Fall 2019 Edition

WH Workplace Health

Expanding the Regional Reach of Workplace Health to include Florida and Alabama

Regional Calendar of Events
See page 3

Transformational Medical Case Management Services in the Southeast

COMING SOON! Telehealth platform for mental health evaluation, treatment, counseling, and IME's for injured workers

Find out more inside on page 28 >>

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- 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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Pre-Cert Coordinator: Linda Bertrand 404-920-4956 lbertrand@spinepains.com

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In memory of Michelle Byrd

We want to take this chance to say goodbye to our co-worker, but most importantly, our friend, Michelle. She was an inspiration to all who knew her and she touched so many lives. I'm proud of her for the character she has shown us all though her struggle with cancer. You are missed already… so much… and by so many. Your goodness will be a part of our lives you touched forever. Goodbye, my friend.

Dr. Robin Fowler, Alliance Spine and Pain Centers

From the moment I met Michelle, it was clear she was a giant. She was tenacious, fiercely independent, and fearless to the end. She was the matriarch in the office and her presence was inspiring. I miss you, Michelle.

Dr. Zwade Marshall, Alliance Spine and Pain Centers

I will never forget you, Michelle. One of the strongest, most honest, and compassionate women I've ever met. One hell of a storyteller, too. She never stopped fighting. Thank you for everything.

Dr. Shalin Shah, Alliance Spine and Pain Centers

Michelle, you were an amazing person, work mother, and friend. All these years we have worked together, you showed me how to be a fighter and how to have confidence in all I do. You will always have a special place in my heart and I will forever be grateful for the time I had with you. Love you always.

Alicia Trammell, Workers' Comp Manager at Alliance Spine and Pain Centers

Michelle, thank you so much for being an awesome boss and for always having our back. Forever… you will live in our memories and in our heart. We love you, sleep peacefully.

Linda Bertrand, Workers' Comp Pre-Cert coordinator at Alliance Spine and Pain Centers

WH Workplace Health

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2019 Upcoming Educational Events
Workplace Health Magazine gets around!

August

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

15: Society for Human Resource Managers Chapter Lunch Meeting
Jacksonville, Florida

15-17: Florida League of Cities Conference
Orlando, Florida

22-23: American Case Management Conference
Orlando, Florida

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

25-28: Human Resources Florida
Kissimmee, Florida

September

4-6: Georgia Safety Conference
Savannah, Georgia

12: Society for Human Resource Managers Breakfast Meeting
Jacksonville, Florida

13: Optim Orthopedics Lunch and Learn
Savannah, Georgia

19: South Florida PRIMA
Ft. Lauderdale, Florida

19: Georgia Manufacturing Alliance Plant Tour
Grenzebach Corporation
Newnan, Georgia

20: Central Florida PRIMA
Orlando, Florida

27: Society for Human Resource Managers Georgia Workforce Strategy
Statesboro, Georgia

October

30-3: Self-Insureds of America National Conference
San Francisco, California

3: Society for Human Resource Managers Meeting
Jacksonville, Florida

9: 2019 Georgia Manufacturing Summit
Atlanta, Georgia

9: Georgia PRIMA
Griffin, Georgia

10: Physio/Emory CEU Seminar
Atlanta, Georgia

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

17-19: Georgia Occupational Health Nurses Conference
Lagrange, Georgia

20-23: Florida PRIMA
Naples, Florida

21: Atlanta Chapter of Risk and Insurance Management Society Golf and Tennis Tournament
Atlanta, Georgia

30: Georgia Workers' Compensation Association Fall Conference
Atlanta, Georgia

November

4-5: Risk and Insurance Management Society Enterprise Risk Management Conference
New Orleans, Louisiana

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

7: Alabama Department of Labor Seminar
Birmingham, Alabama

7: Georgia Employers' Association Fall Conference
Greensboro, Georgia

7: Society for Human Resource Managers Breakfast Meeting
Jacksonville, Florida

12: Tampa Bay PRIMA
Lunch and Learn
Clearwater, Florida

21: South Florida PRIMA
Lunch and Learn
Hollywood, Florida

December

5: Workers' Compensation Claims Professionals Holiday Party
Tampa, Florida

5: Society for Human Resource Managers ½ Day Legislative Update
Jacksonville, Florida

6: Central Florida PRIMA
Orlando, Florida

January 2020

9: Society for Human Resource Management Breakfast Meeting
Jacksonville, Florida

15: Georgia PRIMA Quarterly Meeting
TBD

February 2020

6: Society for Human Resource Management Lunch Meeting
Jacksonville, Florida

13-14: Atlanta Chapter of Risk and Insurance Management Society Educational Conference
Atlanta, Georgia

28: Destination Workplace Health Conference
Savannah, Georgia

March

5: Society for Human Resource Management Lunch Meeting
Jacksonville, Florida

April

6-9: National Case Management and Transitions of Care Annual Conference
Chicago, Illinois

22-24: Georgia PRIMA Annual Conference
Savannah, Georgia

May

3-6: Risk and Insurance Management Society
Denver, Colorado

7: Society for Human Resource Management Breakfast Meeting
Jacksonville, Florida

17-19: Georgia Employers' Association Spring Conference
Savannah, Georgia

June

4: Society for Human Resource Management Lunch Meeting
Jacksonville, Florida

14-17: PRIMA National Conference
Nashville, Tennessee

July

9: Society for Human Resource Management Breakfast Legislative Update
Jacksonville, Florida

27- Aug 2: Risk and Insurance Management Society Florida Meeting
Naples, Florida

August

16-19: Workers' Compensation Institute Annual Conference
Orlando, Florida

Not just a Spinal Cord Injury - Dual Diagnosis

Michael Samogala, RN, CRRN, CBIS

An individual experiencing both a traumatic brain injury (TBI) and a spinal cord injury (SCI), described as a dual diagnosis, can present significant challenges compared to sustaining these injuries separately. According to data, greater than sixty percent (60%) of those individuals presenting to the trauma center with a spinal cord injury are later identified with a dual diagnosis. An occult TBI diagnosis is commonly first identified by behaviors which may be perceived as an inability to learn, a negative emotional reaction to the spinal cord injury, decreased motivation, or non-compliance in the rehabilitation process.

Focused attention must be given to the many medical complications which may accompany both the TBI and SCI and how a dual diagnosis further impedes both diagnoses and treatment. Statistics regarding dual diagnoses indicate a sixty-seven percent (67%) re-hospitalization rate directly related to additional diagnoses or complications. One of the most detrimental challenges for patients with a dual diagnosis is the inability to learn and retain information associated with their injuries and early identification of possible complications.

Within a true Commission on Accreditation of Rehabilitation Facilities (CARF) accredited post-acute program, the dual diagnosis and the specific needs related to these individuals are addressed in a formal, repetitive education program by all disciplines including: medicine, nursing, physical therapy, occupational therapy, speech language pathology/cognitive specialists, neuropsychology, and psychiatry staff and evaluated in a consistent manner. The appropriate documentation and communication of the identified needs and barriers to effective education/retention are shared with all individuals involved in the client's care and discharge.

Behaviors may be apparent in various forms dependent on the injury area and the severity of the TBI. Procurement of consistent supervision—if needed and reassessment by post-acute rehabilitation professionals within the client's community—is a necessity. As we now understand TBI, individuals may experience significant deficits far beyond their original date of injury. The responsibility to these individuals does not end once they are discharged from any facility in that traumatic brain injury is most often a life-changing and/or catastrophic event demanding frequent reassessment, intervention, planning, and evaluation.

In final analysis, the consequences of dual diagnosis in various discharge settings regarding behavioral incidents, length of stay, medical/nursing/therapy hours, and economic resources can all be negatively affected, mostly due to the occult cognitive and learning deficiencies that often go unrecognized until a later time. Early identification and specialized post-acute intervention within a true CARF accredited post-acute program, such as NeuLife Rehab, may assist in meeting the unique and complex demands of this population, thus improving their quality of life, level of independence, and reducing the negative impact on the health care system to ensure the most successful sustained outcome.

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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Healthy Footwear in the Workplace

Michael J. Clark, M.D.

Our feet are something we regularly take for granted. When they are in pain—whether from an injury or chronic wear and tear—we wish it could have been prevented. Frequently, our daily shoe choices, especially those worn while working, can lead to discomfort and the development of painful, chronic conditions.

