relief with knee OA since the 1950s and help relieve inflammation and pain, but they do not restore knee joint cartilage. They are effective, simple, relatively inexpensive, and have few side effects. The pain relief from an injection can last about six months, although the duration of relief can vary from patient to patient.

In 2013, the American Academy of Orthopaedic Surgeons (AAOS) published clinical practice guidelines stating the improvement from injections was "small and not clinically meaningful." Thus, insurance companies have become increasingly reluctant to pay for this treatment even though it remains a viable option for those who wish to avoid surgery.

Recently, the use of injectable biologic agents—such as platelet rich plasma (PRP) and mesenchymal stem cells (MSC)—in OA treatment has increased. These may reduce inflammation in the knee and promote healing of cartilage lesions. PRP is obtained by drawing off a patient's platelet rich plasma layer which is then injected into the knee. Since patients are receiving an injection of a product from their own blood, they are quite safe. MSC come from the patient's own body, harvested from bone marrow or fatty tissue or may come from donor placental and amniotic tissue. While MSC use studies show improvement, stem cells are often combined with injections or surgical procedures. PRP and MSC injections are relatively expensive and their superiority to other injections has not been proven; therefore, additional studies are needed on both methods.

A number of effective treatment options are available for OA patients, but the injectable substance or drug that restores a worn, damaged joint surface to its original condition remains elusive.

Robert Hoffman, M.D., specializes in treating shoulder and knee problems, including shoulder and knee arthroscopy, knee ligament reconstruction, and shoulder and knee replacement surgery. He is a graduate of Duke University School of Medicine and completed his residency at the University of Iowa Hospitals. He served four years as an orthopaedic surgeon and Lieutenant Commander in the United States Navy. He is Board Certified in orthopaedic surgery and has a Certificate of Added Qualification in sports medicine awarded.

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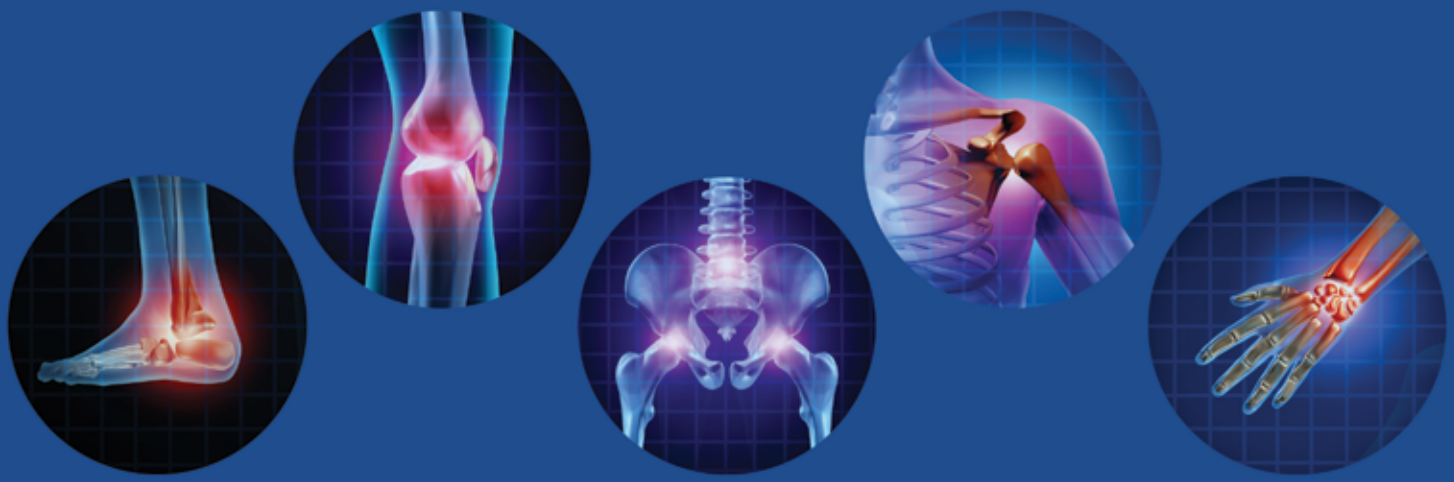
John I. Foster, III, MD - An orthopaedic surgeon specializing in sports medicine, Dr. Foster is the founder of Atlanta based Dominion Orthopaedic and Spine Clinic. After earning his MD from the University of Virginia, Dr. Foster completed his residency at Portsmouth Naval Hospital and received advanced training in sports medicine and joint replacement. He is well versed in the treatment of a full range of orthopaedic conditions with over 25 years expertise in adults and children including arthroscopic, open surgery of the shoulder and knee as well as of the hand and upper extremity.

Nicole E. Forsythe, MD - Dr. Nicole Forsythe is a physiatrist specializing in interventional spine and sports medicine. She completed her residency training in physical medicine and rehabilitation at the University of North Carolina - Chapel Hill School of Medicine, followed by an interventional spine fellowship at Non-Surgical Orthopaedics in Marietta, GA. In addition to specializing in treating neck and back pain with both interventional and non-interventional methods, she also treats general musculoskeletal and sports medicine injuries.



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How to Avoid Becoming a #YouToo Employer

W. Jonathan Martin, II

Over the last year, there have been a number of high profile sexual harassment cases. Employees have been fired, lawsuits have been filed, and reputations (individual and corporate) have been destroyed. The #MeToo movement is expanding and our society is now focused on addressing the widespread issues of sexual harassment and assault.

For employers, it is important to provide employees with a safe work environment free of harassment, sexual or otherwise. At the same time, employers must also consider how to protect themselves from legal liability due to improper workplace conduct beyond their control.

