Spring 2019 Edition

WH Workplace Health

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2019 Regional Calendar of Events

See page 3

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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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Diagnostic Procedures in Low Back Pain: Facetogenic Pain

Will Epps, M.D.

Low back pain (LBP) is the chronic pain syndrome responsible for the greatest clinical, social, economic, and public health burden. It can result in serious and prolonged patient suffering, diminished quality of life, and disability. In the United States, roughly two (2%) percent of the adult population is disabled by chronic LBP. LBP is the most common reason cited for reduction of activity by young adults and for sick leave from work in all age groups.

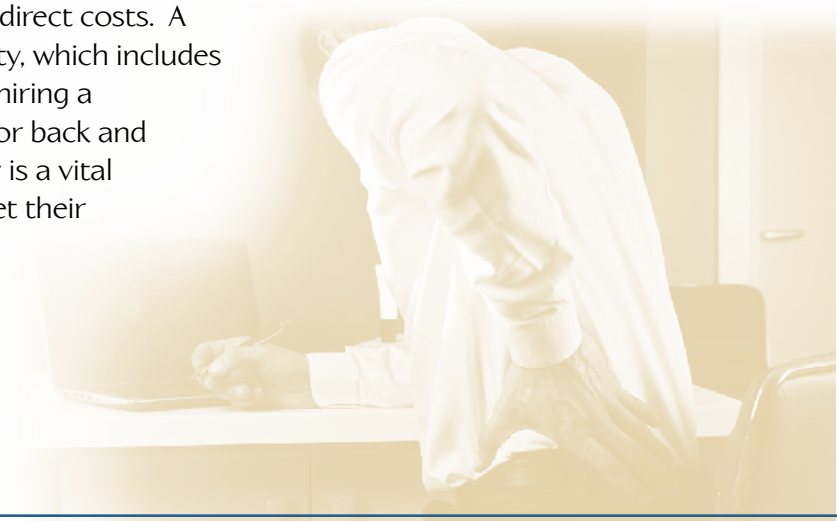
The diagnostic evaluation of patients with LBP can be challenging and requires complex clinical decision-making. Nevertheless, the identification of the pain generator is of fundamental importance in determining the appropriate therapeutic approach. This work-up often involves diagnostic interventions best administered by a board-certified interventional spine and pain specialist.

Lumbar zygapophyseal (facet joint) pain has been estimated to account for up to thirty (30%) percent of LBP cases. The lumbar facet joints are the posterior articular points of the lumbar spine. They are formed from the inferior process of upper vertebra and the superior articular process of lower vertebra. The joints facilitate motion of the spine in all directions and can be stressed or strained.

Lumbar facet joints can be anesthetized by injecting local anesthetic onto the medial branches of the dorsal rami (posterior spinal cord division) that innervate (supply with nerves) the target joint under x-ray guidance. The joint is considered the source of LBP if the pain is relieved or reduced after blockade of the medical branch nerve (MBN). If the first MBN block is successful in reducing pain, a second block is performed to rule out "false positives." After confirming the MBN as the pain generator, a radio frequency denervation procedure can be performed at the target facet joint to provide longer lasting pain relief (i.e. three (3) months or more) allowing the patient to be more functional and productive.

The cervical spine also has facet joints that may be stressed or strained. A similar diagnostic algorithm is utilized in the treatment of axial neck pain believed to be facetogenic in nature.

While the healthcare costs for LBP are substantial, they may account for as little as fifteen (15%) percent of total costs, with up to eighty-five (85%) percent coming from indirect costs. A large contribution to indirect costs is from lost productivity, which includes absenteeism, impaired productivity, and employer cost of hiring a replacement. Therefore, the use of diagnostic injections for back and neck pain which is not responsive to conservative therapy is a vital part of getting the patient on the road to recovery to meet their medical benefit and get them back to work.



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Will Epps, M.D., brings over five years of pain management practice experience to Alliance Spine and Pain Centers. Board certified in Anesthesia as well as Pain Medicine, Dr. Epps served abroad in the Navy as a Battle Surgeon/General Medical Officer. Dr. Epps is committed to finding comprehensive, innovative solutions to his patients' chronic pain.

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WH CONTENTS

2019 Upcoming Educational Events
Workplace Health Magazine gets around!

APRIL

April 2: Georgia Employers Association Spring Conference
Savannah, Georgia

April 9: Safety in the Workplace - Lunch and Learn
Atlanta, Georgia

April 9: Fastenal Distribution Tour
Atlanta, Georgia

April 10-12: HR Jacksonville Conference
Jacksonville, Florida

April 11: Georgia State Board of Workers' Compensation Regional Seminar
Valdosta, Georgia

April 11: Florida Bar Association Conference
Orlando, Florida

April 15: Red Hare Brewery Tour and Social
Marietta, Georgia

April 16-18: Georgia PRIMA
Savannah, Georgia

April 17: Georgia State Board of Workers' Compensation Regional Seminar
Lawrenceville, Georgia

April 18: Atlanta Claims Association Seminar
Atlanta, Georgia

April 24: GainCo Plant Tour
Gainesville, Georgia

April 25: QuickStart Workforce Development Tour
Atlanta, Georgia

April 28 – May 1: RIMS Annual Conference
Boston, Massachusetts

MAY

May 1-2: Georgia Mining Association Safety Workshop
Macon, Georgia

May 1-3: Florida State Association of Rehabilitative Nurses
Orlando, Florida

May 2: Georgia State Board of Workers' Compensation Regional Seminar
Savannah, Georgia

May 7-9: Self-Insured Workers' Compensation Forum - Southeast
Nashville, Tennessee

May 9: Emory Rehabilitation Outpatient Center Georgia Workers' Compensation Symposium
Atlanta, Georgia

May 9-10: Alabama Workers' Compensation Organization
Birmingham, Alabama

May 14-16: ISSA International Workers' Compensation/ Captives/Group Health Conference
Miami, Florida

May 16: Levy, Sibley, Foreman, and Speir and Fish, Nelson, and Holden
Workers' Compensation Seminar for Georgia/Alabama
Cobb Galleria Centre - Atlanta, Georgia

May 16: Atlanta RIMS Meeting
Dunwoody, Georgia

JUNE

June 5-7: Georgia Workers Compensation Association Spring Conference
Jekyll Island, Georgia

June 9-12: PRIMA Annual Conference
Orlando, Florida

June 9-12: Claims Management and Leadership
Bonita Springs, Florida

June 20: Alabama Department of Labor Seminar
Birmingham, Alabama

June 20: Atlanta RIMS Luncheon
Dunwoody, Georgia

June 23-26: Society of Human Resource Managers National Conference
Las Vegas, Nevada

June 26-29: Florida Bar Association Conference
Boca Raton, Florida

June 27: Moore, Ingram, Steele, and Johnson Claims Adjuster Seminar
Atlanta, Georgia

JULY

July 10: Georgia PRIMA Quarterly Meeting
Douglasville, Georgia

July 18-21: Florida Society of Interventional Pain Physicians
Hollywood, Florida

July 21-24: Florida Association of Self-Insured Annual Conference
Naples, Florida

July 29 – August 2: Southern Association of Workers' Compensation Administrators
Savannah, Georgia

July 30 – August 3: Florida RIMS
Naples, Florida

AUGUST

August 4-6: Alabama Self-Insured Association Summer Conference
Sandestin, Florida

August 11-14: Workers' Compensation Institution Annual Conference
Orlando, Florida

August 15-17: Florida League of Cities Annual Conference
World Center Marriott
Orlando, Florida

August 25-28: Georgia State Board of Workers' Compensation Annual Conference
Alpharetta, Georgia

August 25-28: HR Florida
Kissimmee, Florida

SEPTEMBER

September 4-6
Georgia Safety Conference
Savannah, Georgia

September 15: Case Management Society of America Seminar
Atlanta, Georgia

OCTOBER

October 9: Georgia Manufacturing Summit
Atlanta, Georgia

October 10-12: Bones Society of Florida
St. Petersburg, Florida

October 15-17: Southwest Florida PRIMA
Sarasota, Florida

NOVEMBER

November 6-8: National Workers' Compensation and Disability Conference and Expo
Las Vegas, Nevada

November 7: Alabama Department of Labor Seminar
Birmingham, Alabama

November 7: Georgia Employers Association Fall Conference
Greensboro, Georgia

Which Foot Care Doctor is for You?

Phillip Walton, Jr., M.D.

This topic continues to be the source of numerous questions, sometimes contentious debates and confusion, regarding the appropriate care of foot and ankle conditions. Both orthopaedic foot and ankle surgeons, as well as podiatrists are specialists in the care of foot and ankle conditions.

As a fellowship-trained orthopaedic foot and ankle surgeon, I do not believe blanket statements can be made about the level of care provided by both groups. As part of my fellowship training, I have worked alongside podiatric attendings, residents, and fellows, and know they are passionate care providers for the foot and ankle. Ultimately, choosing a foot and ankle specialist should be conducted in the similar manner as one would other healthcare providers. There are many well-trained orthopaedic foot and ankle surgeons, just as there are well-trained podiatrists. One should research the provider's educational background, scope of their current practice, specific clinical interests, and personal recommendations from friends and family, if appropriate.

For some patients, the choice of doctor is made easier by examining the medical education and training backgrounds of the two groups.

Orthopaedic foot and ankle surgeons complete undergraduate education at accredited four-year college or university followed by a four-year medical college. This level of training includes classroom-based coursework, cadaveric dissection in the first year, and hospital-based rotations covering various medical and surgical subspecialties. During this undergraduate training, medical students are also required to pass a national standardized exam, the USMLE, demonstrating proficiency in medical knowledge. When successfully completed, the graduate is granted the M.D. degree and is a medical doctor. Following completion of degree, those medical students interested in orthopaedic surgery participate in a residency program for five years of additional training, focusing on the surgical and non-surgical treatment of the musculoskeletal system.

Typically, residency programs include hands-on rotations in the various orthopaedic subspecialties, including: pediatric, sports medicine, hand and upper extremity, joint replacement, foot and ankle, spine, and orthopaedic oncology. After completion of orthopaedic residency, those interested in pursuing additional specialized training, an additional year of highly-focused clinical and surgical training foot and ankle surgery.