Many orthopedic injuries occur as a result of a slip and fall and have the potential to be life-changing. Therefore, most workplaces have stipulations on the types of shoes worn. At places such as construction zones or warehouses, a steel-toe work boot may be required to prevent foot injury. Crush injuries or lacerations can be devastating and possibly require surgery, many times leading to chronic foot pain. Slip-resistant shoes may also be recommended in workplaces where poor traction may lead to a heightened risk of falls. Workers should regularly inspect the treads of the shoe's soles to ensure they are not worn down or clogged with debris.

Less dangerous work conditions are an overlooked area in terms of proper footwear. For those whose jobs require standing for long periods, it is important their shoes are supportive and comfortable. To determine proper shoe support for patients in my office, I take the shoe they are considering and push firmly on the toe and heel areas, bending the sole to determine rigidity. If it is easily manipulated, then it is not supportive enough. Less supportive shoes transmit greater force by placing increased stress on the foot while walking and/or standing. This extra strain can result in pain and deterioration of the foot joints which can lead to long-term complications.

Arch support is also very important. In patients with flat feet, a supporting insole or orthotic can help avoid debilitating pain from an unsupported arch which may progress to chronic ankle pain, tendonitis, and arthritis. The majority of the time, these conditions can be prevented or managed with simple over-the-counter orthotics rather than pricier custom-made ones. Even those patients with no history of arch problems may want to consider supportive orthotics if they are on their feet for long hours.

Perhaps the most important consideration is the most obvious. Do not sacrifice comfort and support for "something cute." I see patients in my clinic daily with pain and injuries to their feet and ankles which can be blamed on their shoe choices over the years. Sometimes the damage is so significant that corrective surgery is needed.

Patients in these situations time and again look back with regret, wishing they had been more sensible in their footwear choices.

Make good shoe choices and enjoy your feet.

Michael J. Clark, M.D. specializes in Adult reconstruction of the foot and ankle, Total Ankle Replacement, Foot and Ankle Arthritis, Bunion Surgery, and Sports Medicine.

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National PRIMA Orlando

SHRM Georgia Leadership

SHRM Jacksonville Conference

TROY LANCE GREENE ATTORNEY AT LAW

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.

TGL
TROY LANCE GREENE
ATTORNEY AT LAW

P.O. DRAWER 1168
602 CHURCH STREET
VIDALIA, GEORGIA 30475-1168

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Hands On: Treatment of Osteoarthritis

Waldo E. Floyd, III, M.D.

Osteoarthritis (OA) is the "wear and tear" form of arthritis we all suffer with age. The saddle joint at the thumb base is the most common site of OA, a condition known as basal joint OA or OA of the first carpometacarpal joint. The condition is more common in women, but it is present in significant numbers in both genders.

In the early stages, OA symptoms are associated with activities such as turning a key or opening a jar. As the condition worsens, pain may develop at rest and not be associated with symptom-provoking tasks. Over time, the joint may partially dislocate and the thumb may develop deformity and limited motion. Some patients with minimal deformity will experience significant symptoms and other patients with severe deformity may have little associated pain.

The diagnosis of OA is made by a physical examination of the involved joint, as well as x-rays. The condition is frequently in both thumbs where there may be a familial predisposition. Treatment is tailored to the patient's symptoms. Patients having slight pain, despite deformity and severe x-ray changes, usually do not require medical intervention.

Patients with pain may find long-term relief from a cortisone injection in the joint. The injection may be repeated as required on an occasional basis. Wearing a thumb splint helps ease discomfort while the splint is being worn. However, pain may return with splint removal. Cortisone injections may become ineffective over time.

Some patients will require surgery to manage recalcitrant symptoms. The surgery is usually done as an outpatient procedure with regional anesthesia. Rarely, the joint is fused. More often, surgery for basal joint OA involves removal of the trapezium, the smaller wrist bone at the thumb base. Stability may be maintained with a tendon and sometimes a temporary pin. Unlike many artificial joint replacements, most basal joint arthroplasties do not wear out over time as the reconstruction involves the patient's own tissue. In cases where deformity has developed in adjacent joints, surgery may be done at those sites. The patient's thumb and wrist are immobilized in a splint or cast for about four weeks and upon removal of support, occupational therapy is instituted with a certified hand therapist to regain motion and strength. Most patients experience significant long term pain relief and increase in pinch strength.

Many patients with basal joint OA are treated at OrthoGeorgia and though many of these patients do not require surgery, hundreds annually undergo surgery for this common and frequently painful condition.

Waldo Floyd, III, M.D., is a certified in Orthopaedic Surgery and Surgery of the Hand by the American Board of Orthopaedic Surgery. A graduate of Emory University School of Medicine, Dr. Floyd is Clinical Professor of Surgery (Hand) at the Mercer University School of Medicine and is a member of the American Orthopaedic Association. He is an author of many peer reviewed articles and publications and has been a Consultant Reviewer for the Journal of Hand Surgery.

Medicalization of Cannabis and Hemp Products

Carlos J. Giron, M.D.

This past year, I was invited to speak at various conferences and meetings regarding opioid alternative treatments in Pain Management within the Workers' Compensation system. Initially, my presentations focused on traditional medical treatments, but it became clear that the audiences were also quite interested in hearing about the "Green Wave" of medical cannabis.

There is much confusion about hemp and marijuana. Both plants are in the cannabis family. Marijuana contains a multitude of chemical compounds including over ten percent (10%) CBD (Cannabidiol) and up to thirty percent (30%) THC (Tetrahydrocannabinol), the psychoactive component known for producing the "high" sensation. Hemp contains the same non-high producing chemical cannabinoid compounds including over twenty percent (20%) CBD and less than 0.3% THC. These chemicals work at the endocannabinoid receptor system in the human body. The CB-1 receptors are in the central nervous system, including brain and nerve tissue, where they are thought to exert effects on cognition, pain relief, and anxiety. CB-2 receptors are present in the peripheral tissues, including white blood cells, and can exert effects in the regulation of cytokine release and inflammation.

Understanding these scientific concepts is critical to understanding the potential clinical applications of CBD products for patients in chronic intractable pain, many of whom are injured workers.

The Farm Bill, also known as the Agricultural Improvement Act of 2018, was signed by President Donald Trump last December. It lifted the ban on hemp production and cultivation, allowed research, and amended the Controlled Substances Act exempting hemp from the list of Schedule I drugs. It permitted interstate commerce of hemp and allowed hemp CBD containing no more than 0.3% THC to be legal. This has created significant momentum for the availability and use of such products. The wave of hemp and cannabis products—not regulated by the Food and Drug Administration—is everywhere and inescapable. There are many products making outlandish, unsubstantiated health claims; therefore, without proper regulation, the public could be ingesting worthless or potentially harmful substances.

As I educate patients and physicians on the use of CBD oil in reducing opioids and benzodiazepines, I advocate a logical, systematic, and organized approach to their use. Cannabinoids are medicine and should not be used in a cavalier fashion. Physicians must take into account the other medications and comorbidities of their patients before starting them on CBD/hemp oil or associated products. Providing guidance as to proper concentrations, dosing, and reliable legitimate manufacturers for those products is a reasonable way to improve patient safety.

Medicalizing the use of these substances is crucial to harm reduction strategies for opioid wean and reduction. These products should not be considered opioid replacements, but they are part of a larger biopsychosocial treatment plan that produces better outcomes and reduced claims costs for injured workers suffering from chronic pain.

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.

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CARLOS J. GIRON, M.D.

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Benefits for Occupational Hearing Loss

C. Todd Ross, Esq.

Georgia's Workers' Compensation Act provides benefits for hearing loss caused by exposure to harmful noise in the workplace. This article outlines the statutory elements of a claim for occupational loss of hearing, the exception, establishing the date of accident, benefits available, evidentiary requirements, and the elements of an affirmative defense to such claims.

DEFINITION: O.C.G.A. § 34-9-264 defines "occupational loss of hearing" as the loss of hearing in both ears caused by prolonged exposure to harmful noises in employment.

EXCEPTION: O.C.G.A. § 34-9-264 does NOT cover partial or permanent loss of hearing due to sudden traumatic injuries. An acute, specific event that causes partial or permanent hearing loss is treated as an "injury" pursuant to O.C.G.A. § 34-9-1(4), and entitles the employee to benefits like any other accident under the Act.

DATE OF ACCIDENT: The date of the accident for "occupational hearing loss" is the first time the injury:

- prevents the employee from working, or
- constitutes a disability recognized by the Act.