A few simple steps can help prevent your company from being the next front page story:

1. Have a Comprehensive Harassment Policy: This should address all types of harassing behavior, including harassment based on race, color, sex, gender, age, national origin, sexual orientation, religion, and disability. Having a comprehensive harassment policy is the best way to detect problems and defend against a lawsuit. If an employer can demonstrate that it exercised reasonable care to prevent and correct the harassing behavior and the employee unreasonably failed to take advantage of the opportunity, then the law provides a defense to the harassment claims. Accordingly, it is extremely important to have a comprehensive harassment policy in place and have employees acknowledge, in writing, that they have read and understand the policy.

2. Use the Harassment Policy: Investigating allegations of harassment and promptly fixing the problem is the best way to avoid litigation.

3. Ask for Help: Employers frequently ask the wrong questions during interviews and fail to properly document the steps taken to address harassment concerns. Lawsuits are serious business. A short phone call with an attorney or other expert helps ensure that the company is investigating properly and spots other legal issues with the allegations.

4. Train, Train, Train: It is important to have annual training for employees, especially supervisors and managers. Supervisors and managers need to be able to spot signs of harassment and know to take all allegations seriously. Training not only lets employees know harassing conduct will be taken seriously in the workplace, but it also gives an employer documentation to show how the employee was aware of the current harassment policies.

By using these four steps, an employer will be well on the way to making efforts to prevent harassment and creating the documentation needed to defend against allegations of illegal workplace conduct should they arise.

W. Jonathan Martin, II is a partner at Constangy Brooks, Smith & Prophete LLP. He received his Bachelor of Business Administration from the University of Georgia and his Juris Doctorate from Mercer University School of Law. He served as a lawyer in the Air Force Judge Advocate General's Department while an officer in the Air Force Reserve. He focuses his practice on defending companies in employment discrimination litigations and related state law matters.

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- **Job Demands Analysis**
- **Wellness and Work Injury Prevention Programs**

Trending Technology in Workers' Compensation

Rodney R. McColloch, Esq.

The landscape of Workers' Compensation is changing with tools to more efficiently provide benefits, reduce costs, and improve communication, such as:

New Transportation Services: Transportation hiccups can lead to frustration and costly delays in medical treatment. Fortunately, new developments streamline injured workers' needs with user-friendly platforms allowing them to request a ride with a mobile app called RelayRIDE, a partnering of Lyft and One Call Care Management. Claim handlers can track workers' trips in real time to monitor traffic delays, mileage, etc.

New Surveillance Tools: If surveillance is needed to expose potentially fraudulent claims, choose an aggressive investigator who utilizes the latest technologies to locate and monitor an injured worker. Mass license plate recognition allows investigators to track a claimant's vehicle. Reconnaissance stake outs are no longer necessary since social media mining and online activity checks often uncover injured workers who "tell" on themselves before surveillance begins.

Mobile Apps: According to Statistica, 197 billion mobile app were downloaded worldwide last year. Mobile claim management apps can allow injured workers to send communication to adjusters easily, track scheduled indemnity payments, and stay on top of upcoming medical appointments.

Wearable Technology: Wearable technology—such as ViSafe—collects real-time movement data via body sensors. This data is then analyzed and utilized by employers, medical providers, and therapists. Employers can use video feedback to document workers' activities, presenting an opportunity to create a safer work environment and an understanding of how injuries occur.

Remote Translation: When a translator is needed, carriers find remote translation services to be a time/cost-saving business measure. An interpreter can attend an appointment via video chat and provide translation in real time. Not only does this technology save on travel charges, but it avoids no-show fees and extra costs associated with traffic delays or long wait times.

Telemedicine: Telemedicine use improves injured workers' access to care, lessens wait time, lowers travel-related costs, and reduces missed time from work. The worker can also complete rehab exercises from home via telemedicine. For injured workers with internet access, this trend is an excellent option and could bring specialized care to more remote areas to help those who cannot spend several hours getting to a specialist.

Pharmacogenetics (Genetic Testing): Trial and error is a time-consuming and expensive practice when determining the best prescription(s) for a patient's symptoms. To combat this, some providers are ordering genetic testing of blood and/or saliva samples to define compatible medications based on genetic makeup. This trend has the potential to shorten the life of claims; however, there is concern over privacy.

Rodney R. McColloch joined Moore Ingram Johnson & Steele in 1996 and is a partner in the firm's Litigation Department. He has worked for numerous insurance companies, third party administrators, and self-insured companies in both the Insurance Defense and Workers' Compensation area. He is currently on the Chairman's Steering Committee for the Annual State Board of Workers' Compensation Education Conference. He frequently speaks on topics related to Workers' Compensation Laws in Georgia. Be sure to join him at the 2018 State Board of Workers' Compensation Educational Conference for a Panel discussion titled: Spotlight on Technology: New Innovations Guaranteed to STEAL THE SHOW (August 28, 2018 at 3:00 PM)