Podiatrists complete undergraduate coursework and then enroll in a four-year podiatric medical school where, upon completion, they are granted a doctor of podiatric medicine degree. Next, podiatrists typically enroll in a three-year residency program. Depending on the accreditation of the program, podiatrists will be granted a certification for specific regions of the foot, forefoot, midfoot, or hindfoot.

While both providers are trained in the care of foot and ankle conditions, podiatrists are not medical doctors. Furthermore, not all podiatrists have received certification for surgical treatment of the totality of the foot and ankle. In choosing a podiatrist, it is important patients find out about the podiatrist's certification for treating their specific condition.

No matter the choice, patients need to make sure their provider can effectively address their needs both from a surgical and non-surgical treatment perspective.

Phillip Walton, Jr., M.D., specializes in Adult Reconstruction of the Foot & Ankle, Sports Medicine of the Foot & Ankle, Total Ankle Replacement, and General Orthopaedics.

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Georgia Workers' Compensation Death Benefits

C. Todd Ross, Esq.

Georgia's Workers' Compensation Act provides benefits when an employee suffers death from a work-related injury. This article outlines the death benefits available following a compensable fatality.

MEDICAL: The employer is responsible for payment of related medical care provided to the injured worker prior to their death. This provision of medical benefits is pursuant to the fee schedule.

INDEMNITY: For a fatality that does not occur instantly, the injured employee is entitled to receive temporary total disability benefits until such time as their death as a result of the work-related injury. Thereafter, the dependents of the employee are entitled to TTD benefits as outlined below.

FUNERAL EXPENSES: Reasonable expenses of burial up to $7,500.00.

DEPENDENT SPOUSE: The wife or husband of a deceased employee is presumed dependent and entitled to any unpaid TTD. Currently, this benefit is capped at $230,000.00 for a spouse who is the sole dependent. However, when there are multiple dependents, the spouse is entitled to TTD benefits for the 400-week cap or until age 65, whichever is greater. Dependency ends once the widow(er) cohabitates in a meretricious relationship which is similar or akin to marriage.

DEPENDENT CHILDREN: Children of the deceased employee are entitled to share in TTD benefits until age 22, as long as they are enrolled in a post-secondary institution of higher learning. Critically, any child over age 18 who is physically or mentally incapable of earning a livelihood remains entitled to TTD benefits for the remainder of that incapacitated child's life. The Workers' Compensation Act defines a "child" to include dependent stepchildren, legally adopted children, posthumous children, and acknowledged children born out of wedlock but does not include married children.

OTHER DEPENDENTS: Dependency, in whole or in part, can also be shown by anyone able to establish dependency. For example, an aunt, uncle, cousin, or even a friend who can show to the satisfaction of the Board that the deceased regularly provided payments or support to them is entitled to dependency benefits.

NO DEPENDENTS: When there are no dependents to receive dependency benefits, the Insurer or Self-Insurer are required to make a payment to the State Board of Workers' Compensation of $10,000.00.

This outline of death benefits under Georgia's Workers' Compensation Act provides a broad overview, but many details remain. One such example is the fact that dependency benefits may not be suspended except upon written order of the Board. Adjusters must use caution when seeking to suspend dependency benefits or they may face fines, penalties, and assessed attorney's fees.

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-insured, and at State Bar of Georgia seminars. He is also very active with the Georgia Association of Manufacturers.


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Pictured: Holmes B. Marchman, MD

Options for Rotator Cuff Injuries

Holmes B. Marchman, M.D.

The rotator cuff is a set of muscles and tendons that helps stabilize the shoulder and keeps the arm in its socket. If the rotator cuff becomes damaged or torn, moving one's arm can be extremely difficult and painful.

Risk Factors

People who perform overhead motions repeatedly in their jobs or activities (carpenters, tennis players, painters, etc.) are at higher risk of injuring their rotator cuffs. Increased age is also a risk factor. The rotator cuff can be damaged by an acute injury, such as a fall.

Symptoms/Signs

Signs of a rotator cuff injury may be a dull shoulder ache that worsens when sleeping on the injured side. The patient experiences a loss in range of motion as well as weakness and/or pain in the upper shoulder, making simple activities, such as brushing your hair or scratching your back, difficult. The ache associated with a torn rotator cuff can extend from the shoulder to the elbow and can cause neck pain and headaches.

Diagnosis

Diagnostic imaging, such as X-rays, is necessary to rule out other issues, like arthritis or fractures, and an MRI may be recommended to assess the tissue of the rotator cuff. A physiatrist or orthopedist will perform a series of manual tests to gauge the responsiveness of the shoulder. Combined with imaging results, the physician can determine the specific injury and recommend an appropriate treatment plan.

Treatment

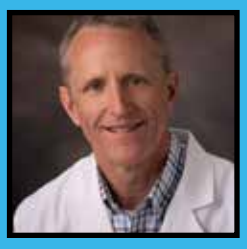
Surgery should only be considered after noninvasive, conventional methods have been exhausted, including home exercise, physical therapy, and over-the-counter anti-inflammatories/pain relievers. These things can strengthen the muscles surrounding the shoulder joint, decrease pain, and improve flexibility.

Surgery

Sometimes, surgery is the only option to repair the damage, restore range of motion, and stop the pain of an injured rotator cuff. There are several options depending on the severity of the tear. If it's only partially torn, an orthopedic surgeon may opt to trim or smooth the tendon. If the tendon is completely detached, the surgeon can reattach it to bone or stitch the sides back together. For the most severe cases, joint replacement may be necessary. Open repair is the traditional surgical method, but is only used if the tear is severe. Otherwise, the arthroscopic method, where an incision is made and small tools are used to repair the tendon, is preferable because it allows for a quicker recovery rate and less risk of post-surgery infection.

Follow-Up

Post-operative rehabilitation is extremely important; however, the recovery process varies from person-to-person. It also depends on a number of factors including: type of surgical repair, age, health, and activity level. Typically, the shoulder will be immobilized and in a sling for the first few weeks. Afterward, physical therapy can be utilized to improve range of motion and strengthen the arm for four to twelve (4-12) weeks. If rehab is successful, a patient can expect normal function to return in four to six (4-6) months.



Holmes B. Marchman, M.D., is a board-certified physiatrist at Longstreet Clinic, where he is a founding partner. He also serves as medical director for Northeast Georgia Medical Center's Inpatient Rehabilitation program. Longstreet Clinic is a multi-specialty practice with 11 locations across North Georgia. Workers' Compensation services span specialties including vascular surgery, general surgery (hernias), orthopedics, neurosurgery, physical medicine and rehabilitation, neurology and more.

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New Therapies Showing Promising Results

Daniel Nicholson, M.D.

What is Orthobiologics?

Orthobiologics, a field of musculoskeletal care, aims to utilize the body's natural healing response to treat acute and chronic conditions and injuries. These therapeutic options can treat conditions without surgery or as an adjunct to surgical intervention. When used for non-operative treatment, often, these therapies can be applied through simple procedures performed in the doctor's office.

Research shows improved outcomes with orthobiologics in treating a variety of conditions, including cartilage injuries, arthritis of the joints, as well as soft tissue conditions such as rotator cuff and ligament tears, muscular and tendon strains, and chronic tendonitis such as tennis or golfer's elbow.

What is PRP?

Available orthobiologic therapies include platelet rich plasma (PRP) and stem cell therapy. PRP therapy involves a simple blood draw which is then placed in a centrifuge to spin and separate the blood into layers. This process concentrates the platelets and growth factors—both of which play a central role in healing—into a specific layer which is extracted and used to activate the body's natural healing response. This is commonly performed by injecting the PRP into the damaged tissue site.

Stem Cells Enhance Natural Healing

Stem cells are naturally occurring cells with the ability to become a variety of tissues including cartilage, bone, muscle, tendon, or ligament. Sources for stem cells include bone marrow, adipose tissue, and donor stem cells known as allograft. Stem cell therapy has generated excitement within the orthopedic community as it enhances the body's natural healing response and provides cells which can take part directly in curing diseased and damaged tissue.

Results

Orthobiologics has had superior results to more standard treatment options when used for certain musculoskeletal conditions. For example, multiple research studies have demonstrated improved results with both PRP and stem cell use in the treatment of knee osteoarthritis when compared to steroid or other injections. Similarly, PRP therapy has been shown to improve tennis elbow when compared to the more common treatment of steroid injections and oral anti-inflammatory medications.

In addition to non-operative treatment, PRP and stem cells can be used as an adjunct to surgical intervention for musculoskeletal conditions. Numerous research studies have demonstrated improved rate and speed of healing with the addition of PRP or stem cells to common orthopedic surgical procedures such as repair of rotator cuff tears in the shoulder and cartilage injuries in the knee. Orthobiologics is one of the most studied fields of musculoskeletal care. While all the potential uses of these treatment options have yet to be discovered, orthobiologics provide options which are often less invasive and superior to more traditional treatment modalities.

Daniel Nicholson, M.D., is a board certified orthopaedic surgeon with fellowship training in sports medicine. He specializes in arthroscopic surgery of the shoulder, knee, hip, and elbow. He completed his residency at Northwestern University, followed by a fellowship at Baylor. He served as a member of the medical staff with Houston's Texans, Astros, Rockets, and Dynamos.

GEORGIA

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- Networking opportunities throughout the year, allowing members to effectively share and exchange ideas and solutions with their colleagues.

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Workplace Health Magazine is looking forward to covering the 2019 Conference and this years NEW Award winners!!

New Blood Pressure Guidelines May Mean More Workers' Compensation Claims

Michael Arington, Attorney

Employers and defense attorneys can expect more workers' compensation claims for high blood pressure because of new guidelines from two leading medical associations: the American Heart Association and the America College of Cardiology. These new requirements could mean more people will qualify for diagnoses of hypertension, resulting in more claims from first responders, claimants needing cardiac clearance for surgery, and claimant attorneys arguing hindrance to recovery claims.

These recently published guidelines subsequently have been endorsed by every major physicians association. After reviewing decades of hypertension cases, the new guidelines concluded hypertension was a serious health problem, calling for earlier diagnosis and treatment.

For decades, a diagnosis of hypertension required a blood pressure reading that exceeded 140/90. The new guides have lowered the threshold. A doctor can assign a diagnosis of hypertension and start treatment when blood pressure exceeds 130/80.