BENEFITS: The employee can only recover permanent partial disability benefits and medical benefits. The Board may order provision of a hearing aid. Recovery for lost wages/benefits for temporary total or temporary partial benefits is specifically excluded. O.C.G.A. § 34-9-264 (b)(5).

EVIDENTIARY REQUIREMENTS: The employee must prove eight (8) prerequisites to establish compensability:

(1) The loss of hearing must be permanent rather than temporary;
(2) It must be a sensorineural hearing loss rather than tinnitus or a psychogenic origin;
(3) The hearing loss must be present in both ears, unless there is a pre-existing loss of hearing due to congenital deafness, disease, or trauma in one ear;
(4) The loss of hearing must be present at the frequencies of 500, 1,000, 2,000, and 3,000 cycles per second;
(5) The loss of hearing must average greater than twenty-five (25) decibels in all frequencies (500, 1,000, 2,000, and 3,000 cycles per second);
(6) The loss of hearing must be caused by "prolonged" exposure in Georgia employment (at least ninety days);
(7) The loss of hearing must be caused by "harmful noises" in employment. Harmful is defined as sound of an intensity of ninety (90) decibels, a scale, or greater. O.C.G.A. § 34-9-264 (a)(1);
(8) Finally, the employee cannot file the claim until six (6) months after their exposure to harmful noise with the last employer.

AFFIRMATIVE DEFENSE: Should the employee prove the mandatory prerequisites, the claim may still be barred. However, to successfully bar recovery, the employer must show:

(1) They provided hearing protection device(s) to the employee,
(2) That the device(s) was capable of preventing hearing loss from the harmful noise,
(3) That the employee failed to regularly utilize the device(s).

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.

A Word from the Chairman

By Frank R. McKay, Chairman and Chief Appellate Judge, State Board of Workers' Compensation

Annual Conference

The 2019 Annual Education Conference will be held at the hotel at Avalon & Alpharetta Conference Center on August 26-28, 2019. This year's theme is Hollywood: Workers' Compensation Walk of Fame. We are rolling out the red carpet to celebrate the new venue and to show our appreciation for our attendees, vendors, sponsors, and speakers. With the educational sessions and exhibit space all on one floor, this will be a fun and exciting opportunity to network and meet other workers' compensation professionals. Keeping in tune with the Hollywood theme, Jasmine Guy is this year's keynote speaker. Ms. Guy is a well-known actress, director, singer, and dancer and is mostly remembered for her role as Whitley in the television sitcom A Different World. Ms. Guy has also appeared in several Broadway shows and movies.

We are also fortunate to have nationally-known, Mark Walls (Safety National) and Kimberly George (Sedgwick) present their popular "Out Front Ideas" educational series which includes conversations about the most trending topics being discussed in the workers' compensation system. Our legal, medical, rehabilitation, and licensure sessions will provide discussions on matters to both educate and entertain all workers' compensation professionals. Presentations will include the latest information about alternative pain treatments, the use of cannabis and CBD oils, advanced technology in treating the injured worker, legacy claims, and much more.

ADR Division

On May 15, 2019, our Alternative Dispute Resolution Division Director, Judge Janice Askin, left the SBWC for Washington, D.C. to assume an appellate court position with the U.S. Department of Labor as one of three permanent members of the Employees' Compensation Appeals Board (ECAB) that hears the appeals of federal workers' compensation claims under the Federal Employees' Compensation Act (FECA). Judge Askin was with us for nineteen years and did a fabulous job leading our ADR Division to unprecedented success and we will greatly miss her.

The loss of Judge Askin provided an opportunity for the appointments of a new Division Director and new judge in our ADR Division. In May, ADR Deputy Division Director, Judge Liesa Gholson, was promoted to Division Director and in June, Edwina Charles was appointed Administrative Law Judge in the ADR Division. Congratulations to both Judge Gholson and Judge Charles.

EDI/ICMS Filing

On January 1, 2019, the requirement to file WC-1 First Reports of Injury for medical-only claims went into effect. We are excited about the additional data we are receiving through the increase in WC-1's. Also, effective December 1, 2018, we launched an update of our EDI R3.0 Claims requirements including, but not limited to, allowing medical-only claims to be filed via EDI. EDI processing is current with most EDI transactions processed within 24-48 hours. On December 1, 2018, we removed the Social Security number/board tracking number (SSN/BTN) from our ICMS system and from our Board forms. Access to ICMS for our insurers, self-insured employers, group funds, and claims offices has been expanded. To date, we have registered over 800 users and the feedback has been very positive. If you would like more information regarding ICMS access, please send an email to ICMSTraining@sbwc.ga.gov.

Rate Filing

In March, NCCI proposed and the Department of Insurance approved an 8.9% premium reduction for the voluntary market. Georgia experienced a 4% increase in written premium highlighting the growing payrolls for Georgia employers. Seventeen new carriers were issued a Certificate of Authority from the Board in the first six months of 2019. These new carriers include e-insurance carriers as the market continues to add more choices for workers' compensation coverage for employers.

Opioid Research

In a June 2019 report on Interstate Variations in Use of Opioids, 5th Ed., the Workers' Compensation Research Institute (WCRI) found that receipt of longer duration opioid prescriptions initially is correlated with the receipt of chronic opioids. WCRI also found in states where a higher proportion of claims had the first opioid prescription

exceeding seven and fourteen days of supply, the chronic opioid use rate was also higher. Id. p. 13. WCRI studied Georgia claims with dates of injury occurring from October 1, 2015, through September 30, 2016, with more than seven days of lost time and prescriptions filled through March 31, 2018. It found that fifty-four percent (54%) of the claims with a prescription drug had opioids and twenty-nine percent (29%) of those claims had two or more opioid prescriptions with the average being 3.1 prescriptions. The average number of opioid pills per claim was 154 with an average of forty-nine pills per opioid prescription. Eighteen percent (18%) of the opioid prescriptions were physician-dispensed. Id. Table 3.1, p. 39.

We look forward to seeing you at the Avalon in Alpharetta in August at our Annual Educational Conference.

Judge McKay was appointed Chairman of the State Board of Workers' Compensation on March 1, 2013. 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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Florida Legislative Update

David Langham, Deputy Chief Judge

Florida is the third most populous state, after California and Texas. The unemployment rate in Florida has been notably low. There are reports of significant construction throughout the state accommodating the population and job influx. Of course, the construction itself creates employment. While there is positive job growth, there are critics whose perceptions of wage growth are not keeping pace with employment. Overall, however, Florida's economic outlook appears positive.

Both the Florida House and Senate introduced significant workers' compensation reform bills in 2019, House Bill 1399 and Senate Bill 1636. Both had similarities, but noteworthy differences. The House version passed two committees, but the Senate bill did not get a vote. In Florida, legislative reform requires a bill to progress independently in each chamber in most circumstances. Because the bills did not pass, a variety of potential issues, including temporary disability, attorney fees, medical fee schedules, and premiums, were not amended.

There were bills passed that potentially impact the workplace, in general, and perhaps workers' compensation. House Bill 107 places major restrictions on use of a cell phone while driving. It is already illegal to text and drive in Florida, but it was not a "primary offense." The bill retains the prohibition on texting/typing and reading, but adds a broad prohibition on "using a wireless" device while driving in a "school crossing, school zone, or work zone (if workers are present)." Privacy concerns are also addressed, which requires officers to inform drivers of their right to "decline a search of" her/his phone when stopped. This may be of importance for workers' compensation through section 440.09(5) ("knowing refusal" to "observe a safety rule").

The Legislature also passed Senate Bill 426. While not a workers' compensation bill, it may impact the community. It provides benefits for firefighters who have suffered from certain cancers, joining many other states already doing the same. While the impact is predicted to primarily affect municipalities and other government entities, it is worthy of consideration and understanding. In 2018, Florida joined the states providing mental-only compensability for certain "first responders" in the event of certain circumstances.

Finally, House Bill 23, provides the foundation for using telemedicine in Florida. In conjunction with perceptions of changing consumers' medicine preferences, in part attributed to Millennials as their market impact grows, telemedicine may have an important impact on Florida medical care. While the bill does not mention workers' compensation, the absence of any specific exception of workers' compensation is seen by some as perhaps enabling telemedicine in this community.