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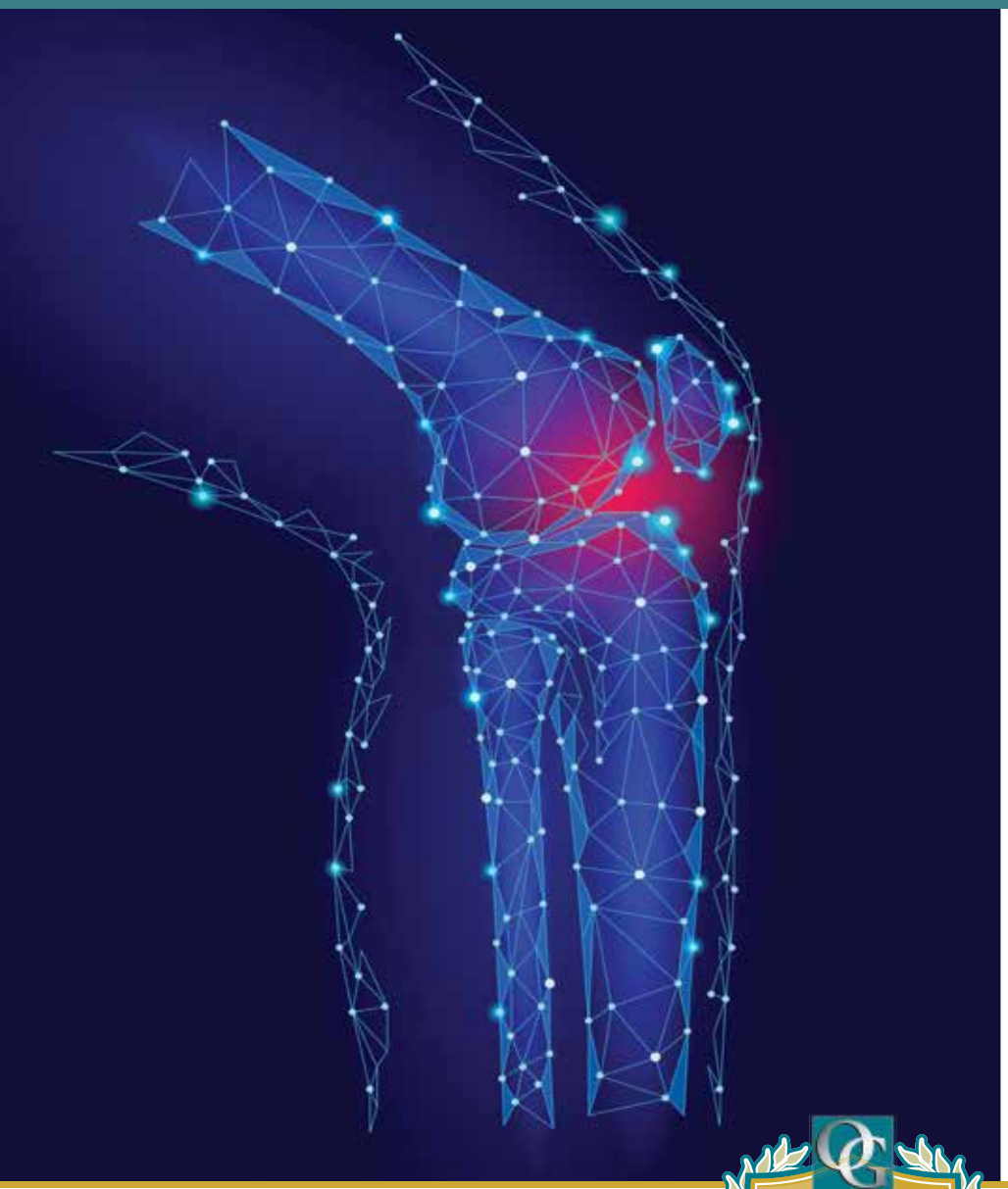

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Knee Procedures Performed with Highly-Advanced Robotic Arm Technology

Robert M. Thornsberry, M.D.

OrthoGeorgia Outpatient Surgery Center was the first outpatient surgery center in the state of Georgia to offer Mako Partial Knee Replacement procedures, performed using the Mako Robotic-Arm Assisted Surgery System marketed by Stryker.

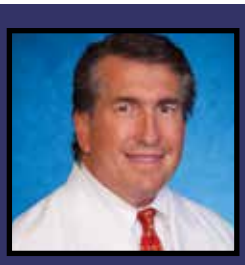
The Mako system is a surgeon-controlled robotic arm system that enables accurate alignment and placement of implants.

Accuracy is key in planning and performing partial knee procedures. For a good outcome, you need to align and position the implants just right. The Mako system enables surgeons to personalize partial knee arthroplasties to achieve optimal results at a level of accuracy and reproducibility previously unattainable with conventional instrumentation.

The Mako System features a patient-specific visualization system and proprietary tactile robotic arm technology that is integrated with intelligent surgical instruments. It assists surgeons in pre-planning and in treating each patient uniquely and with consistently reproducible procedure.

Mako Partial Knee Replacement is a treatment option for adults living with early to mid-stage osteoarthritis that has not yet progressed to all three compartments of the knee. It is less invasive than traditional total knee surgery. A pre-surgical plan is created based on a CT scan of the patient's knee. The surgeon then uses the robotic arm during surgery to resurface the diseased portion of the knee, sparing healthy bone and surrounding tissue for a more natural feeling knee. An implant is then secured in the joint to allow the knee to move smoothly again.

This article initially ran in the Macon Telegraph October 27, 2016 and is reprinted with permission.



Robert M. Thornsberry, M.D., is a graduate of Davidson College and received his Medical Degree from The Medical College of Georgia. He completed an orthopaedic surgery residency at the University of Kentucky where he spent a year at the Shriner's Hospital for Crippled Children. Thornsberry specializes in sports medicine, shoulder and knee arthroscopy, and total joint arthroplasty. He is certified by the American Board of Orthopaedic Surgery and is a member of the American Academy of Orthopaedic Surgeons.

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Since 1981, the Georgia Employers' Association (GEA) has provided training, consulting services, and a range of products and resources to help businesses manage risk, develop leadership capabilities, and build an engaged workforce.

The Georgia Employers' Association also provides members with a cost-effective source for legal and regulatory information, recruiting assistance, and human resources services. GEA offers a single source for an umbrella of resources businesses need to operate profitably and efficiently. From legal assistance to insurance, GEA provides the best options for professional services members need to succeed.