The Center for Disease Control estimates 75 million adults—one in three—has hypertension. The new guidelines estimate an additional 1.5 million adults will automatically qualify for diagnoses of hypertension, making them eligible for medications and frequent testing under insurance coverage, including workers' compensation. The new guidelines will result in more workers' compensation claims from at least three groups of employees: 1) first responders (fire, police, and corrections), 2) claimants needing cardiac clearance for surgery, and 3) claimants saying hypertension hinders treatment of their compensable injury.

Claimant attorneys in first responder claims are already arguing the new guidelines as evidence of hypertension to obtain workers' compensation benefits under the statutory presumption of compensability for heart claim. For the past ten years, claimant attorneys filed claims when a first responder went to a doctor and was diagnosed with hypertension, demanding medical treatment and impairment benefits equal to at least thirty-two weeks at the maximum compensation rate. The new guidelines would lower the threshold for claims by first responders.

These updated guidelines may also lead to more claims for cardiac surgery clearance. Many doctors send older claimants to a cardiologist for clearance before performing surgeries with long and difficult procedures or with extended recovery times. Under the new guidelines, more doctors will send more claimants more often for cardiac clearance because more patients will have blood pressure readings that qualify as hypertensive.

Claimants who do not get cardiac clearance for surgery will be expected to file claims under Florida's hindrance to recovery doctrine to make employers treat hypertension until it no longer interferes with effective treatment of the compensable injury. Hindrance to recovery benefits can last for years. Even claimants with hypertension—not facing surgery—can claims for treatment of hypertension under the hindrance to recovery doctrine. As long as a physician says hypertension hinders treatment of the compensable injury, or recovery from it, an employer may have to pay for hypertension.

The new guidelines can be found online at the American Heart Association or American College of Cardiologists websites.

Michael Arington received his undergraduate degree in Business Administration from the University of North Florida in 1978 and received his law degree from the University of Florida in 1983. He was admitted to the Florida Bar Association in 1984. His current practice areas are workers compensation defense and administrative law. Mr. Arington is a member of the Florida Bar Association and the Workers Compensation Section of the Florida Bar Association.

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CBD Oil and Opioid Reduction: A Win-Win

Carlos Giron, M.D.

The opioid crisis has birthed a paradigm shift away from dangerous pain medications toward a biopsychosocial approach to managing pain.

My Interventional Pain Management practice specializes in treating the most difficult of patients: workers with acute injuries that can develop into chronic pain conditions. In my practice, we've reduced opioid dosages by sixty to sixty-five (60-65%) percent while improving the patients' function. Among the methods utilized are diagnostic and therapeutic injection procedures, land-based physical and aquatic therapy, Cognitive Behavioral Therapy, non-opioid medications, and, most recently, the use of legal CBD/hemp oil.

This involves a relationship of trust built upon good communication with the injured person and setting realistic expectations for pain relief. Early in treatment, the patient is taught to own the responsibility for getting better. This shift in mindset is valuable in motivating their recovery of function and subsequent maintenance of their improvements.

"Give a man a fish and he eats for a day.
Teach a man to fish and he eats for a lifetime."

My patients are taught to become their own physical therapists when they have completed formal therapy. They enroll in local wellness centers and gyms via independent exercise programs designed specifically for them. This is much more cost-effective than intermittent rounds of physical therapy with poor continuity and accountability. The patient learns the coping skillset for their pain conditions and life situations in Cognitive Behavioral Therapy so they can maintain those skills for a lifetime.

In 2015, the State of Georgia established a Low-THC Oil Registry allowing several medical conditions to be treated with oil containing less than five (5%) percent THC, the psychoactive component in cannabis which produces the "high." When the Center for Disease Control (CDC) opioid guidelines were published in 2016 recommending significant opioid reductions, I took the opportunity to "medicalize" the use of CBD/hemp oil for patients with the support of law enforcement.

Between 2015 and 2018, I began working with patients who were starting to use CBD/hemp oil which seemed to be extremely beneficial in helping to wean and taper a patient from their opioid dosages. Those patients did not get high, rather; they experienced functional and cognitive improvements due to improved sleep, reduced anxiety, and often, less pain. I was able to lower their morphine equivalent daily dosages consistently which reduced cost and increased safety.

In 2018, chronic intractable pain was added to the conditions eligible for the use of legal CBD oil. I began dosing regimens and protocols that have improved the safety of treatment for hundreds of patients, thus far. It is medicine and should be prescribed by trained physicians in the Low-THC Oil Physician Registry, not by personnel at dispensaries, pharmacies, vape shops, gas stations, and health-food stores.

Dr. Carlos J. Giron, M.D., 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

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

State of the State

The State Board of Workers' Compensation (SBWC) is off to a fast start for this new year. Georgia was recognized as being number one state in the nation for business by *Site Selection Magazine* for a record sixth year in a row. Georgia is also sustaining record low unemployment rates and over 800,000 private sector jobs were added to the state's economy over the past eight years. Those numbers continue to grow under the newly-elected governor, Brian Kemp, who was sworn in on January 14 as Georgia's 83rd governor. Governor Kemp has pledged to build a stronger, more diverse economy and make Georgia number one for small businesses as well as provide a business-friendly government. Balancing the costs and benefits in Georgia's workers' compensation system plays a role in the economic development future.

Keeping Up With Claims

The Board's Integrated Claims Management System (ICMS) is open to claims handling professionals to file Board forms and access the claim file. **Upon completing of a training session, claims adjusters (non-EDI) will be able** to view ICMS claim files, file initial WC-1 First Reports of Injury, and other various Board forms in existing claims. In addition, claims handlers will be able to check the SBWC calendar to verify dates for hearings, mediations, rehab conferences, and oral arguments for claims in which they are listed as a party. There is also a section called "Legal Notices and Email Notifications" where users can view filings and generated documents for the last ten (10) day period. This includes Board Form filings, Approved Settlement Stipulations, Notices (hearing, mediation, conference, and oral argument), and Awards/Orders/Administrative Decisions. The SBWC is also granting access to insurers, self-insurers, and group fund users to view ICMS claim files, and file annual licensure documents (WC-131A, WC-26, WC-121 and WC-11). Like claims adjusters, users will also be able to check the SBWC calendar and Legal Notices, as well as Email Notifications.

Please note that pursuant to O.C.G.A. § 34-9-12(a) a WC-1 First Report of Injury is required to be filed for all claims, both medical only and lost time ones. Effective January 1, 2019, the Board will enforce compliance with the existing statute and issue penalties for non-compliance. The filing of a WC-1 First Report of Injury for all claims will provide the Board with accurate data regarding the numbers of medical only and lost time claims. To comply with identity theft concerns and cyber security threats, the social security numbers of employees have been removed from all Board forms as of December 1, 2018.

Upcoming Seminars and Events

These above filing requirements and other tips for successfully handling a workers' compensation claim will be discussed at the Board's 2019 Regional Educational Seminars. The Board's Public Education Committee will be travelling to five cities in Georgia to present a half-day seminar on hot topics in workers' compensation. These topics will include: return to work issues, panel of physicians, expedited medical treatment in compliance with the Workers' Compensation Act, investigation, common defenses to claims, supervening and superadded injuries, and much more. The seminars will be held: March 20th in Cartersville; March 28th in Newnan; April 11th in Valdosta; April 17th in Lawrenceville; and May 2nd in Savannah.

The Continued Opioid Matter

The Centers for Disease Control and Prevention (CDC) reported nationwide there were 17,029 opioid prescription overdose deaths in 2017. In Georgia, there were 568 reported opioid prescription overdose deaths in 2017. Therefore, the Advisory Council's Medical Committee continues to work on the issues involved in implementing an

opioid drug formulary into the Georgia workers' compensation system. This will include making a recommendation to the Georgia Legislature.

A Productive 2018

In 2018, the Board received 15,272 requests for hearings and 16,527 stipulations for full or partial settlements. The ADR Division scheduled 5,926 mediations and eighty-one (81%) percent were successfully resolved. The Hearing Division issued 1,235 awards and orders and the ADR Division issued an additional 714 orders on motions.

We hope to see you at a conference or seminar event soon.

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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Workers in the Gig Economy: Employee or Contractor

Ken Bishop, Attorney

The "Gig Economy" describes forms of contingent work arrangements that require digital platforms. This name has been given to task-driven jobs like Uber, Lyft, Thumbtack, and apps for getting groceries, for example. When a Gig Economy worker is injured while performing a task, questions arise regarding their employment status. Is the person an employee of the individual requesting the task? Are they an employee of the company who owns the app? Or, are they independent contractors? Since the answer to this question can be murky, many state legislatures have been stepping in to provide clarity.

In 2018, six (6) states have passed Gig Economy laws saying workers using portable service apps are independent contractors as opposed to employees. Georgia had a similar bill that passed the State House recently, but it was tabled by the State Senate at the end of this year's legislative session.

As the Gig Economy continues to grow, Gig workers hoping for workers' compensation coverage face an uncertain future. Their employment status, or lack thereof, and therefore their eligibility for workers' comp benefits is often determined by how tightly the Gig company controls their schedules and other aspects of their work.

In the California federal court case *Lawson v. Grubhub Inc. et al.*, a judge ruled in January 2019 in favor of Chicago-based Grubhub Inc., an online and mobile food ordering company which allows users to receive deliveries from local restaurants. The judge ruled that since Grubhub did not control how the driver made deliveries, his transportation, his appearance, or his schedule, he was considered to be an independent contractor. While the case centers on wage and hour issues, some experts say it is significant for the Gig Economy and the misclassification question, which could determine whether workers can receive workers' compensation benefits.

Georgia's bill, like those in the other six states, states plainly:

"The marketplace contractors performing services arranged through the marketplace platform's digital network are independent contractors and are not agents or employees of the marketplace platform."

The bill makes it clear that workers and the platform company would have to agree in writing they are an independent contractor. Legislators in Georgia and across the country are supporting legislation that focuses on creating a clear test for worker classification in the on-demand sector because this sector is not going away. It is the future.

Kenny Bishop, Attorney, focuses his practice in Workers' Compensation defense, representing employers and insurers in all aspects of workers' compensation claims and disputes throughout Georgia. More information can be found at http://www.eraclides.com/.

Tapering Off Opioids

Keith C. Raziano, M.D.

Opioid overuse in the treatment of acute and chronic pain has been a well-established issue and has created many problems in the clinical setting. Over the past several decades, this overprescribing culminated in an opioid crisis which has resulted in multiple regulatory changes to help curb the use and prescription of opioid medications.