The telemedicine advantages are obvious, but bear reiterating. A patient could be seen without traveling, waiting at the doctor's office, and/or the risk of getting sick from others (cold, flu, etc.) There are doubters that telemedicine is a viable replacement for all physician or nurse interactions, but many see promise in the potential for follow-up visits, medication and symptom monitoring, and patient compliance encouragement. It is possible telemedicine will become a staple of Florida medical care in years to come.

Overall, the Florida workers' compensation community is reasonably stable. It is possible 2020 will bring more debate regarding legislative reform, but time will tell.

David W. Langham has been the Florida Deputy Chief Judge of Compensation Claims since 2006. His legal experience includes workers' compensation, employment litigation, and medical malpractice. He has delivered hundreds of professional lectures, published over forty articles in professional publications, and has published over 950 blog posts regarding the law, technology, and professionalism. David is a student, a teacher, a critic, a coach, and a leader. He lives in Pensacola, Florida, with his wife, Pamela Langham, Esq.

Forward Thinkers in Risk Management

Christie Simpson

Injuries are going to happen, so it is going to take forward thinkers in the field of risk management to stay ahead of the upcoming losses. We plan, train, and put all the precautions in place, yet there are still injuries. It is what the workers' compensation industry was designed for in the first place: to take care of those who are injured on the job.

However, I have recently developed a forward-thinking strategy to push the limits of what formally has been a taboo subject. Optimal Health: Creating a Healthy Mind and a Healthy Body of our workers.

Many times, we, as employers, are forced to look at the bottom line. Have you had to review your loss runs recently in preparation of an upcoming claim review or workers' compensation policy renewal? Were you shocked at the total amount in outstanding reserves for what appeared to be a simple knee contusion?

If you reviewed those types of claims ten, fifteen, or even twenty years ago, you would notice the rising costs of these claims have jumped at an astonishing rate. Go back and look at the overall health of each individual employee pre-injury. You would be surprised at how much co-morbidities can play a huge role in not only a contributing cause, but in their overall recovery and return to work capabilities.

In the fast-paced world we live in these days, our population is growing less and less active. Technology makes us more advanced in business, yet our overall personal health is feeling the impact. We have fast cars, fast computers, fast phones, and we have fast processed foods at our fingertips. However, we also are seeing a rising population of obese and morbidly obese individuals in the workforce. Have you ever read about the amount of additional force that is placed on the joints by being overweight? How about your flexibility during your daily work duties? For every pound of weight we carry, it adds ten pounds of pressure on the feet, ankle, knees, and hips. What about those shoulder injuries? What body part is used when you are trying to get up from a seated position or out of bed? You use your shoulders and arms to push yourself up. Now, think about an employee who may be eighty pounds overweight.

What if your employee needs a particular surgery? Is their overall BMI in a safe range to be able to be put to sleep? You may think it would be up to the physician, right? But, who pays for the physician? How about the lost wages? What about prescription drug costs? Finally, what about replacing an injured employee for their recuperation time?

What if we took a proactive approach with our employees before the injury? For example, let's look at a healthy twenty-six-year-old labor worker who has a knee injury versus an obese forty-five-year-old uncontrolled diabetic labor worker with a similar injury. What if we had been able to assist the second worker in losing weight and stabilizing their blood sugar? As employers, need to take a more proactive approach in our employees' lives outside of work. We can't force anyone to live a healthier life, but we can offer a solution for those who do. A happier, healthier individual means a happier, healthier employee. And, a happier, healthier injured worker might lead to fewer missed days and lower impairment ratings.

Forward Thinkers, we must do more. We must educate, equip, and empower our employees to want a better life for themselves and, in turn, we will have more loyal employees.

Christie Simpson has spent the last twenty years in the workers' compensation industry. She is a multi-state licensed and certified health coach. She is a wife and mother of two daughters and one son. Her pride and joy are her three grandchildren. She is a hobbyist photographer and golfer.

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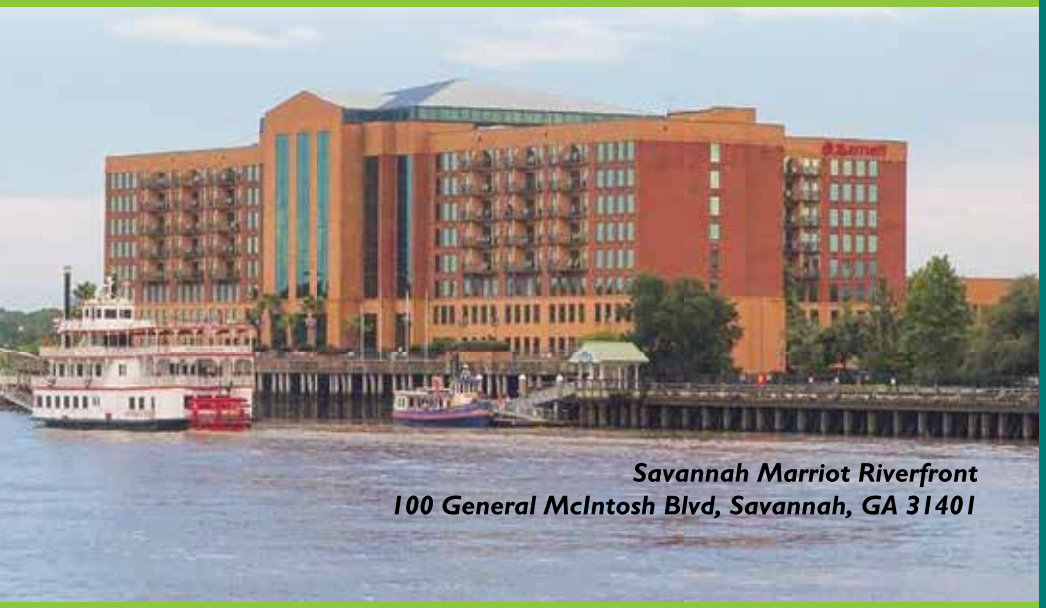

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Shepherd Center Releases Video Series for Women with Spinal Cord Injury

Videos funded by grant from Craig H. Neilsen Foundation address life after SCI for women.

Shepherd Center recently released "Empowering Women After SCI: Safe Health Care Goes Beyond Accessibility," a video series that aims to empower women who have sustained spinal cord injuries (SCI) to advocate for their own health and wellness. The videos also serve to better equip healthcare providers to treat women with SCI.

"Research shows that while both men and women with disabilities are at a greater risk for health challenges and health care disparities, women in particular are more likely to delay or avoid routine primary and preventative healthcare appointments, such as mammograms, pelvic exams and screenings for cervical cancer than their counterparts who do not have disabilities," said Teresa Foy, OT, Comprehensive Rehabilitation Unit program manager at ShepherdCenter. "Without these routine screenings and preventative care, women with disabilities are at an even higher risk for serious health complications. Through this video series, we hope to create opportunities for women with SCI to seek out the medical expertise they need and deserve to pursue lifelong health and wellness."

The video series was funded by a generous grant from the Craig H. Neilsen Foundation and donations from grateful Shepherd Center patients and families. The series covers topics ranging from doctor's office visits, diet and exercise, medical care, pregnancy, childbirth, parenting, fashion, dating and intimacy. The final content was determined based on the feedback from focus groups comprised of local consultants, consumers, peer supporters, ShepherdCenter's women's SCI support group and expert SCI clinicians. The videos feature open and honest commentary with female patients who have sustained spinal cord injuries, as well as interviews with medical experts.

You can view all nine videos on MyShepherd Connection or on ShepherdCenter's YouTube channel.

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Meniscus Tears in the Workplace

Raymond Hui, M.D.

It's nearly impossible to imagine a job-related activity where we don't use our knee. Almost every movement we engage in on the job requires walking, kneeling, sitting, standing, lifting, or even crawling. Some jobs require being able to move in very tight spaces on your knees. Because of this, meniscus tears are one of the most common injuries seen in workers' compensation claims. Activities that cause a rotation or twist of the knee can result in a meniscus tear.

A meniscus is a crescent-shaped structure of soft cartilage that sits between the femur and the tibia. There are two meniscuses that sit within your knee joint are the medial and lateral. The medial meniscus sits on the inner side of the knee joint while the lateral meniscus sits on the outer side of the knee joint.