When you join GEA, you receive these valuable services:

• ***Weekly E-Newsletter –*** The weekly GEA newsletter provides subscribers with current information about legal, regulatory, and HR-related topics. It's a quick way to stay up-to-date and learn about upcoming workshops and other events.

• ***HR and Legal Services –*** GEA provides members with direct access to HR and legal professionals with answers to most human resources questions. They respond promptly to email or phone inquiries offering practical solutions. Legal input from attorneys at Constangy, Brooks, Smith, & Prophete, LLP is available to GEA members without additional cost.

• ***Conferences, Seminars, and Webinars –*** GEA sponsors four major conferences each year, plus additional seminars and webinars to provide briefings on key issues and topics important to Georgia business professionals.

• ***Educational Workshops –*** GEA members benefit from a wealth of information and training opportunities provided online, onsite, and in-person. Over twenty workshops and webinars are offered each year designed to increase the skills and knowledge of HR staff, team leaders, and supervisors. Custom onsite training is also offered to meet the specific workplace needs of member companies.

• ***Information Resources –*** GEA publishes a weekly E-newsletter and occasional bulletins to inform subscribers about critical issues or upcoming events. Online resources include News and Blog sections on the GEA website and 24/7 member access to HR Answers Now, an extensive database of legal, regulatory, and human resources information.

• ***Annual Wage and Benefits Survey –*** Each year, GEA conducts a statewide survey of wages and benefits including over ninety positions common to Georgia employers. Members find survey data useful for planning and benchmarking to assure their compensation packages are competitive.

• ***Training for Professional Certifications (PHR, SPHR, aPHR) –*** Members receive discounted rates for professional training to prepare for HRCI certifications. Recertification credits are available to attendees of many GEA seminars and workshops and GEA members are eligible for up to twelve recertification hours with proof of association membership. Members also receive a discounted exam fees and a dedicated HRCI representative to provide assistance and answer questions about certification and recertification.

Georgia Employers' Conference was held April 16-17 at the Westin Savannah Harbor Resort.
Visit their website at www.georgiaemployers.org to see an overview of the presentations you missed.

Topics of Discussion:

- **Overview of the Trump Administration's accomplishments one year into the first term and what's still on the agenda – Jeff Thompson**
- **Overview of key issues for HR – Alyssa Peters**
- **Labor Relations in a Trump Administration: Why It Matters To You – W. Jonathan Martin, II**
- **Don't Tell Me You Can't Find a Job – Mark Butler, Georgia Labor Commissioner**

Georgia Labor Commissioner, Mark Butler with W. Melvin Haas, III, Partner Constangy Brooks, Smith & Prophete LLP and Terri McCrea of DSC Logistics on right.

For more membership information, call Buddy McGehee, Executive Director, at 478.722.8282 or visit www.georgiaemployers.org.

2018/2019 Upcoming Educational Events
Workplace Health Magazine gets around! See us at:

August
5-7 Alabama Self Insured – San Destin, Florida
19-22 WCI Safety and Health – Orlando, Florida
26-29 Georgia State Board of Workers' Compensation – Atlanta, Georgia

September
5-7 Georgia Safety and Georgia SHRM – Savannah, Georgia
6-8 Georgia Association of Occupational Health Nurses Conference – Savannah, Georgia
20 DOL Alabama WC – Huntsville, Alabama

October
10 Georgia Manufacturing Summit – Cobb Galleria, Atlanta, Georgia
18 DOL Alabama WC – Birmingham, Alabama
26 4th Annual Boo Bash – Savannah, Georgia
30 GWCA Fall Conference – Atlanta, Georgia
31-November 2 – Southeast Mine Conference – Birmingham, Alabama

November
5-7 Georgia Orthopaedics Executive Conference – Amelia Island, Florida
7-8 Georgia Employers Association Fall Conference – Lake Oconee, Georgia
7-9 Georgia Association of School Business Officials (GASBO) – Augusta, Georgia

December
4-7 National Workers' Compensation Conference – Las Vegas, Nevada

February 2019
22 The Savannah Workplace Health Conference – Savannah, Georgia

April 2019
11-12 Georgia Employers Association – Savannah, Georgia
16-18 PRIMA - Savannah, Georgia

June 2019
5-7 GWCA Spring Conference – Jekyll Island, Georgia

WH EVENTS

Lilly Ledbetter, Keynote Speaker for the Spring GA SHRM Conference and The SelectOne team

Dr. Leanna Kart and Michelle Wilds attending the Georgia Chiropractic Association Conference in Savannah, GA

The St. Patrick's Day networking event was held at the Fogo de Chao in Atlanta.

GSIPP Conference/The Ritz Carlton at Lake Oconee

Karaoke Fun at the PRIMA Conference

PRIMA Conference

The famous Dillon Dixon, Songwriter and Topliner from Nashville performing at the GWCA conference in Jekyll Island

Workplace Health – Covering Key Events!

Swinging Medallions Band/GWCA Conference at Jekyll Island.

Workplace Health Conference in Savannah

SelectOne Team with Dr. Brooks, Ortho GA and Dr. Heinsch, Georgia Bone and Joint
Our physicians were invited to participate in the Moore Ingram Adjuster Seminar

Expert workers' compensation claims resolution — bringing balance between payers and providers

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The Importance of Getting Authorization

Cassandra Copeland

In the life of a workers' compensation claim, no procedure should be done without authorization from the adjuster.

The authorization is the most vital information needed when scheduling a new or established injured worker for an appointment or procedure. This is *critical* to getting services paid for by the insurance companies.