However, altering a treatment algorithm in a chronic case is more difficult than merely tapering medications. Appropriate patient care should not have a singular focus of medication dose. A good patient outcome is measured not only by the patient's satisfaction, but on their overall functionality, too.

When tapering opioid medications, the use of adjuvant medication as well as non-pharmacologic treatment is critical. As it relates to adjuvant medication, the opioid medications are able to be substituted for safer, non-addictive options. Topical medications, antidepressants, and antiepileptic medication have been well-established in the medical literature as being effective. The safety that they bring is an added benefit. But, unfortunately, adjuvant medications are seldom successful by themselves in allowing for meaningful opioid tapering. Adjuvant treatment is also required.

A survey of options available as a substitution for opioids includes cognitive behavioral therapy and comprehensive residential rehabilitation programs which have well-established outcomes in the literature. The only drawback to these treatment options is that they may not be readily available to the patient on a daily basis. Fortunately, a newer option has become available in the form of distraction based therapy, virtual reality therapy. Virtual reality therapy is a very meaningful option which has become available to patients who are undergoing opioid tapering. It allows for true distraction from the daily struggle with chronic pain and is an option which is also available to them on a daily basis. The approach is that a patient is provided a headset which they are able to utilize on a daily basis and the comfort of their own home. It can be utilized multiple times per day and allows the patient in pain to reach for a treatment option other than a pill bottle. Due to the technological nature of the treatment, compliance can be tracked so that adherence to the treatment protocol can be maintained. Outcomes in chronic pain populations have shown true benefit and this is a treatment algorithm which needs to be embraced and expanded in the medical community.

Keith C. Raziano, M.D., is the CEO and Managing Director of The Physicians. He received his undergraduate degree in Biology from the University of Miami and his medical degree from the University of Miami School of Medicine. He completed his surgical internship at Orlando Regional Medical Center. He later completed residency training at Emory University Hospital, where he served as the chief resident and clinical instructor.

Dr. Raziano is board certified in Physical Medicine and Rehabilitation and subspecialty board certified in Pain Medicine. He has an academic appointment in the Department of Physical Medicine and Rehabilitation at Emory University and was voted Attending of the Year in 2008.

In certain regions of the U.S. 25% of working age adults cannot pass a drug test.

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Outpatient Total Joint Replacement

Mary J. Albert, M.D.

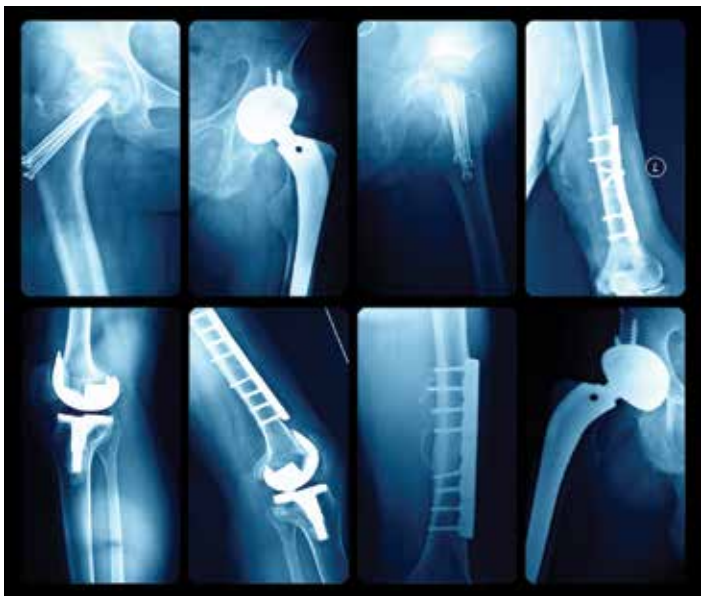
Total hip and knee joint replacements are some of the most successful procedures performed by orthopaedic surgeons. Although traditionally thought of as an inpatient surgery (requiring a hospital stay), innovations in anesthesia, improvements in surgical techniques, and the development of new protocols for managing post-operative pain now allow replacement surgery to be safely performed in the outpatient setting.

The goal of joint replacement is to provide a patient with a durable and well-functioning joint while minimizing complications. Once the decision has been made to have replacement surgery, your doctor will discuss whether or not outpatient surgery is an option. One important consideration is the patient's overall health status as outpatient joint replacement is most appropriate for healthy individuals without serious medical conditions.

Another essential element is having adequate home support. Family members or friends must be available and comfortable with caring for the patient once home. Instructional materials are provided that include a step-by-step description of the procedure and what to expect before, during, and after surgery. An educational class for the patient and family members offers additional information and another opportunity to ask questions. The nursing staff will explain the details of wound care and how to identify any problems.

Several measures are used for controlling pain after surgery. Preoperative medications, both oral and intravenous, are administered to help with postoperative pain. The anesthesiologist can perform a nerve block to decrease pain. During surgery, long-acting local anesthetics can be injected to numb the soft tissues around the joint. This multimodal approach is designed to keep the patient comfortable at home and reduce the need for narcotic medications which have serious side effects such as sedation, nausea, and constipation.

When surgery has been completed, the physical therapy staff will assist to stand and walk, climb stairs, and use the restroom. They will also work with family members on activities of daily living. When all goals are met, the patient is discharged to home, usually three to four hours after surgery. During the first week, a physical therapist will come to the patient's home to continue the rehab program.



The transition of joint replacement surgery to the outpatient setting allows patients to recover in the comfort of their own home. The advantages include a reduced chance for hospital-acquired infections, fewer complications, and an increase in-patient satisfaction with their experience. More information on hip and knee replacement surgery is available in the education section of the Resurgens' website at www.resurgens.com.

Mary J. Albert, M.D. specializes in Total Joint Replacement, Outpatient Hip and Knee Replacement, Anterior Hip Replacement, and Partial Knee Replacement.

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Shoulder to the Grindstone

Mark Kamaleson. M.D.

According to the National Safety Council, overuse is a leading cause of workplace injury. In fact, the data shows overuse causes more than thirty-three (33%) percent of all work-related injuries and is, by far, the largest contributor to workers' compensation costs.

Overuse injuries are caused by repetitive motion tasks. Overuse is also the number one reason for lost work days. These injuries are a result of common activities such as lifting, pushing, turning, holding, carrying, and/or throwing.

Shoulders are particularly prone to injury due to their high degree of mobility. The shoulder is a complex structure and not as stable as other joints. It is comprised of a ball-and-socket joint with three major bones: upper arm bone (humerus), shoulder blade (scapula), and collarbone (clavicle). For the shoulder to remain in a stable position, it must be anchored by muscles, tendons, and ligaments, all working together to give a lot of mobility in the joint.

Shoulder injuries can be painful and cause limitations in movement which prevents employees from performing their job duties. These injuries can vary from strains and sprains to more serious injuries requiring surgery. Some of the most common shoulder injuries are:

Impingement

Shoulder impingement is a painful pinching of soft tissues in the shoulder. This is a common workplace injury when employees raise their hands above their shoulders and irritate the tendons of the rotator cuff muscles.

Rotator Cuff Tears

The rotator cuff is a group of muscles and tendons in the shoulder and holds the upper arm bone into the shoulder socket. It keeps the arm stable while allowing it to lift and rotate. Too much stress on the rotator cuff can cause a painful tear. A rotator cuff tear can happen because of a fall with an outstretched arm or lifting something heavy using a jerking motion. It can also develop over time as part of the normal wear and tear of aging, especially if a worker has done repetitive motions on a long-term basis.

Dislocated Shoulder

The ball of your upper arm bone fits into a socket in your shoulder blade. If the ball slips completely out of its socket, your shoulder has "dislocated." The shoulder joint is extremely mobile, which is why you can swing your arm all the way around, as if throwing a baseball. However, because of this mobility, the shoulder is one of the easiest joints to dislocate. When it becomes dislocated, there is a sensation in the shoulder "popping" or "rolling" out of place. The most common cause of a dislocated shoulder is a traumatic event, such as a fall or a direct blow. The dislocation results in immediate and severe pain and could be followed by muscle spasms as well as a decrease in mobility, muscle spasms, bruising, swelling, and numbness.

Most work-related shoulder conditions can be treated with injections, anti-inflammatories, and therapy. Only a minority of patients will require surgery. An orthopedic surgeon can outline the nonsurgical treatments and minimally-invasive surgical options available to treat shoulder injuries.

Mark Kamaleson, M.D., is a board-certified and fellowship trained orthopedic surgeon at Optim Orthopedics in Savannah, Georgia. For more information, visit optimhealth.com or call 912.644.5384.

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Kyphoplasty: Advanced Spine Treatment

Nickie Creviston

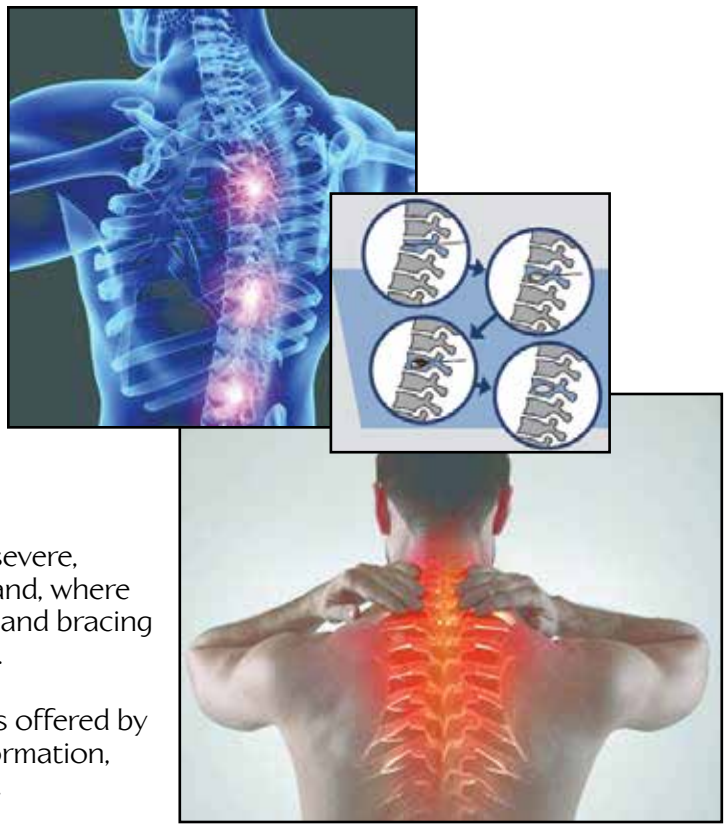
A vertebral compression fracture (VCF) is caused when one or more of the bones (vertebra) within the spinal column weakens and partially collapses. On the job, a VCF can result from a hard fall or impact to the head. Such injuries most often occur in the thoracic spine, but can also occur in the cervical or lumbar spine. VCFs can be especially painful and debilitating. Left untreated, they can result in further damage to the spinal cord.