Meniscus injuries occur with an average incidence of sixty-six per 100,000 employees. It usually happens when an employee loads and rotates the knee or foot. Workers who perform standing, kneeling, and squatting activities at work are more prone to meniscus injuries. Other ways a person can injure themselves include slips and falls, being struck by objects in the workplace, car accidents, or lifting something that is too heavy. Jobs that see these types of injuries include nurses, factory workers, construction, delivery workers, truck drivers, and professional athletes. Treatment options fall into three main categories:

1. Non-operative
2. Menisectomy, or
3. Meniscal repair

These options involve both patient factors and tear characteristics. An older patient with a degenerative tear and no mechanical symptoms may be treated non-operatively with physical therapy and rest. Menisectomy is performed on symptomatic patients not amenable to correction. Meniscus repair is suitable for younger patients with reducible peripheral tears.

Meniscus tears are tough to prevent since they are usually the result of an accident. Some precautions can reduce the risk of a meniscus tear from happening in the first place. Many jobs offer exercise programs and/or yoga in the workplace as an employee benefit and will help employees avoid injury by keeping their thigh muscles strong with regular exercise. Warming up before exercise or before performing heavy lifting on the job will also help prevent a meniscus tear from occurring. Another way to reduce the risk of injury is by making sure you have shoes with proper support that fit correctly.

With proper diagnosis, treatment, and prevention measures, most employees can return to work full duty without restrictions. By following these simple steps, you can decrease the risk of knee injuries occurring in the workplace. Employers can work closely with their orthopaedic surgeon to help the physician better understand the job demands and ultimately help get the patient back to work quickly. To request a workers' compensation appointment with a Resurgens Orthopaedics physician, please visit www.resurgens.com/worklink or call us at 404-531-8484.

Raymond C. Hui, M.D., specializes in Reconstructive Surgery, Total Joint Replacement, Anterior Approach Total Hip Replacement, Hip Arthroscopy, Sports Medicine, and Trauma.

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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Chronic Pain? Consider the Minimally-Invasive Option

Rekha Suthar, M.D.

Chronic pain is defined as pain lasting longer than three months. For those with chronic pain, the most common areas are in the cervical and lumbar spine, as well as joints.

Not all chronic pain is caused by workplace injuries, although it may be exacerbated by job demands. Many problems are simply the result of the aging process and can include arthritis, spinal stenosis, or herniated disk.

In the past, there were two options for treating chronic pain: 1) long term medication, or 2) surgery.

The most powerful pain medications—opioids—have an unfortunate side effect: addiction. Even seemingly harmless over-the-counter medications, like ibuprofen, are linked to stomach, heart, and kidney problems with long-term use.

For a large number of patients who undergo surgery for chronic pain, it is not uncommon to have some form of recurrent pain after initial relief following their operation. The common causes for recurrent pain are an injury at a new site or recurrence at the site operated upon.

Today, patients have the option of interventional pain management which offers minimally-invasive treatments for those who wish to avoid surgery and/or long-term medication use. Undergoing minimally-invasive pain relief interventions does not exclude patients from being a candidate for future surgical intervention, if necessary.

Treatments are performed by a doctor with specialized training in interventional pain management, who uses imaging (such as fluoroscopy or ultrasound) to precisely guide treatment to the area of the body where pain originates. Treatments include spine injections, nerve blocks, and other techniques that are clinically proven to relieve pain.

There are many more ways now to treat chronic pain than ever before. This has given patients important new options that, in some cases, may fit better with their specific circumstances. Not all of our patients receive injections. We start with a consultation and a comprehensive diagnosis. For many, non-opioid medications or physical therapy may solve the problem, so we may try this approach first. If pain persists, we can then look at doing a minimally-invasive procedure.

Advantages of this minimally-invasive approach compared to surgery include a shorter procedure (about fifteen minutes), a faster recovery, and less risk of a complication or infection. Most patients experience relief in five to seven days and report an improved quality of life.

In many workers' compensation cases, interventional pain management is a win-win for both patient and employer. Now, we can treat chronic pain less invasively, lower overall cost with less risk, and the patient feels better so they can return to work sooner.

Rekha Suthar, M.D., is an interventional pain management specialist with Lakeland Vascular Institute. She has treated patients with workplace injuries, neck, and spine pain caused by aging, chronic headaches, athletic injuries and even pain resulting from progression of cancer. For more information about interventional pain management radiology, please visit www.LakelandVascular.com or call 863.577.0316.

Technology-Driven Medical Case Management

Suzanne Tambasco, DNP, PMHNP-BC

Medical case management and rehabilitation counseling have long been the glue providing constant structure and support in the workers' compensation arena for the provision of medical services and restoration of health and wellness. Case managers and client relationships are based on mutual trust through effective communication, leadership, and the delivery of care that promotes independence through equal partnership.

MMI Medical Management Services, LLC, is a boutique-style catastrophic medical case management organization that harnesses the power of technology alongside the ability to establish effective therapeutic relationships, the primary components of any healthcare interaction. These two factors are transformational in improving access, efficiency, cost effectiveness, and patient satisfaction.

MMI understands that an effective therapeutic patient relationship through non-judgmental interaction and authenticity improves patient outcomes which ultimately improve the claims result. MMI uses a unique case management model which includes a custom case management electronic medical record, paperless environment, a group calendar, and HIPAA compliant messaging to improve the speed and safety of communication. By eliminating paper, case managers have more time to spend on the actual clients.

The case managers at MMI understand early identification of complications improves morbidity and mortality, increases patients' quality of life, and saves money. By first-hand assessment of a problem—regardless of the time of day—case managers save lives. For catastrophic patients, eliminating subsequent hospitalizations is critical to longevity as every inpatient stay escalates the risk of nosocomial complications and weakens the patients' overall health status. Catastrophic case management services are estimated to save $7.00 - $9.00 on every dollar spent and, $3,000 in every care transition.

Each member of the diverse MMI team is certified as catastrophic for the State of Georgia or is completing the process. Furthermore, every staff member is educated in workers' compensation statute. CEO and founder, Suzanne Tambasco, DNP, PMHNP-BC, states, "It is imperative that an individual understands and obeys the statute within their own industry or they do a disservice to their clients." Upon hiring, an MMI case manager is provided with education leading to certification for life care planning or Medicare Set-Asides so continuity of care is preserved from the date of injury through case resolution.

Brandi Milford, M.S, CCM, CRC; Beth Valencik, RN, CRRN; Stacy Middleton, CCM; and Connie Germundsen, RN, BSN, MS, CRRN, NLCP, all make up MMI's Georgia team. The most important aspect of this team is that they work together and support each other to support their clients. Studies show there is a direct correlation between positive workplace culture and excellence in patient outcomes. Brandi Milford, Director of Case Management Services notes, " We really care about each other here and we take care of each other–That is definitely felt by our clients."

Access to certain care is difficult, especially in rural areas. Therefore, MMI once again is harnessing technology to establish and provide the industry with telehealth mental health, pain services, and rehabilitation. Research shows pairing telepsychiatry, pain or rehabilitation services with in-person visits improved compliance, timeliness, and satisfaction with care (Hughes, M. C., Gorman, J. M., Ren, Y., Khalid, S., & Clayton, C. (2019). "Increasing access to rural mental health care using hybrid care that includes telepsychiatry." *Journal of Rural Mental Health*, 43(1), 30-37). MMI will unite a network of mental health and pain providers who are experts in the provision of care in workers' compensation and telehealth platforms to bring services to those who need them the most, overall reducing unnecessary travel and no-show appointment fees. Timely access to healthcare reduces complications and helps to restore health.

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ACL Reconstruction: Avoiding Re-Injury Risk

Daniel Nicholson, M.D.

Modern anterior cruciate ligament (ACL) reconstruction techniques have led to a steep decline in the rate of re-rupture of the reconstructed ACL. Still, several factors can increase the risk of re-injury, so it's important to do everything you can to lessen the risk of incurring damage in the same area. Here are seven tips to reduce the likelihood of it "re-happening" to you:

1. **Discuss with your doctor the graft tissue to be used to replace the damaged ligament.** During ACL re-construction, the torn ligament is removed before the graft is inserted and attached to knee bones. Common grafts include those taken from elsewhere in your body, such as the patellar tendon and hamstring or grafts taken from a cadaveric donor. However, what's right for one person may not be the best choice for another. Age, activity level, and other patient characteristics factor into the decision.

2. **Confirm your surgeon is using the most up-to-date ACL reconstruction techniques to ensure the graft is being placed in a position that recreates the anatomy of the native ACL.** Poor tunnel positioning at the time of surgery is the leading cause of re-rupture.