When the physician makes a referral or requests a procedure, the workers' compensation coordinator will need to get the specific service approved by initiating contact with the adjuster and/or nurse case manager. This can be transmitted through fax, email, or phone. Most adjusters prefer emails since they are usually handling a hundred or more claimants at a time. Email communication creates an easy to follow paper trail. The adjuster then reviews the referral and necessary documents that justify the request before giving approval.

It's important to have a good working relationship with the adjusters in order to make sure the process continues smoothly for all involved.

One of the obstacles some surgeons and billing divisions face are the authorizations for performing surgeries. The physician may have the anticipated Current Procedural Terminology (CPT) codes authorized prior to surgery; however, while performing said surgery, they may see an additional procedure that needs to be performed. Even though this additional procedure had not been previously authorized, the physician will still make the surgical correction at that time, as opposed to leaving it undone, spending time obtaining another authorization, and forcing the patient to endure another surgery.

An example of this would be when the surgeon has the approval to perform a shoulder arthroscopy and bone part removal, but once inside the shoulder, to see exactly what is happening, the surgeon may then need to do a shoulder repair and collar bone partial removal, leaving the last two procedures unapproved and unpaid.

Such change affects the billing division by causing a delay in payment since the unexpected, additional procedures were not initially authorized. The billing team sometimes must fight and appeal to get the surgeons paid for the work they performed.

One must ask if the surgeon should go ahead and do these unauthorized procedures and risk not getting paid or should they not and force the patient to endure yet another surgery in the same area?

This is a real and pressing problem we must face and solve in the Workers' Comp arena.

Cassandra Copeland is the Managing Director of Operations leading the Workers' Compensation Division at Synartis Asset Management. Cassandra is a New Jersey native, mother, United States Air Force veteran, entrepreneur, business developer, avid reader, networking strategist, and a music lover.

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- Independent Medical Evaluations
- Second Opinions
- Injury Prevention Training
- Rehabilitation

WORKERS COMPENSATION CONTACTS:

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"Because of my excellent care at Pinnacle Orthopaedics...

*Patient **Nick Marine** (right) back to work with his new shoulder!*

"Dr. Bonnaig is an amazing surgeon and I'm so glad he performed my surgery."

Nicolas Marine came to Pinnacle with severe pain in his right shoulder. He is a plumber and was doing some heavy lifting when he felt a sharp tearing in his shoulder. It hurt more when he raised his arm. He had been treating the pain with cortisone injections, physical therapy and anti-inflammatory medicine but there was no improvement. He met with Dr. Nicolas Bonnaig and was diagnosed with a labrum tear, partial tear in the rotator cuff and a complete rupture in his biceps tendon. Dr. Bonnaig discussed different options and Mr. Marine decided to proceed with surgery.

A couple of weeks later, Mr. Marine had arthroscopic surgery to repair his injured shoulder. Arthroscopic surgery was performed to remove some arthritis at the end of his collarbone as well as a bone spur impinging on his rotator cuff. Three weeks after surgery, he was not in pain and began physical therapy. After about three weeks of Physical Therapy and four weeks of limited movement, he was able to go back to work full time as a master plumber with full mobility and no limitations!

Mr. Marine says of his experience with Pinnacle...
"I have been to many doctors in search of one with a good bedside manner and who doesn't keep you locked up in waiting rooms. Dr. Bonnaig is very knowledgeable and great to talk with. He respects my time and all appointments that I have had with him, he never kept me waiting like many other doctors. My shoulder surgery went better than expected and I didn't need as much therapy as we first thought. When speaking to others who have used other 'procedure methods', they seem to have a lot more problems, lost time from work and had months of return visits. Dr Bonnaig is an amazing surgeon and I'm so glad he performed my surgery. He has worked on two other veteran friends of mine and we all admire him greatly!"

- **Nicolas Marine** *(patient)*

MD: Nicolas Bonnaig, MD
Procedure: Arthroscopic Shoulder Surgery

...Now I can work with no limitations."

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Minimally Invasive Spine Surgery in Workers' Compensation

E. Scott Middlebrooks, M.D.

Neck and back injuries in the workplace can cause employers and insurers headaches. The good news is the majority of injured workers will recover from their neck or back injuries without surgery. With conservative management—including rest, physical therapy, medications, and controlled return to normal activity—these patients are frequently back to full activity within a few weeks.

However, some injuries do not resolve and may require spine surgery in an attempt to get the injured worker back to their baseline status. The goals of spine surgery include decompressing the neural elements, removing damaged tissue, and stabilizing the spinal column. Regardless of the approach used for the surgery, the intent is to accomplish the same goals with less pain, shorter hospital stays, and a more rapid return to work.

With the advent of tubular retractors, we are able to access the pathologic anatomy with less disruption of the surrounding muscle and fascial tissue. In the cervical and lumbar spine, this has led to the ability to remove herniated discs and bone spurs in an outpatient setting. Studies of these techniques have shown patients experience less post-operative pain, use fewer narcotic medications, have a lower incidence of post-operative infections, and return to work sooner than patients treated with traditional open surgery. Some long term studies have shown a lower incidence of chronic residual pain, as well.

With the emergence of cervical disc arthroplasty, patients no longer require immobilization in cervical collars and can return to full activity sooner than with a fusion.

When more involved procedures, such as fusions, are required, these less invasive techniques can, in many cases, still be utilized. With the use of larger or sometimes expandable retractors, lumbar fusion can be performed, as well. These approaches still allow for the removal of nerve compression and the insertion of hardware and bone grafts. Research indicates patients can recover faster with shorter hospitalization and return to work sooner following minimally invasive lumbar fusion.

There are some limitations with minimally invasive techniques. The procedure tends to expose the surgeon and the patient to more radiation from the use of intra-operative fluoroscopy. Some studies have shown a higher revision rate due to incomplete healing of fusions.