Fortunately, advances in interventional radiology have given us a highly effective, minimally invasive treatment for vertebral compression fractures that results in less pain, a quicker recovery, and lower infection rates compared with major surgery.

Kyphoplasty—also known as "balloon kyphoplasty" or vertebral augmentation – is an outpatient procedure done under local or general anesthesia. It takes about thirty minutes to treat each fracture and the patient can usually return home the same day.

During the procedure, a type of X-ray called a fluoroscope is used by the doctor to guide a needle into the fracture or area of compression. A special balloon is then inserted and inflated to open up a space or "cavity" inside the vertebra. Then, a fast-drying bone cement is injected into the cavity, restoring height to the vertebrae and relieving pain and other symptoms almost immediately.

"The vast majority of patients have reported that kyphoplasty provides immediate pain relief and has improved their quality of life," says Dr. Venkat Tummala with Lakeland Vascular Institute (LVI), home of some of Florida's most experienced physicians at performing kyphoplasty. "Another benefit to this procedure is that it is proven to decrease the need for pain medication, which is especially important to patients who want to avoid the long term use of opioids and the risk of addiction it comes with."



Tummala and his colleagues perform the kyphoplasty procedure at LVI's outpatient center, a state-of-the-art facility using the most advanced technology and monitoring equipment.

"Many patients prefer to have this procedure done in an outpatient location versus a hospital," says Dr. Fakhir Elmasri of LVI. "In addition to the convenience, there is a much lower risk of exposure to hospital-acquired infections. Also, the cost of the procedure at our outpatient location is considerably less expensive than at a hospital."

Kyphoplasty is recommended for patients with persistent, severe, focal back pain related to fractures of the vertebral body; and, where conservative management – including bed rest, analgesics, and bracing – has failed, resulting in a reduction of daily living activities.

Kyphoplasty is one of several minimally invasive procedures offered by the physicians of Lakeland Vascular Institute. For more information, please call 863-577-0316 or visit www.lakelandvascular.com.

Nickie Creviston is a graduate of The University of Central Florida with a Bachelors in Science, she is the Director of Marketing for Radiology and Imaging Specialists. Radiology and Imaging Specialists (RIS) is physician-owned and for over 45 years has provided our community with the highest quality medical imaging services.

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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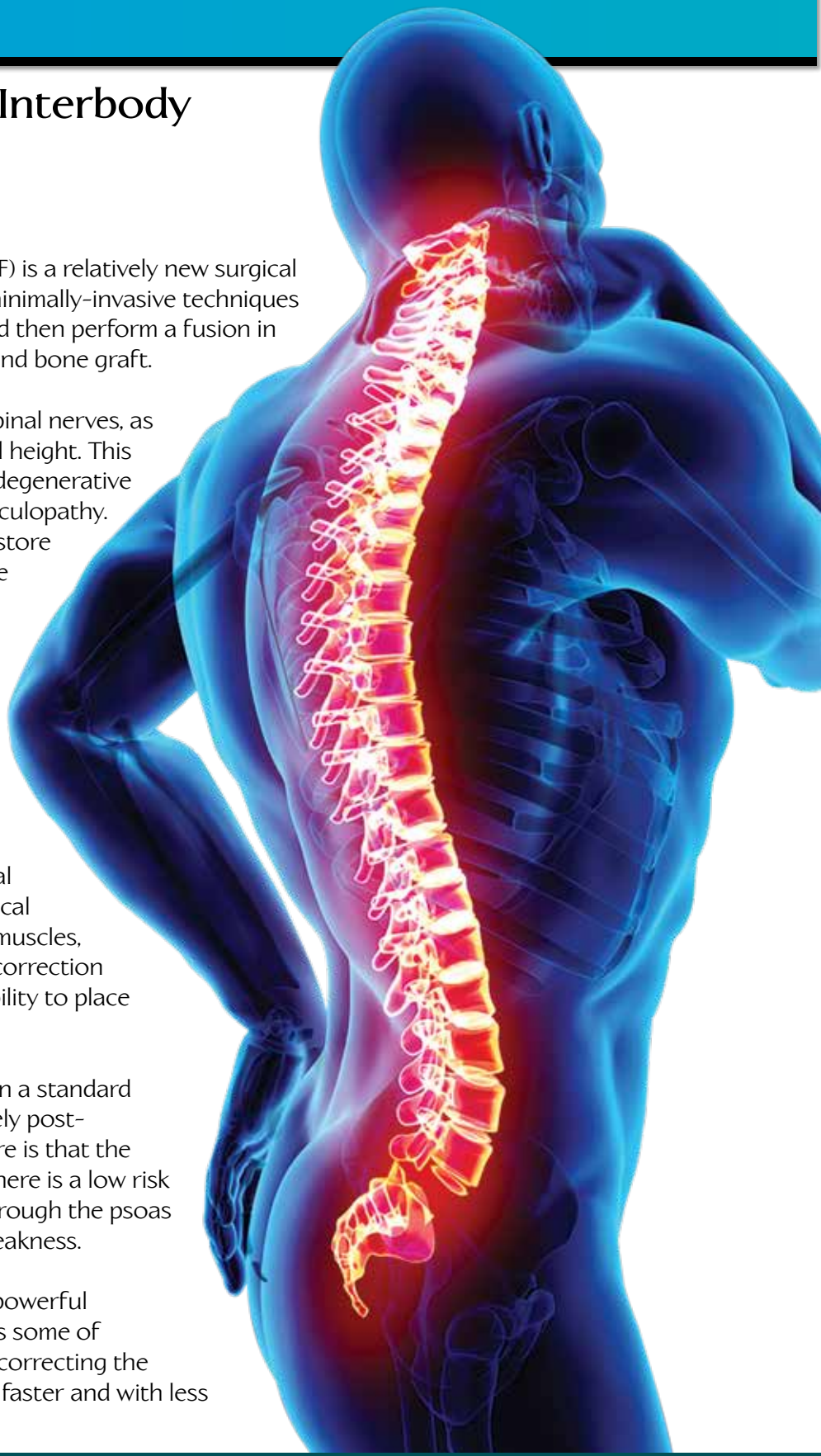
Extreme Lateral Lumbar Interbody Fusion (XLIF)

William W. Brooks, M.D.



Extreme Lateral Lumbar Interbody fusion (XLIF) is a relatively new surgical procedure which allows the surgeon to use minimally-invasive techniques to perform a complete lumbar discectomy and then perform a fusion in the interbody space with a mechanical cage and bone graft.

This technique indirectly decompresses the spinal nerves, as well as restores the lumbar disc to the normal height. This surgery is indicated for patients with lumbar degenerative disc disease, lumbar stenosis, and lumbar radiculopathy. Additionally, this procedure worked well to restore lumbar lordosis (excessive inward curve of the spine) and correct scoliosis (curvature of the spine.)

The surgery is performed through a small incision with the patient in a lateral decubitus position (where the patient lies on his/her side) under general anesthesia. The hip flexor muscle (psoas) is gently moved out of the way allowing the surgeon to directly visualize the lumbar disc space from the lateral side of L1/L2 to L4/L5. Advantages to this surgical technique is less damage to the midline back muscles, easier access to the disc spaces, and greater correction of spinal balance and alignment due to the ability to place larger bony cages.

Additionally, patients often recover faster than a standard posterior fusion and have less pain immediately post-operatively. The disadvantage of the procedure is that the L5-S1 disc space can often not be accessed. There is a low risk of injury to the network of nerves running through the psoas muscle that could cause numbness pain or weakness.

Extreme lateral Lumbar Interbody fusion is a powerful minimally-invasive spine technique that avoids some of the pitfalls of posterior lumbar surgery while correcting the patient's condition and allowing them to heal faster and with less postoperative pain.

William W. Brooks, M.D., is a board certified and fellowship trained orthopedic spine surgeon who specializes in the conservative and surgical treatment of all spinal conditions. He earned his medical degree from the University of Georgia and did his residency at the Atlanta Medical Center followed by a fellowship in spine at New England Baptist Hospital in Boston. Dr. Brooks is from middle Georgia and is proud to serve the community where he grew up. He has authored numerous national medical journal articles, medical text book chapters, and has made presentations on a national level.

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Addressing Evolving Workplace Violence

Rushe Hudzinski

Workplace violence incidents are statistically growing, but organizational preparedness and effective crisis policy management has been intensely avoided. In reaction to workplace violence incidents that have widespread impact: communities are focused on public safety and organizations are fixated on assets, stakeholders, and ongoing operations creatomg a chasm that needs to be addressed and closed.

Human Resource Professionals, Safety Managers, Risk Management Professionals, and Executive Business Leaders provide a perfect strategic liaison role when provided with the essential tools to analyze risk, improve crisis plan efficiency, and conduct preparedness training in collaboration with first responder entities and law enforcement.

The *Preserving Human Capital* education and training program initiative was created to furnish these necessary components to organizations before workplace violence incidents occur to achieve alignment between organizational policy, public safety response, and minimization of loss of life. In addition, addressing employee mental health, drug usage, domestic violence affects, workers' compensation coverages, and applying necessary changes in corporate insurance liability plans is essential to the organizational workplace violence response blueprint.

Questions for the Organization:

- Do you have a policy and training program in place to assist staff in identifying potential dangers? What does it include?
- Do you go beyond the *"Run, Hide, Fight"* platform as an annual training module?
- Do you have mental health support structures for employees for handling critical life situations?
- Do you have mental health support structures to assist after a workplace violence event occurs?
- Do you have a policy and training program to assist staff and new hires in reacting to a terroristic incident and minimizing chaos?
- What should you expect from Law Enforcement, EMS, and Fire when they respond to your location? What essential information do they need when they respond to be the most efficient?
- How do you let folks know which areas are safe and which areas are in crisis without using normal means of communication?
- Are organizational emergency plans in check with the reality of public safety response?
- Are you prepared for a lone wolf incident?
- Do you have the correct organizational insurance and workers' compensation plans in place that include coverage for this event?
- Is your organization prepared for the liability involved as lawsuits are triggered?