3. Patients who returned to sports had a four times greater risk for re-injury than those who did not. **But, re-injury was reduced significantly for each month a patient delayed their return.** While the goal of surgery is to return to your previous level of activity, complete graft healing can take from eight to twelve months. So, give it time to fully heal before returning to your previous exercise regimen.

4. **Working on the quadriceps muscles so there is equal quad strength in both legs** has been shown to significantly reduce knee re-injury. Strengthening leg muscles overall to support and protect the knees is important for reducing the chance of injury to begin with. Athletes with stronger quadriceps, hamstrings, and thighs suffer fewer injuries overall.

5. **Enter physical therapy and strictly comply with the therapists instructions.** Through physical therapy, range of motion and strength and balance are restored. Regaining these will assure you're able to return close to the same skill level you had prior to the injury.

6. **Improve balance.** There are several exercises to improve balance. Yoga, in particular, is excellent for improving balance and regaining range of motion.

7. **Neurological messages control movement.** Movements of the lower extremity, including the knee, are controlled through mind and memory. After any injury, the **mind needs time to reconnect with the injured area** until movement is innate and function is restored, which takes time.

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

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Tips for Reducing Sprains and Strains

P. Justin Lancaster, M.D.

Whether you're a paramedic loading and unloading patients into an ambulance or a retail employee working in the stockroom, sprains and strains can easily occur on the job. In 2017, Bureau of Labor Statistics data showed sprains and strains as the most frequently occurring injuries in the workplace, resulting in lost work time, transfer, or restrictions in five of six industries studied.

Strains and sprains are injuries to muscles, tendons, and ligaments which are common and often painful workplace injuries. They are usually caused by overuse, improper technique, or lack of conditioning.

A sprain is a stretching or tearing of ligaments, the tough bands of fibrous tissue that connect two bones together in your joints. Sprains are caused when a joint is forced to move into an unnatural position. For example, twisting your ankle causes a sprain to the ligaments around the ankle as the joint is stretched inappropriately.

A strain is an injury to either a muscle or a tendon and can happen suddenly or evolve over days or weeks. It can be a simple overstretch of the muscle or tendon or it can be a partial or complete tear. If you try to lift something before warming up your muscles, the sudden pull on a cold muscle can result in a strain. The back and the hamstring muscles are two areas where employees can experience a strain more frequently.

Following are some tips to help reduce the risk of sprains or strains:

- Wear appropriate and properly fitted footwear to reduce stress on the ankle, foot, and leg joints.
- Employees should avoid activities for which they haven't been properly trained.
- Always warm up and stretch, slowly moving the joints around, before lifting or doing any other type of physical activity.
- Take breaks and stretch throughout the day.
- Don't be shy about asking for help when lifting heavy or awkward loads.
- Always lift with your knees instead of your back. Properly align your arms and legs so there is no twisting motion.
- Be on the lookout for slip or trip hazards in work areas.
- It's always better to push items rather than pull them.
- Employees sitting at a desk should keep their spine straight, shoulders back, head and neck aligned, and legs parallel to the ground with feet flat on the floor.

P. Justin Lancaster, M.D., of Optim Sports Medicine in Statesboro, Georgia, is board certified in family practice as well as being fellowship trained and board certified in sports medicine. He specializes in non-operative sports medicine. His primary care practice focuses on helping a wide variety of patients maintain their active lifestyles and overall good health. After completing his undergraduate studies at the University of Georgia, Dr. Lancaster graduated from Mercer University Medical School. He completed his residency at Phoebe Putney Memorial Hospital in Albany, Georgia, and then completed his fellowship with Andrews Sports Medicine at the American Sports Medicine Institute in Birmingham, Alabama.

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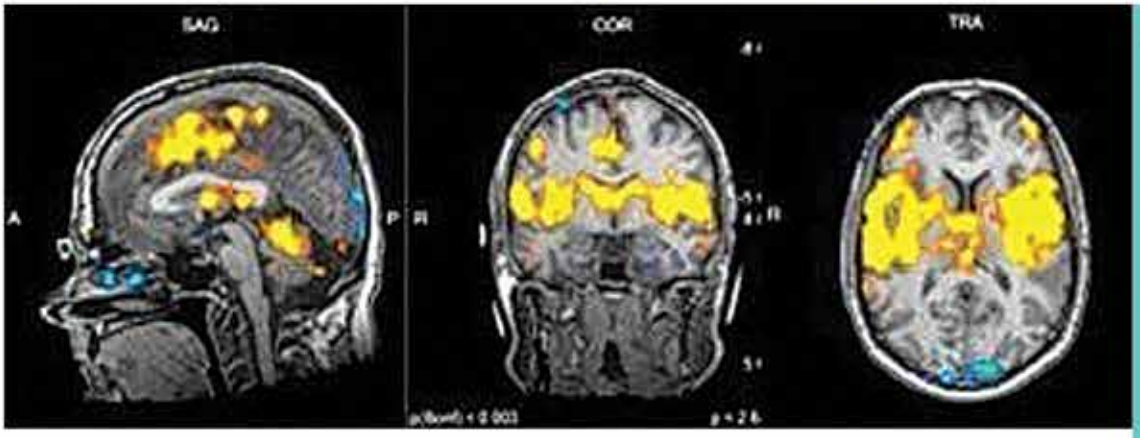
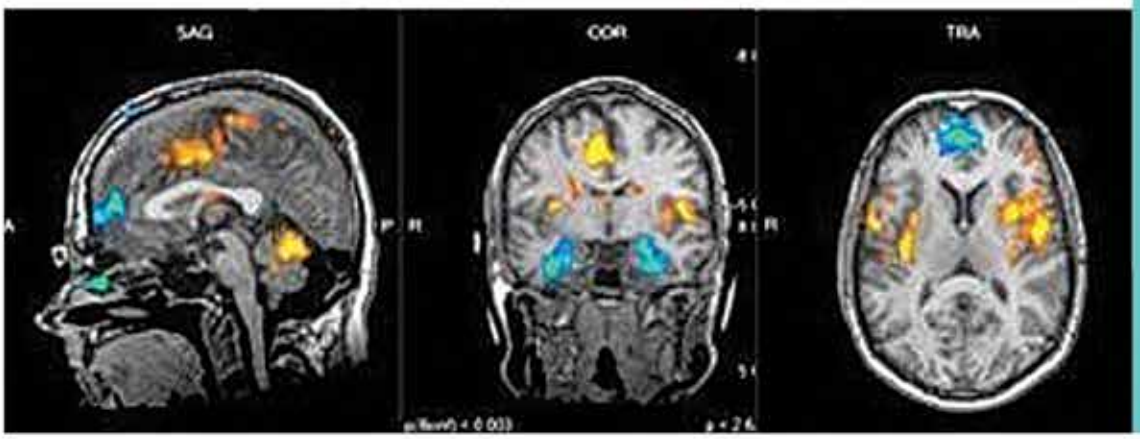
This is the brain experiencing pain



This is the brain experiencing Vx™ Pain Relief



The yellow color in the fMRI images (left) depicts the areas of the brain as they are perceiving pain. During immersive Virtual Reality Therapy (VRT), the same pain receptors are noticeably diminished.

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Workplace Health and *SelectOne Network* would like to congratulate three of the Optim Orthopedic Workers' Compensation team members on receiving their CWCP Certification. Congratulations Monica Wilson, Maria Bowers, and Stacy Sloan on this wonderful achievement!

First of all, I want to thank Optim for allowing their staff to participate in the CWCP program. And a huge shout out for Monica, Maria, and Stacy for all the work they had to do to obtain their Certified Workers' Compensation Designation. Their desire to better understand Georgia's worker's compensation system will benefit all the stakeholders in our system. We are celebrating our 20th year administering the CWCP program and we are proud to have these three ladies join our program.

Steve Heinen – Administer of the CWCP Program

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Cervical Total Disc Replacement

Tapan K. Daftari, M.D.

A patient under forty-five years of age is often engaged in a primarily manual type job and is more exposed to cervical spine injuries. These injuries can occur with a back and forth movement of the head and neck known as flexion-extension injury. They occur with a direct force to the upper back, such as by falling and striking the floor or wall or a box falling on someone. Fortunately, most neck injuries are strains and do not involve significant injury to the intervertebral disc.

In about ten to twenty percent (10-20%) of cases, the patient suffers a herniated disc which causes neck and arm pain, which we refer to as radiculopathy. Those patients suffering from cervical radiculopathy can also be treated without surgery with physical therapy, traction, and possibly epidurals. However, about one third of these patients will require surgical treatment.