Not all patients are candidates for minimally invasive spine surgery. When used in the right patient, the results can be dramatic with rapid patient recovery and high patient satisfaction.

E. Scott Middlebrooks, M.D. specializes in Reconstructive Spine Surgery, Minimally Invasive Spine Surgery, Cervical and Lumbar Spine Surgery, Total Disc Arthroplasty, Kryphoplasty, Orthopaedic Trauma, and General Orthopaedics. Dr. Middlebrooks is currently the Chief of Orthopaedics at Gwinnett Medical Center. With 104 physicians, Resurgens Orthopaedics provides specialized expertise and broad experience in sports medicine, joint replacement, neck and back surgery, foot and ankle surgery, shoulder and elbow surgery, non-operative spine care, hand surgery, arthroscopic surgery, epidural steroid injection, general orthopaedics, and trauma care.

For more information, visit: www.resurgens.com/worklink

Opioid Alternatives: A Moral Call to Action

Craig Segasser, Vice-President Harvard MedTech

It should come as no surprise that our nation is in the midst of an opioid crisis. The truth is, for many, prescription pain medications are effective at minimizing their pain. But, the fact that they can be powerfully addictive means they should only be considered for immediate and short-term results.

For far too long, it has been easy to prescribe these potent pills and difficult to stop using them—both for doctors and patients. It was the perfect storm… short-term gains for pharmaceutical companies and dispensaries, but long-term consequences for society. The ramifications of this crisis continue to ripple through our communities, our workforces, and the nation as a whole.

This is an instance of broken trust and something not easily undone. It will take time to heal. Time is also partly to blame. A doctor cannot easily say to their patient, "Please wait two to three months while we come up with a good solution", when even two to three minutes might be excruciatingly painful for the patient.

The patients, too, bear some responsibility because they demand relief now. Too often, though, quick relief came in the form of highly-addictive medications with no plan to replace or diminish their use over time. This is simply a recipe for drug dependence.

And, there it is… the Catch-22. Without the drug, a patient has chronic pain. Yet, with prolonged use of the drug, the patient also has pain in the form of lost productivity, lost jobs, lost relationships, etc. It's a lose/lose situation.

Regulations and oversight will come with time. Clinics and programs will be instituted for assistance. What about now, though? What can be done for individuals suffering from pain at the present? Fortunately, there is a therapy that holds promise and it comes in the form of technology. Virtual Reality Therapy (VRT) has proven to be an effective treatment for a range of conditions from post-traumatic stress disorder to chronic pain.

Harvard MedTech offers VRT regimens for treating chronic pain with the Smart-Tech VR™ Program, a comprehensive, turn-key, and cost-effective way to empower and enable patients and provide physicians with an alternative to prescribing opioid medications. This innovative program also assists payers in cost reduction through the use of smart device technology with personalized home care services.

VRT can be used as stand-alone treatments or in conjunction with medication and/or surgery. VRT has over ten years of clinically validated results in helping to reduce and manage pain with no known side effects. It can even be used to wean patients from prescription pain medication without risk of addiction. The SmartTech-VR program features in-home treatments which positively impact patient compliance and speeds recovery times.

Dr. Raziano of The Physicians and Judge McKay trying out the VRT Unit

Craig Segasser has a passion for empowering people and has made his career serving a range of paramedical services. Harvard MedTech's breakthrough health technology is physician-driven and patient-centric, relying on evidence-based, protocol driven solutions that result in objectively measurable outcomes and return on investment. HMT provides physicians who treat chronic pain and musculoskeletal disorders with a comprehensive turnkey solution for their patients.

Virtual Relief for Real Pain

For millions of Americans who suffer from chronic pain, the risk of opioid addiction is real. And the consequences of living with the addiction can be as bad as the pain from which they seek relief. **Virtual Reality Therapy** (VRT) offers hope for millions of patients, giving doctors a new tool to prescribe, that provides relief—without fear of addiction.

VRT is a conservative alternative to prescription medications clinically proven to reduce or eliminate chronic pain—helping people to return to work and move on with their lives.

Is your practice offering Virtual Reality Therapy?

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Interventional Orthopedics in Pain Medicine Practice

Khalique U. Rehman, M.D.

Interventional pain physicians are in a unique position to take advantage of regenerative medicine technology to improve patient outcomes and decrease the invasiveness of orthopedic procedural care.

The use of platelet-rich plasma (PRP) and stem cells is rapidly expanding and likely altering the orthopedic care landscape in disruptive ways. In addition, interventional pain physicians have distinct skills allowing them to take advantage of this technology to decrease the invasiveness of orthopedic procedural care. However, that shift away from surgical orthopedics to interventional care would take significant changes to the educational system.

In 1989, the coronary artery bypass graft rate for coronary artery disease was 141/100,000. By the year 2015, it was 60/100,000, a fifty-nine percent (59%) drop. The likely reason for the dramatic reduction in cardiothoracic surgery rates is the adoption of interventional cardiology, allowing less invasive ways to restore normal coronary circulation. Orthopedic care is poised on the brink of the same change.

Autologous biologics include PRP and stem cell therapies. PRP contains numerous cytokines that degranulate from whole platelets to enhance tissue repair. Stem cell therapies, the most common type deployed in orthopedics, are the isolation of the centrifuged bone marrow fraction containing mesenchymal and hematopoietic stem cells, otherwise known as bone marrow concentrate (BMC) or bone marrow aspirate concentrate.

Interventional orthopedics (IO) requires the ability to accurately place injectates into parts of the peripheral joints, tendons, ligaments, and muscles that are not readily visible under fluoroscopy. For example, ultrasound is superior for imaging of the soft tissues such as tendons, ligaments, and muscles.