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

Rushe Hudzinski is a professor of Management and Human Resources at Savannah Technical College and serves as the Business Strategy Educational partner for Workplace Health/ SelectOne Network. She is a graduate of Elmira College and Syracuse University. She holds the Global Professional in Human Resources (GPHR) and the SHRM Senior Certified Professional (SHRM-SCP) certifications and presents on strategic human resources and risk management trends and practices.

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What is Post-Acute Rehabilitation?

Michael Samogala, RN, CRRN, CBIS

In relation to health care in today's world and economy, many facets of care go undefined and are not considered to be consistent with standards of quality operation and outcome.

> *"The current process of care transitions for individuals with disabling conditions is both ineffective and inefficient. There is a need for clinicians with the necessary knowledge and skills to advocate and facilitate transitions that result in the greatest value to the individuals, their families, and the healthcare delivery system. A review of the literature reveals significant problems with transition to post-acute care (PAC) settings. Care is fragmented, disorganized, and guided by factors unrelated to the quality of care or individual outcomes."* (*Gage, 2009; Sandel et al.*)

As this statement communicates, the effects of fragmented care and services provided affects the success and outcomes of those individuals needing and/or requiring complete post-acute rehabilitation services. We see these negative effects in all phases of the care continuum which include acute individual rehabilitation, skilled nursing facilities, the post-acute care arena, and in the general community.

Transition to post-acute facilities includes preparation and validation of services provided, ideally outside of a pre-determined length of stay and progress parameters. Post-acute settings should focus on the individual and significant other in relation to a rehabilitation process that includes, but is not limited to, a systemic, comprehensive, multidisciplinary assessment in the development of realistic, measurable, and functional goals.

NeuLife Post-Acute program is a Commission on the Accreditation of Rehabilitation Facilities (CARF) accredited brain injury and residential rehabilitation program focusing on the identification of barriers disturbing the rehabilitation process and final discharge outcome. Data from NeuLife's accredited program shows approximately eighty (80%) percent of catastrophic injuries return home or to their communities.

One publication supporting the cost relationship of individuals who received comprehensive post-acute care have proven to have more successful discharge outcomes as well as overall financial cost savings. (*COST/BENEFIT ANALYSIS FOR POST-ACUTE REHABILITATION OF THE TRAUMATICALLY BRAIN-INJURED INDIVIDUAL, M.J. Ashley, David K. Krych, Centre for Neuro Skills Bakersfield, CA Robert R. Lehr, Jr. Department of Communication Disorders and Sciences and Department of Anatomy, School of Medicine, Southern Illinois University, Carbondale, IL 1990*).

In summary, true post-acute services focus on the client's personal needs and barriers, their environment, and the ability to adapt to any actual deficit. The responsibility to acknowledge this challenge lies with all who provide care and services.

Michael Samogala RN, CRRN CBIS, has been directly involved in providing professional nursing and education services to the healthcare community for over 40 years. Most notably receiving board certification in rehabilitation nursing and as a brain injury specialist, he continues to provide professional credited continuing education programs to multiple professionals across the country, and remains in the position of Director of Corporate Education, NeuLife Neurological Services. Michael continues as an active member of The American Nurses Association, The American Association of Rehabilitation Nurses, The Academy of Spinal Cord Injury Professionals, The Academy of Brain Injury Specialists.

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3D Printing Advances in Spine Surgery

Vamsi K. Kancherla, M.D.

Three-dimensional (3D) printing is a rapidly-growing industry, surprisingly, in the area of spinal surgery. Given the complex anatomy of the spine and delicate nature of surrounding structures, 3D printing has the potential to aid surgical planning and procedural accuracy through computer made implants.

Implants are now better than and even resist corrosion and breakage. Equally important, structural enhancements such as the introduction of porosity and a nanoscale environment have augmented cellular integration (i.e. biologic fusion) without sacrificing durability. In the field of spine surgery, we consistently rely upon optimal engineering in pursuit of the best possible outcomes for patients. The addition of 3D printing to interbody implants known as fusion cages has greatly enhanced the opportunity to achieve biologic spinal fusion.

In the era of smaller incisions and minimally-invasive approaches to the spine, orthopaedic spine surgeons are increasingly dependent on biologics and implant technology to achieve their ultimate goal: biologic fusion (i.e., cells meeting cells to become one non-mobile bone mass). While this does not negate the importance of good surgical carpentry, 3D printed spinal implant technology has emerged as one avenue of improving patient outcomes.

More traditional implants often do not have the best biologic properties or favorable architecture to promote biologic fusion. The concept of material properties and good engineering has been well studied by orthopaedic experts performing total hip and knee replacements. Over a period of decades, we have seen optimization of total joint implants to include the most compatible metals. Even the structural properties have evolved to include more porous, lattice-like structures. Such changes overall have clearly yielded better clinical outcomes for our patients.

Not surprisingly, cutting edge technology is initially met with increased upfront cost and subsequent resistance to widespread acceptance. As we see more competition in the implant market, we can expect the cost of surgery to be neutralized by more favorable pricing, better patient outcomes, fewer failures, and lower likelihood for revision surgery. Imagine the scenario where a smoker or diabetic has undergone ACDF (anterior cervical discectomy and fusion) or ALIF (anterior lumber interbody fusion) surgery with a non-porous and/or plastic (PEEK) based implant; more likely than not, fusion may not occur and the patient will be back for revision surgery. In this example, 3D printed technology may offset the less ideal biologic milieu (smoking, diabetes, obesity, liver disease, kidney disease, etc.) and still yield a solid fusion outcome the first time around.

The evolution of minimally-invasive spine surgery into the modern era will continue to rely upon the best surgical techniques. However, the next frontier may ultimately borrow from next generation engineering and 3D printed spinal implants may be the key to even better patient outcomes.

Vamsi K. Kancherla, M.D., specializes in Minimally Invasive Spinal Techniques, Artificial Disc Replacement, Cervical, Thoracic, & Lumbar Spine Surgery, Adult Degenerative Spine Disorders, Robotic & Navigated Spine Surgery, Complex Spine Surgery, and Scoliosis.

With 104 physicians, Resurgens Orthopaedics provides specialized expertise and broad experience in the areas of 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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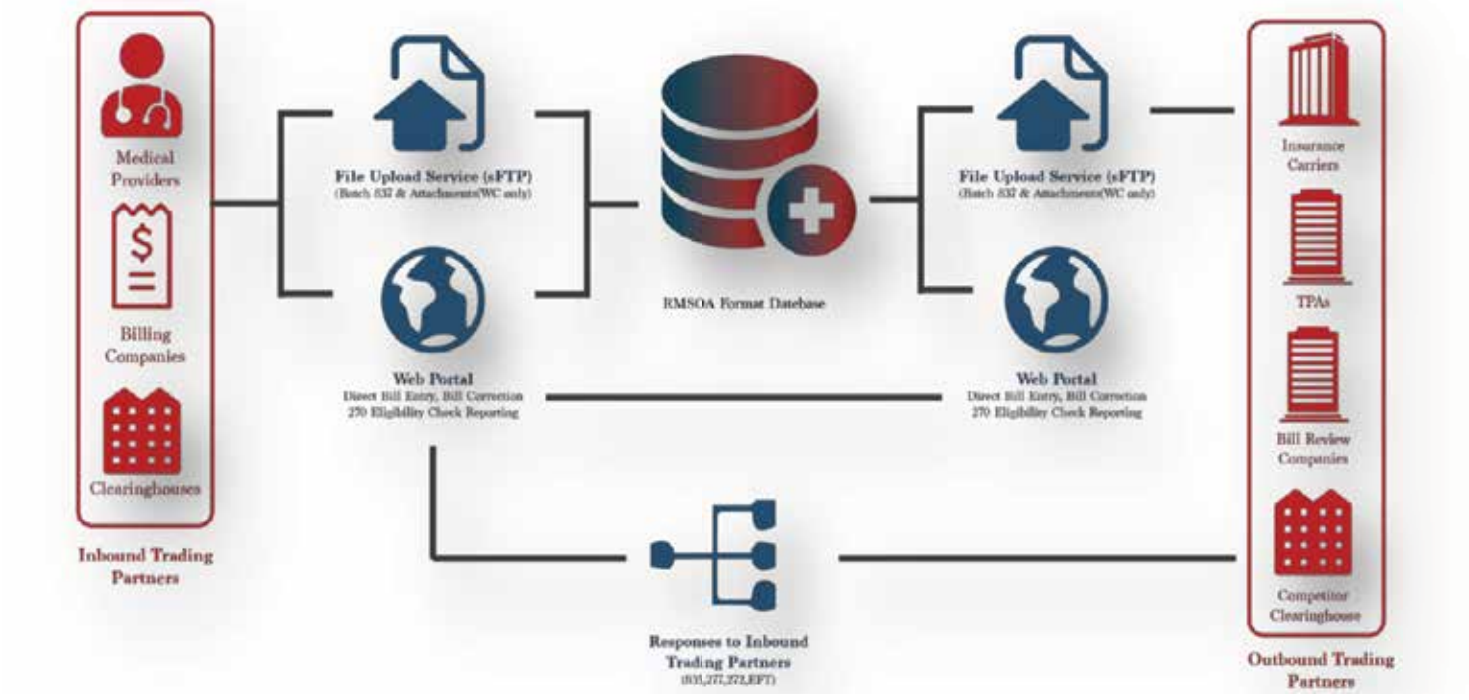

Our philosophy is the longer a claim is open the more challenging it gets for everyone. Swiftivity tools address revenue cycles for medical providers and are designed to get care approved faster reducing patient disability and lost time.

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Bennie Jones, President/CEO, Swiftivity

Buried beneath managing your average file count, balancing empathy, and file closing rates—you can occasionally steal a moment to help someone hurt on the job who is anxious to get back to work.

After overcoming process challenges, you can still be stymied in helping because you are waiting. Waiting for the ever burgeoning "pre-authorization" process or a nurse or a report or information from physicians confirming how the medical treatment is appropriate for the approved workers' compensation injury.

The Swiftivity-Electronic Medical Authorization Portal transforms the claims review process from a Pony Express-type delivery and authorization process to the fast-paced world of "now." The authorization portal is part of a clearing house system (electronic bill payment). The portal addresses one of the biggest treatments and claims adjustment bottle necks—the medical authorization process.