In a patient under forty-five years of age, a dilemma frequently arises if the patient has to undergo a cervical spine fusion. The "gold standard" for cervical spine disc herniation has been anterior cervical discectomy and fusion. The herniated disc is removed and replaced by a piece of graft inserted between the vertebrae and then secured with a titanium plate which bridges the vertebrae involved. The end goal is for the bone to grow from one vertebra to the other by fusing the vertebrae as one motion unit.

The outcomes from anterior cervical fusion have been quite good. The overall success rate is greater than eighty percent (80%), the relief in arm pain is usually greater than ninety percent (90%), and the relief in neck pain is usually seventy percent (70%). Return to work after cervical fusion is roughly sixty percent (60%). In a small percentage of cases, the fusion does not heal and a revision surgery may be needed.

Still, fusion of the spine will change its natural motion. This can result in reduction in range of movement which could be a limiting factor in some occupations. Also, there has been a theory that changing the motion of the spine will lead to other vertebrae having more wear and tear which can increase the rate of future disc disease. This is only a theory because it has not been proven whether or not this advanced rate of disc disease is related to the fusion or to the underlying genetics of the patient.

Artificial disc replacement for the cervical spine is an attractive option in workers' compensation patients. Artificial disc replacement is sometimes called total disc replacement (slang reference). This creates confusion because it can be mistaken for total joint replacement. Currently, in the cervical spine, an artificial disk may be used to replace two cervical disk levels.

Artificial disc replacement has been performed in Europe for more than twenty years. In the United States, artificial disc replacements have been gaining popularity over the last ten years. Finally, two, five, and ten year outcomes have been reported.

When the disc herniation is removed and the pinching of the spinal cord and nerve is relieved, the artificial disc is placed between two vertebrae. It is tethered in place by a keel like a sailboat or spikes. In one model, it is actually secured by screws. Between the top and the bottom cobalt chrome metal plates is a plastic core which allows motion in flexion, extension, side bending, and lateral bending. Biomechanical studies have shown that the cervical artificial disc replacement closely mimics the natural movement of the neck. The preservation of movement has been shown to last ten years or more in European studies.

The outcomes for one and two level cervical artificial disc replacement have been similar to anterior cervical fusion. In some studies, the results have been shown to be superior to that of fusion. The relief of arm pain is greater than ninety percent (90%) while the relief in neck pain is about seventy percent (70%). The overall success rate is greater than eighty percent (80%). The return to work for patients after cervical artificial disc replacement is, again, about sixty percent (60%).

The theoretical advantage of cervical artificial disc replacement would be a slower rate of developing disc disease, a greater range of preserved motion, and a reduced rate of non-fusion. The need for revision surgery is also low. Technically, the surgery for artificial disc replacement requires more experience and skills than fusion because the placement is more precise. Placing the implant in the midpoint in both the frontal (coronal) and side (lateral) planes is important as is accurate sizing.

The selection of the right patient for cervical disc replacement also requires expertise. The Spine Center of Resurgens Orthopedics provides surgeons with such experience in performing cervical artificial disc replacement for the workers' compensation patient.

Tapan K. Daftari, M.D., specializes in Reconstructive Spine Surgery, Cervical Spine Surgery, Minimally Invasive Spinal Techniques, Lumbar Spine Surgery, Cervical and Lumbar Artificial Disc, and Kyphoplasty.

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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- quarterly meetings with topics and speakers directly related to the profession
- our annual Educational Series is generally held in spring, an education-intensive multi-day seminar where members learn, network, and meet with private sector representatives from businesses offering services to the membership.
- Networking opportunities throughout the year, allowing members to effectively share and exchange ideas and solutions with their colleagues.

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Retrospective Review: Workers' Compensation Medicare Set Asides (WCMSA)

Structured settlement annuities are often used by employers and workers' compensation (WC) carriers to fund future medical obligations for WCMSAs because of their ability to provide cost advantages to settling parties while also preserving the injured worker's access to Medicare.

The table below illustrates the results of a WCMSA retrospective review conducted by Independent Life for a large WC excess carrier that was interested in improving its WC claim settlement results.*

Benefit Amount	Length	Premium	Independent Life Premium	$ Difference	% Difference
$11,660	27 years	$184,909	$149,841	-$35,068	-19.0%
$10,070	28 years	$169,245	$157,410	-$11,835	-7.0%
$9,318	32 years	$168,398	$167,006	-$1,392	-0.8%
$9,402	31 years	$167,951	$167,105	-$846	-0.5%
$9,738	27 years	$163,157	$153,727	-$9,430	-5.8%
$10,749	23 years	$162,151	$149,212	-$12,939	-8.0%
$13,251	19 years	$160,283	$154,660	-$5,623	-3.5%
$10,134	18 years	$124,017	$103,408	-$20,609	-16.6%
$6,007	25 years	$94,428	$86,989	-$7,439	-7.9%
$7,427	17 years	$90,889	$65,872	-$25,017	-27.5%
$3,746	31 years	$74,796	$65,104	-$9,692	-13.0%
$4,904	24 years	$74,712	$69,761	-$4,951	-6.6%
$4,760	28 years	$74,508	$66,280	-$8,228	-11.0%
$3,321	25 years	$53,947	$47,947	-$6,000	-11.1%
$3,108	23 years	$46,553	$40,329	-$6,224	-13.4%
		$1,809,944	**$1,644,650**	**-$165,294**	**-9.1%**

Are you ready to take the #ILChallenge?

Allow Independent Life to analyze any of your settled 2018 WCMSAs to find out how much you might have saved!

About Independent Life Insurance Company

Independent Life is the first annuity provider to focus exclusively on the structured settlement market helping personal injury victims and their families.

Independent Life is rated "A" by Egan-Jones and "A-" by KBRA (Kroll Bond Rating Agency), both Nationally Recognized Statistical Rating Organizations (NRSROs) whose rating operations are overseen by the U.S. Securities and Exchange Commission (SEC) and relied upon by the National Association of Insurance Commissioners.

*Reviewed cases were settled in 2018.

www.Independent.Life

Workers' Compensation Medicare Set-Aside Arrangement

Robert A. Sokol, Jr., CMSP

A Workers' Compensation Medicare Set-Aside Arrangement (MSA) is a financial agreement allocating a portion of an individual's total workers' compensation settlement to pay for those injury-related future medical expenses covered and reimbursable by Medicare. These funds must be depleted before Medicare will pay for treatment related to the workers' compensation injury or illness.

Self-insured employers and workers' compensation claim administrators will often use structured settlement annuities to fund future medical obligations for MSAs because of the cost advantage to the settling parties while preserving the injured worker's access to Medicare.

With a structured MSA, the employer or its insurance carrier must make an initial deposit to cover the first surgical procedure or recommended replacement, if applicable, and two years of annual payments. These payments are almost always funded by the purchase of a structured settlement annuity from a financially-secure life insurer.

Structured MSAs can offer advantages to the settling parties of workers' compensation, liability, and no-fault cases to help the parties fully fund the MSA at the lowest cost possible. Once the MSA funds are exhausted within an annual period, Medicare will then kick in to pay the medical costs for the remainder of that period. By contrast, if the injured party received the money as a lump sum, the MSA must be depleted in its entirety before Medicare will resume as the primary payer.

A structured MSA is an effective tool in settlement negotiations where both parties are concerned. The MSA occupies an over-sized portion of the proposed settlement.

Sample Case: A self-insured municipality referred a fifty-four-year old police officer who sustained catastrophic injuries while attempting to take a suspect into custody. He initially received conservative treatment, but eventually underwent multiple surgeries to aid his recovery. Afterwards, complications arose and he was in constant pain. All treatments were part of the workers' compensation claim so the employer sought a Medicare Set-Aside allocation to settle the claim.

The cost to fund future medical care (i.e. the MSA) in many workers' compensation cases can become a disproportionately large part of the settlement negotiations. As was the case above, the projected cost of care for the claimant raised concerns for all parties. On the advice of his attorney, the claimant requested to utilize a structured settlement to lower the cost of the MSA. As a result, the structured MSA was able to effectively fully fund the projected future medical care at the lowest cost possible allowing both parties to confidently settle the claim.

Robert A. Sokol, Jr., is Director of Field Sales for Independent Assignment Company, the only structured settlement annuity company exclusively focused on the structured settlement market and assisting in successfully integrating structured MSAs in workers' compensation settlements. Sokol speaks on Medicare compliance and structured settlements at various national conferences, state claims associations, third-party administrators, and carrier claims teams. Sokol is a Certified Medicare Secondary Payer professional and holds a Life/Health Insurance license in various states. For more information, please visit www.independent.life.