Ultrasound skills for peripheral joint injections allow much more accurate placement of injectate into areas such as tendons, where the structure can be directly observed. Hence, it would seem ultrasound training is a key of IO and adding this component to existing pain management practice would, therefore, be helpful. In addition, IO fellows would need exposure and training to peripheral joint physical examination and the knowledge of the evidence base for orthopedic medicine and surgery.

At its core, interventional orthopedics is the use of ever more sophisticated injectates and tools to allow orthopedic conditions -once treated through surgical means- to be treated less invasively using percutaneous injections. The core tenets of this new medical specialty are:

- Injectates that can facilitate healing of bone, tendon, ligament, muscle, and/or cartilage;
- Precise placement of those injectates into damaged structures using imaging guidance; and,
- The eventual development of new tools to facilitate percutaneous tissue manipulation.

Through all of this, we can enhance pain management practice through the use of IO.

Khalique Rehman, M.D., is a physical medicine and rehabilitation specialist with a subspecialty in Interventional Orthopedics and Pain Management. Dr. Rehman is a part of the prestigious Regenexx Network where Orthopedic Stem Cell Injections were invented. For more information, visit www.mypainclinic.com.

New Technology for the Dispensation of Opioids

Sam Zamarripa, CEO, Intent Solutions

The opioid crisis has hit hard across the board and the Workers' Compensation arena isn't immune to its effects. Research shows twenty-one to twenty-nine percent (21-29%) of patients who are prescribed opioids for chronic pain misuse them.

Everyone—from employers, physicians, and government leaders, to insurers, policy makers, and workers—all agree something must be done.

Whereas the goals of Workers' Compensation programs are to provide the necessary technologies and treatment to help workers get better, get back to work sooner, and to do those things in a cost-efficient way, the drive for new technologies to address the growing opioid crisis is essential.

Intent Solutions, an Atlanta-based medical device, software, and data services company is doing just that. The company's platform includes a daily assist device that controls prescription drug dosage and collects usage data that up to now has not been available. This data can prevent the misuse, abuses, and diversion of opioids and other prescription drugs. Current methods for tracking prescription drug adherence rely on pharmacy refill rates, which provide an inexact picture of prescription compliance or non-compliance by patients and caregivers.

Intent's dispensing device is called tad™ for "take as directed." It is a smart, portable, and programmable device which is easy to use by patients and caregivers. The supporting app it is similar to Fitbit and other lifestyle tools. It offers an engaging environment where prescriptions can be adhered to and daily dosage can be tracked and managed.

Given the nature of the opioid crisis, tad can be used to make sure if someone is injured on the job they don't get exposed to the misuse or abuse of narcotics. The tad device is used by both doctors and patients to provide better outcomes, offer an improved doctor-patient relationship, and afford better insight into what is and isn't working.

Intent Solutions is currently meeting with some of the largest corporations and Fortune 100 companies in Georgia, who are interested in how tad fits into the technology landscape of their Workers' Comp programs, and how the technology can help them improve health outcomes and reduce costs.

Sam Zamarripa is the CEO of Intent Solutions focusing on marketing and capital strategy. He is an avid reader of technology and data trends that impact the company's key markets. He holds a Bachelor of Arts from New College of Sarasota, Florida and a Masters of Public Administration from the Maxwell School of Citizenship at Syracuse University.

FALL PROTECTION AWARENESS

Equipment Operators need Fall Protection Too!

Accessing, operating or maintaining self-propelled mobile equipment often requires activities such as climbing ladders or walking on machinery surfaces which expose miners to fall hazards, in all types of working conditions. Modern mobile equipment is designed to minimize slip and fall hazards; but large machinery, new and old, can require work at heights with a fall potential that can cause serious injury or death. 25 miners died as a result of falls from heights from 2005 through 2012 in Metal and Nonmetal mines.

Best Practices

- **Inspect equipment for icy, wet, or oily areas at the start of each shift and whenever conditions change. Before climbing on, off or around mobile equipment, wear Footwear that is free of mud or other substances that could cause slipping.**
- **Persons climbing on or off mobile equipment should face the machine. Both hands should be free for gripping the ladder, handrail, or handhold. When necessary, a cord, rope, or other line should be used to lift and lower lunch pails, thermos bottles, or tools.**
- **Walkways should be no narrower than their original manufactured widths, constructed with slip-resistant surfaces, and securely attached. Unobstructed access should be provided to all areas of the machine where a person might travel.**
- **Handholds or handrails should be within easy reach at critical locations.**

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FALL PREVENTION SAVES LIVES

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BY THE READERS OF

WH Workplace Health

Gayle Farmer

"Our WC community has many layers and demands, it's a honor to work with someone who truly cares and has the same level of compassion of doing the right thing".

– Roberta Mike, Senior Field Claims Adjuster with Strategic Comp Services

Gayle Farmer
RN, MSN, COHN-S, CCM

Gayle is a healthcare veteran with more than twenty-five years' experience in patient care, utilization, quality and case management.
As a former Certified Rehabilitation RN, she served as Team Leader on the Spinal Cord Unit at Central Georgia Rehabilitation Hospital in Macon. She has provided patient care at Emory Crawford Long Hospital for trauma and other medically complex patients.

Gayle has a broad range of experience in occupational health and Workers' Compensation. She has worked in telephonic and field case management, risk management for a major trucking company, and served as clinical unit supervisor for a major insurer.

Most recently Gayle has worked for Wright Rehabilitation Services as a Field Case Manager, doing what she does best, for nine years. She excels at building relationships with medical providers and all case parties, massaging cases toward recovery and resolution. She is a catalyst, a problem solver and an educator.