There are zero barriers for a workers' compensation adjuster to utilizing our medical authorization portal to transform your work experience of being the person who might deny and delay claims to getting the injured worker back to his/her life.

The overall bill payment process delivers a state-of-the-art revenue management tool. However, we are aware features of the overall system can be reduced to one primary benefit for the workers' compensation adjuster—a more informed and engaged claim. The results are reduced claims cost and increased claimant satisfaction.

Key Adjuster Benefits

- Improved response to medical provider and claimant request while providing tools to allow the claims adjuster immediate okay or ability to ask for more information
- Provides an "audit trail" for the adjuster, claim management, and medical provider
- Allows "two-way" communication between claims adjusters office and medical providers, including automated conference call scheduling

How Does the Electronic Medical Authorization Portal Work?

- When a medical provider requests a treatment authorization, an email is sent to the workers' compensation adjuster with a secure link
- The link goes to the secure requested authorization within the Swiftivity System
- Process involves no system integration or adoption; it simply powers an efficient way to authorize medical care services
- Full integration into a claims management system is available via batch or file
- Allows insurance carrier and physician to audit and process individuals' responsible for accepting and denying authorization requests

If an adjuster has an email account, they have the tools to assist all the people in the claimant's life while becoming someone who helped rather than one who delayed or denied.

Bennie Jones, President/CEO of Swiftivity, an operating division of Risk Management Solutions of America, Inc. (RMSOA) co-founded nearly thirty years ago. Prior to establishing RMSOA Swiftivity, Bennie was President and Founder of Health Cost Consultants (HCC), a managed care provider servicing the workers compensation market. He also served in positions of Insurance Broker, Division Claims Manager, Account Manager Supervisor, and Adjuster in his career with Liberty Mutual Insurance Companies. He currently serves in leadership roles on local, state, national insurance and several community service boards.

Complex Medical Malpractice Claim Solution

The Case

A regional hospital referred a challenging medical malpractice claim involving a child diagnosed with cerebral palsy, epilepsy and significant developmental delays to Independent Life. Due to the nature of the claim the life expectancy, medical cost projections and valuation ranges were each hotly contested items.

The Challenge

The continuing low interest rate environment reduced the benefit of tax free payments using a structured settlement. Combine that with existing insurers' reluctance to recognize the degree of impairment in complex cases and structured settlements are less attractive than cash. Consequently, prior to Independent Life, the hospital's legal and risk management team had elected to not present a structured settlement as part of the negotiation process on this case.

The Independent Life Difference

Complex, high-value cases like this one demand a thorough medical life expectancy evaluation. Only Independent Life is willing to invest the resources needed to accurately evaluate the risk and set a realistic life expectancy. Independent Life is willing to back that up by offering a higher paying life annuity. The lesser offerings of competitors lead to no settlement. Independent Life's offer leads to a discussion on realistic life expectancy and spurs a settlement.

The chart below shows a complete market survey for a $5,000 monthly benefit guaranteed for 30 years and life thereafter for the injured child:

	RATED AGE	MONTHLY BENEFIT	PREMIUM COST	PREMIUM INCREASE	% INCREASE
Independent Life	**60**	**$5,000**	**$1,292,992**	-	-
Berkshire Hathaway	27	$5,000	$1,468,429	$175,437	14%
American General	37	$5,000	$1,512,164	$219,172	17%
Metropolitan Life	29	$5,000	$1,516,530	$223,538	17%
Prudential	16	$5,000	$1,598,465	$305,473	24%
Pacific Life	15	$5,000	$1,639,344	$346,352	27%
Mutual of Omaha	NA	$5,000	$1,644,196	$351,204	27%
New York Life	9	$5,000	$1,721,763	$428,771	33%

After including Independent Life, the plaintiff and defendant reached a settlement using a structure for this complex claim.

"Since the economic crisis of 2008, the claims and legal communities have seen the value proposition of a structured settlement erode. Independent Life has taken a substantial step forward to restore the economic benefit of a structured settlement. Ideally, the improved economics of the structured settlement will help create win-win scenarios on the most complex claims."

– **BRYAN ROTELLA, ESQ.**
GenCo Legal, gencolegal.com

Independent Life

The Importance of Underwriting

Christopher M. Bua, J.D.

If you have been settling workers' compensation claims for a long time and it seems that annuity writers are not recognizing reduced life expectancies for severely injured people like they used to, you are not wrong.

At its peak, twenty-six name-brand insurers vied for this business. With that many chasing a small market, some used overly-aggressive underwriting as a means of justifying a lower price and winning cases. Only when people continued living and collecting benefits more than what the insurer could afford did companies face the fact that being overly-aggressive was not a viable business strategy. Coupled with the 2008 financial crisis, many carriers left the settlement market. Those remaining shifted toward being ultra conservative. They could do that because they could still get all the business they wanted with a larger share of a shrinking market.

Consider this 2008 case of a five-year old with severe cerebral palsy from a birth injury. The life expectancy for people with cerebral palsy varies greatly depending on the degree of incapacity. As shown in the table below, six competitors offered rated ages ranging from 24-64. The table below shows the cost for $11,000 per month, starting immediately where the only difference is the rated age. Note the wide range of costs to provide these benefits, so underwriting really matters to the person footing the bill.

Company	Rated Age in 2008	Price*	Rated Age in 2018	Price
Co. A	64	1,970,714	Left the market	-
Co. B	31	2,543,923	Left the market	-
Co. C	51	2,256,377	Left the market	-
Co. D	24	2,754,876	21	3,255,829
Co. E	39	2,634,872	13	3,436,776
Co. F	53	2,467,876	44	2,698,968
Independent Life	**Not Available**	**Not Available**	**60**	**2,257,177**

By 2018, three of these had left the market. Of those remaining, when presented with exactly the same medical records, it was clear they have gotten much stingier in their offering. Arguably two of these set a price merely to be polite. They clearly don't want to win this case.

Independent Life was formed partially in response to lack of competition and this deterioration in underwriting. We do an in-depth medical evaluation, produce a thoughtful analysis, and make an attractive if somewhat conservative offer.

This shows how much good underwriting can save you. Applying some of the savings to increase the benefits can lead to a resolution of the case. A win-win scenario.

James D. Atkins is the Chief Executive Officer of the Independent Life Insurance Company. James is the former CEO of Legal & General America. Under Atkins leadership, LGA grew sales more than 50% over its previous high- water mark and became the carrier of choice for high valued term life insurance and top 10 provider of protection focused life insurance sold through the independent distribution channel.

OSHA's Final Rule on Silica Exposure

Matthew Pruitt

Do you cut, saw, polish, grind, sandblast, etch, and/or break stone in any way? If you answered yes, there's a good chance OSHA's new ruling affects your business.

Crystalline silica is a common mineral found in the earth's crust. Materials like sand, stone, concrete, and mortar contain crystalline silica. It is also used to make products such as glass, pottery, ceramics, bricks, and artificial stone. Respirable Crystalline Silica is made up of very small particles (at least a hundred times smaller than ordinary sand) that are created when stone is broken, cut, crushed, etc.

As an employer, you are required to protect yourself and your employees from silica exposure. Over-exposure to silica has the potential to lead to silicosis, an incurable lung disease.

OSHA's Respirable Crystalline Silica standard for general industry and maritime requires employers to limit worker exposures to the substance and to take other steps to protect workers. Here are the new rule requirements:

- Assess employee exposures to silica to see if it may be at or above an action level of 25 μg/m3 (micrograms of silica per cubic meter of air), averaged over an eight-hour day;
- Protect workers from respirable crystalline silica exposures above the permissible exposure limit (PEL) of 50 μg/m3, averaged over an eight-hour day;
- Limit workers' access to areas where they could be exposed above the PEL;
- Use dust controls to protect workers from silica exposures above the PEL;
- Provide respirators to workers when dust controls cannot limit exposures to the PEL;
- Use housekeeping methods that do not create airborne dust, if feasible;
- Establish and implement a written exposure control plan identifying tasks that involve exposure and methods used to protect workers;
- Offer medical exams—including chest X-rays and lung function tests—every three years for workers exposed at or above the action level for thirty or more days per year;
- Train workers on work operations that result in silica exposure and ways to limit exposure; and
- Keep records of exposure measurements, objective data, and medical exams.

General industry and maritime employers must comply with all requirements of the standard effective June 23, 2018. Medical surveillance must be offered to employees who will be exposed at or above the action level for thirty or more days a year starting on June 23, 2020.

Matthew Pruitt is the Executive Assistant to the Vice President at the Elberton Granite Association. He serves on the Board of Directors for the Natural Stone Council and is the OSHA/MSHA committee chair within the NSC. He is also a member of the Georgia Mining Association and Natural Stone Institute safety committees. His background covers twenty-one years in the metal/non-metal mining industry including six years in the monument production industry of Elberton, Georgia. His accolades include the 2008 SC Governor's Award for Volunteerism and the Mining Association of South Carolina 2013 Community Citizenship Award.

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For more info and to register please visit: kidschancega.org

Hints for Choosing Occupational Health Services

Terry W. Kuhlwein, M.D.

Most employers will, at some point, require medical services for their employees. Depending on the nature of your business, this could entail a variety of services, including evaluation and management of work-related injuries and illnesses, as well as a variety of exams, forms, certifications, and more. One can get lost in what is required, which is why it's detrimental to find a qualified, competent, and reliable occupational health provider (OCC) to protect your employees, your company (ensure you meet all federal, state, and local guidelines), and your budget.

Here are some helpful tips to use when looking for an occupational health service provider or re-evaluating your current provider:

Inquire
Ask employers in your area who they utilize for their OCC. Are they satisfied with the results? Are evaluations completed and results returned in a timely manner? Do their employees have to wait to be seen by a provider? What are the clinic's strengths and/or weaknesses?

Investigate
Once you have identified a potential provider, contact the office and request information on the practice. Determine what their office hours are and what they do for after-hours service. Are appointments required, or do they also accept walk ins? Do they provide all of the services that your business would require?

Inform
Be clear with the OCC staff as to the nature of your company/business. Ask them if they have worked with similar companies. Be specific in the type of services you need such as workers' comp, drug screens, post offer employment exams, etc. Also, state your preference for receiving results, such as electronically, mail, or returned with the employee.