The Team At *Workplace Health* would like to Thank all the Workers' Comp Case Managers and Case Workers for all your hard work, passion and commitment to helping get our injured workers the best medical care available.

Garlana Mathews, President

Exciting news for 2019!

The Savannah Workplace Health Conference

February 22, 2019

Fellow Human Resources, Workers' Comp and Safety Professionals! You don't want to miss this year's Workplace Health Conference held at Savannah Technical College! Here is a sample of some of the topics we will be covering – and these are just a few!

- **Light Duty / Return to Work Strategies and Issues**
- **Georgia Workers' Comp Update for 2019**
- **Preserving Human Capital: Active Shooter Risk and Response**

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WH Workplace Health

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PGx Use in Analgesia, Pain Management and Recovery for Personal Injury and Worker's Compensation Claims

PGx testing removes the guess work by identifying the safest and most effective analgesics for an individual. In interventional pain management, compliance testing helps confirm the safe use of potentially dangerous medications. When patient responses to prescription treatment protocols do not match with their intended purpose, PGx can identify reasons for lack of response and recommend optimal alternatives.

PGx at intake for personal injury or worker's compensation cases gives the physician an understanding of how the patient will respond without the trial-and-error which results in potential treatment complications and delays to a speedy recovery. This enables the physician to select medications optimally matched to the patient's genetic abilities! Shorter recovery times result in happier patients and employers!

PGx Applications in Pain:

Surgical Work-up
- Post Surgical Analgesia
- Right Drug
- Right Dose
- Avoid Adverse Drug Events
- Patient Satisfaction

Interventional Pain Management
- Explain Non-response
- Aberrant Urine Drug Test Results
- Right Drug
- Right Dose
- Increase Quality of Life

PI & Work Comp Recovery
- Right Therapy
- Right Dose
- Predict Response
- Shorter Pathway to Recovery

The Proof is in the Report – eLab's QuikMED®

eLab facilitates the physician's use of PGX results with QuikMED®, our internally developed validated report engine for correlating individual patient responses over a number of genetic pathways used in metabolizing a wide variety of common pharmaceuticals for interventional pain and recovery. The patient's genetic abilities for their current medication regime are conveniently presented on the first page with non-optimal medications listed first. eLab utilizes a modified physician's desk reference format with recommendations for either a different pharmaceutical using an alternative pathway or modification of the current medication dosage due to unique capabilities of the current pathway. Alternative medications are listed in the remainder of the report with optimal alternatives listed first in alphabetical order for ease of reference.

References:

1. Kalow W, Tang BK, Endrenyi L. Hypothesis: comparisons of inter- and intra-individual variations can substitute for twin studies in drug research.Pharmacogenetics. 1998;8(4):283–289

For more information, visit www.eLabSolutions.com or call 866-990-ELAB (3522)

Rev. 06.22.2018

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Fur bus Schedule

Monday, August 27, 2018

Leaves from Hyatt Regency Atlanta to Johnny's Hideaway on the hour beginning at 9:00 PM with runs back to the hotel on the top of each hour.

The last return bus leaves Johnny's Hideaway at 12:30 a.m.

Additional transportation sponsored by MedTrans GO

ATHENS ORTHOPEDIC CLINIC

New Horizons for Management of Acute Compartment Syndrome

Michael Shuler, MD
Hand, Wrist & Upper Extremity

Acute compartment syndrome (ASC) can be a catastrophic injury if not treated accurately and timely. ACS typically occurs after extremity trauma. Pressure builds in the muscles in closed compartments that can ultimately result in decreased perfusion and tissue death. Missed ACS can result in limb amputation and/or severe neurological and functional deficits.

The management of ACS, fasciotomy, typically requires two large incisions extending from the ankle to knee, or wrist to elbow. These incisions are usually left open for a week and can require skin grafts for ultimate closure. Fasciotomy can result in delayed healing of associated fractures, increased infection rates, chronic venous congestion and decreased strength. The management of ACS is not benign and should not be performed without consideration.

With so much on the line, it is critical to make an accurate and timely diagnosis of ACS. Current guidelines for the diagnosis of ACS are difficult at best since the diagnosis relies on intramuscular pressure measurements and clinical signs. Clinical signs can be very limited due to the fact that in many cases the patients can be obtunded due to intoxication, medical management or decreased consciousness. Pain can be difficult to access in these instances, and in some cases the patient might even be intubated.

Intramuscular pressure measurements (IMPM) can also be difficult to interpret. IMPM requires an invasive needle stick (typically 4 sticks for each compartment in the leg or arm). Measurements only provide a single measurement (snap shot) with no indication of how the pressures are or will change. Typical monitoring requires repeated measurements every two hours. The needles required to obtain IMPM are large bore and can be both painful and increase risk of disease transmission.

New technology and research may offer a new means to both monitor and diagnose ACS. Near infrared spectroscopy (NIRS) uses red light similar to a pulse-ox monitor to calculate the percentage of oxygenated and deoxygenated hemoglobin in the blood. NIRS is FDA approved to monitor perfusion approximately 2-3 centimeters below the skin. Its main use has been in anesthesia, to monitor brain perfusion during high risk surgeries. The sensor, a sticker, is similar to an EKG pad and provides multiple measurements a second. NIRS is continual, noninvasive and responsive in real time to changes in perfusion.

Our recent research has shown NIRS to be responsive and highly correlated to perfusion; however, there have been some challenges in monitoring traumatized tissue due to tissue heterogeneity and increased perfusion associated with inflammation and trauma. Work made possible through Department of Defense funding is underway to refine and validate this technology for widespread use in both the civilian and military setting.

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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