Invite
Ask the OCC to visit your job site(s) to get a better understanding of the work your employees do and the potential hazards involved. You may also take the opportunity to show the OCC the modified duty you may have available for injured employees.

Initiate
Once you have identified an OCC you prefer, you should initiate the relationship and develop written protocols with the clinic clearly outlining services to be provided, how results are to be reported, and the expected time frame.

Innovate
Schedule periodic meetings with the clinic staff and providers to review how the relationship is working for both parties and look for improvement opportunities.

Terry W. Kuhlwein, M.D., is a board-certified family physician with extensive practice experience in emergency medicine and family medicine and occupational medicine. Since 2010, he has been practicing at Mayo Clinic in Florida where he serves as the Medical Director of Occupational Medicine, the Chair of the Mayo Clinic Florida Environmental Health, Safety, and Security Subcommittee, and he is a member of the enterprise-wide Mayo Clinic Environmental Health and Safety Committee.

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Married to Construction – In Love with Safety

Daniel Nunn

I've been a builder since my earliest memories of carving out bunkers for my GI Joes in our backyard (or site work as we'd say today.) Like many of my colleagues, I was introduced to Construction by a parent or role model who glorified the ability to create profound structures with human tenacity. As a teenager, I was fascinated with so many moving pieces by so many moving craftsmen and craftswomen it seemed like organized chaos.

After serving my country, I returned home and committed to Construction. I put a ring on that finger after being involved almost thirty years.

Our marriage has been the typical roller coaster of give and take you find in any relationship, although finances almost drove us to divorce in 2007. It was only through a strong faith and reputation that we conquered those challenges and continued to prosper.

We were recruited by a great company in Savannah who shared many of the same values we were accustomed. In 2015, my employer re-branded our safety culture and I was introduced to a new Safety that looked nothing like any I'd seen. Others I'd worked with had been rude and impatient. This Safety was different; it was personable and caring. Construction has never been a touchy-feely kind of partner and communication was definitely not its strong point. This new Safety caught my eye, but I was not prepared when I was partnered with Safety and given the lead on our office's ONELIFE culture.

It didn't take long for Safety to have my undivided attention. After so many years with Construction, it was invigorating to dive into unknown territory and continuously learn something new. Construction had influenced me to be process-driven over the years. This mindset was valuable when courting Safety toward a new committed relationship. The experiences Construction had long before we were involved created a culture of minimalism, achieving as much as possible with as little resources used as necessary.

This mindset of Construction is not necessarily wrong as it allowed the industry to stand the test of time. However, once I got a good look at Safety, my expectations could not help but rise. Safety does come with a higher demand for my resources, but the return on that investment is priceless.

People often ask me if I'm afraid I'll lose Construction because of my relationship with Safety. The reality is partnering with Safety is the only way I can ensure I am forever with Construction. ONELIFE.

Daniel Nunn, Owner and Safety Director for Choate Construction Company, has twenty-three years of experience in the construction industry. Originally from San Diego, He resides with his wife and two children in Savannah, GA.. He is also the Chairman of the Savannah Safety Shared Information Group.

Symptom Magnification: Disarm and Engage

Jaime Sigurdsson

When an injured worker presents to a medical professional with symptoms that don't match their diagnosis or seem exaggerated what is the expected plan of care? How do you determine which symptoms are sincere? Which limitations are valid? What is an appropriate treatment plan? And, how many diagnostic tests do we allow? What's the best course of action?

Before responding, you need to define symptom magnification and explain the difference between magnification and malingering:

> *Symptom magnification* is the conscious or sub-conscious behavioral pattern where the individual's subjective reports of symptoms are inconsistent with the known impairment. The individual exhibits a tendency to under-rate their abilities and/or over-state their limitations; however, it does not imply intent.
>
> *Malingering* is when the magnification is both conscious and intended for a variety of secondary gains such a financial compensation, avoiding school, work, or military; obtaining drugs, etc.

Malingering is often tied to fraud; whereas symptom magnification without the goal of a secondary gain may simply require a deeper interaction between the medical professional and the patient to determine the cause of the behavior.

When a worker gets injured, the initial reaction is fear. However, the difference between an injured worker and someone who injures themselves when not working is the ability to guide and determine their medical treatment. An injury that does not occur at work allows the injured to make all treatment decisions, whereas, if it happens on the job, the injured worker is told which doctor to see, when treatment is authorized, and which medications are approved. Although the medical professionals chosen for the injured workers are often the best in their field, the choice of provider was not made by the injured worker and therefore preconceived notions of "not being in their best interest" are often formulated. If this is, in fact, the belief of the injured worker, then the goal is to disarm and engage from day one. However, often this is not the case and therefore their need to be heard is compounded with each and every medical choice that is made for them.

Physical therapy is often the easiest place to disarm and engage due to the frequency and duration of the rehabilitation process. Instead of constant physician visits, the injured worker may attend therapy two to three

times a week for up to eight weeks, depending on the extent of the injury. The therapist can defuse any fears or exaggeration needs during the patient's initial evaluation. They should keep the patient involved in the treatment plan and goal-setting. This aids in recovery which aids in returning the patient to work as quickly as possible.

In addition to physical therapy, medical providers can help patients overcome symptom magnification by putting more weight on the objective findings and test results. It is vital for the providers to listen to the injured worker's concerns and have a discussion about the expected symptoms that correlate with the diagnosis and the normal course of treatment. It is important for the medical provider to be the authority and expert and direct the plan of care. When patients are given the expected rate of recovery and have reasonable expectation of residual pain while feeling heard, they are more likely to accept the process and return to work when able to perform the essential job demands safely.

With a goal of return to work, all barriers to rehabilitation should be identified, including symptom magnification. When the barrier has the potential to be overcome, then it's the responsibility of the medical provider to acknowledge the limitation to recovery and make every attempt to eliminate or reduce its role in the patient's treatment. By listening to the injured worker, disarming and engaging them, and allowing them to commit to their recovery, one can facilitate faster discharge to work and back to function.

Jaime Sigurdsson, CEAS, Director of Workers' Compensation, CORA Physical Therapy, graduated from the University of Florida with a BS in Exercise Science. Jaime has worked with CORA for over seventeen years and oversees CORA's WorkTracks program.

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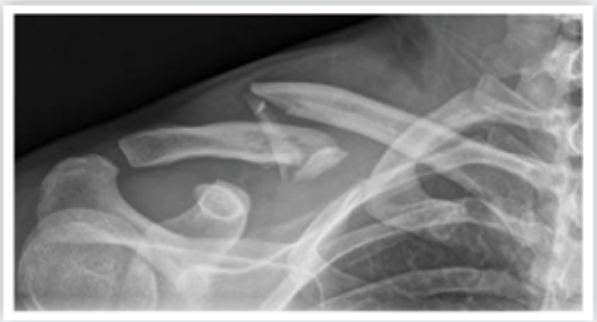
WH WORKPLACE HEALTH

Injuries of the Clavicle and AC Joint

By: Brett Rosenberg, MD

The clavicle is also known as the collar bone. It attaches to the chest at the sternum and attaches to the rest of the shoulder at the Acromioclavicular Joint (AC joint). Some of the most common injuries to young active adults, especially manual laborers and athletes, happen in these two areas of the shoulder. Depending on the mechanism of injury, one will usually suffer a clavicle fracture or an AC sprain (which is sometimes called a shoulder separation). Clavicle fractures are one of the most common types of fractures, with 75-80% of them occurring in the middle 1/3 of the bone. Both clavicle and AC injuries occur due to a fall onto the shoulder, but clavicle fractures can occur as a result of a fall onto an outstretched hand.

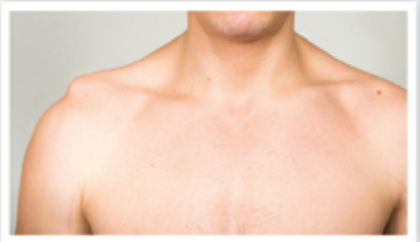
How are they diagnosed? Both clavicle fractures and AC sprains can be diagnosed by x-ray and physical exam. Both can cause an abnormal prominence at the site of injury. The stability of the AC joint is due to ligaments at, and adjacent to, the joint. Falls often cause disruption of those ligaments while muscle pull on the bone causes the visual deformity of the shoulder.



AC separations are differentiated into Grades I-VI with I-III being the most common. Grade I is non-displaced and grade III is 100% displaced.

Clavicle fractures are usually differentiated into displaced or non-displaced. The amount of displacement determines treatment.

How are they treated? Type I, II and most type III AC sprains are treated non-operatively with good results. We recommend a brief period of sling immobilization, rest, ice and physical therapy to prevent stiffness and accelerate recovery. Although we sometimes operate on Type III sprains on some elite athletes or high demand laborers, most studies indicate there is no guarantee of a better outcome, except perhaps cosmetically. I recommend that the patient consider waiting 6 weeks on Type IIIs before they decide to proceed with surgery.



If treated operatively, the ligaments are reconstructed after reducing the clavicle to its original location. New techniques allow for this to happen, for the most part, arthroscopically.

With regards to clavicle fractures, if a fracture is non-displaced or is shortened less than 2cm, we recommend non-operative treatment which includes a sling for 2 weeks, followed by gentle range of motion exercises. Assuming appropriate healing on follow-up x-ray, the patient will start strengthening at 6 weeks with a physical therapist.

Although operating on clavicle fractures in the past was rare, over the last 10 years, multiple studies have indicated that if there is greater than 2cm of displacement or overlap of the bone ends, especially with comminution (multiple fragments), surgery is recommended. This is due to the risk of non-union (not healing). Even if the fracture heals in poor position, it may lead to decreased shoulder strength and endurance. Open reduction and internal fixation with a titanium plate and screws is the gold standard for repair. Furthermore, recent research shows that operative fixation is more cost-effective than non-operative treatment.

Recovery after surgery. Recovery is similar for both injuries. Patient wear a sling for 7-10 days and start strengthening at 6 weeks. Patients are usually ready to return to work by 3 months, but contact sports are not recommended for at least 6 months.

Up to 30% of patients will have the titanium plate removed if it is an irritant, but it is not recommended for at least 6 months.

If you have questions about any of the services we offer or would like to schedule an appointment, please contact Alexis Hill, Director of Workers' Compensation, at (706) 286-7666 or ahill@AthensOrthopedicClinic.com.

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