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This incredible increase in circulation will allow us to expand into new markets to research and report on the challenges and needs of both employers and their workers. These changes will allow *Workplace Health Magazine* to broaden our reach and build upon our relationships within the Workers' Compensation industry throughout Georgia, Florida, and Alabama.

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Let's Get Physical…Therapy

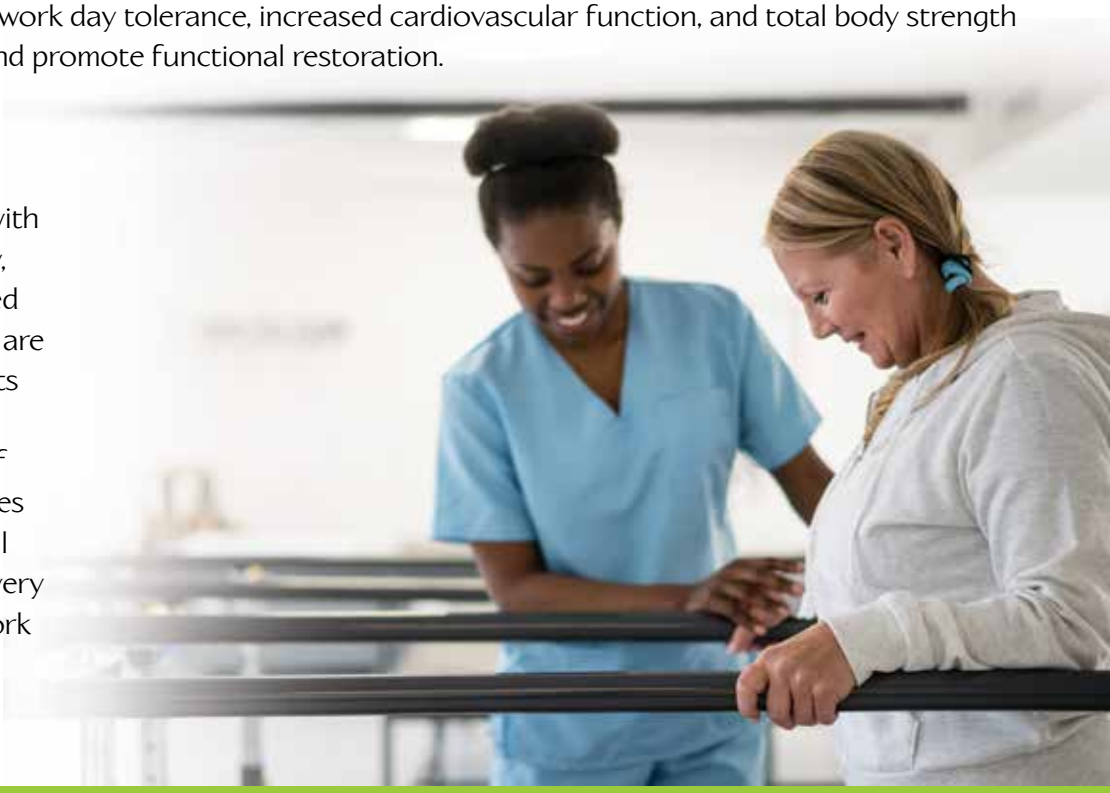
Jaime Sigurdsson, CEAS

The practice of physical therapy has been around since the early 1800s and consists of massage, manipulation, and exercise, all of which are proven to aid in improved range of motion and strength. Range of motion and strength allow for improved mobility which is essential in performing the physical demands required at work and home. In addition, research shows people with musculoskeletal pain report reduction in pain and improved function when movement and exercise are included in their recovery and maintenance programs.

For injured workers, fear of movement can have a negative impact on recovery. However, by including physical therapy in the recovery plan of care, the injured worker's treatment will include the basic exercises and functional activities necessary to allow for increased ability to perform their essential job demands. By understanding and addressing fear avoidance and providing education about the body's natural healing process, the injured worker is given a chance to move past the acute pain focus and understand the importance of improved range of motion, strength, and mobility. Although the body's natural response to acute pain is to limit movement, persistent immobility is harmful and can limit the ability for the body to heal and return to its pre-injury function.

At times, injuries are more extensive and require surgery and or longer periods of recovery. These types of injuries usually result in overall whole body deconditioning due to the body's inability to perform at the same pre-injury level of exercise and function. For injured workers who were functioning at a Sedentary to Light demand level, this may not be an issue. However, for the injured workers who are expected to return to work performing Medium to Very Heavy physical work, loss of endurance, and overall strength can negatively impact their ability to perform the essential job demands safely, even after the injured body part has healed. In these cases, there are physical therapy programs that focus on work day tolerance, increased cardiovascular function, and total body strength which aid in pain management and promote functional restoration.

Whether acute, sub-acute, or chronic pain, movement and exercise have proven beneficial with pain reduction, reduced disability, reduced depression. and improved quality of life. Physical therapists are movement and exercise specialists and educators who provide the knowledge and understanding of the body's physiological responses to pain. By incorporating physical therapy at all stages of the recovery process, the goal of return to work is more likely achieved.



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.

Treatment of High-Impact Chronic Pain in Response to the Opioid Crisis

Paul Mefferd, D.O., and Randy Rizor, M.D.

Writing a prescription to an injured worker for more than a week's worth of opioids can double the risk of disability down the road, triple the cost of claims, and result in a five-fold increase in the number of missed work days. Opioid dependence can occur two weeks to three months, leading to tolerance, dosage escalation, and addiction. Often, opioids are prescribed long after the worker's injury occurred. The opioid dosages can escalate to the point of causing disability and loss of employment, even when the initial injury has resolved.

The opioid epidemic has brought an increase in the prevalence of high-impact chronic pain, a multi-factorial condition where physical pain is not usually the main contributing factor. However, those patients affected describe their problem in pain-related terms, creating the misconception among healthcare providers that treatment should be directed at the symptoms. This approach has led to inappropriate opioid prescriptions, as well as the overutilization of interventional treatments and surgery. Unfortunately, complications related to medications and surgical treatment are frequently major contributors to the development and worsening of high-impact chronic pain.

Effective treatment of such high-impact chronic pain requires looking past symptoms and focusing on specific causes of functional impairment:

- **Medication side effects:** Chronic exposure to opioid medications causes a reactive hypersensitivity in the central nervous system resulting in increased sensitivity to pain, headaches, muscle spasm, sleep disturbance, nausea, constipation, decreased sex drive, confusion, and memory loss, all which cause additional function degradation. Furthermore, medications used to treat opioid side effects, such as muscle relaxants, antidepressants, additional pain medications, and sedatives or stimulants, produce their own side effects which compound the problem. Even non-opioid medications can produce disabling side effects when prescribed incorrectly. Eliminating inappropriate prescriptions requires concise control of medication use throughout the tapering process to prevent withdrawal or rebound reactions.

- **Physical deconditioning:** A common misconception following an injury is that rest is needed for recovery when actually the opposite is true. Muscle strength and range of motion decrease rapidly with inactivity. Repeated surgeries, prolonged use of braces and splints, and sedative effects of medications all contribute to degradation of range of motion and endurance. Treatment of severe deconditioning requires a customized and highly-monitored program of daily exercise to correct specific functional deficits. Intensive coaching is also required to overcome previously-reinforced disability behaviors and dependence on assistive devices.

- **Loss of self-efficacy:** Experiencing the functional difficulties resulting from medication side effects and physical deconditioning over time causes loss of personal responsibility for decisions regarding self-care and social function. As with physical reconditioning, restoring executive function requires a carefully-managed step-by-step program of goal-oriented cognitive-behavioral therapy.

Treating the root causes of high-impact chronic pain requires a team of specialists—physicians, nurses, physical and occupational therapists, and cognitive-behavioral therapists—working together to influence a highly-coordinated course of action. A residential treatment setting is preferred, since conditions in the home environment are often key factors developing and reinforcing high-impact chronic pain. These requirements are associated with administrative, logistical, and financial specifications that have markedly limited availability of treatment.

The Physicians Spine and Rehabilitation Specialists has the first program in Georgia dedicated for the treatment of high-impact chronic pain. The Rizor Institute is a comprehensive, residential rehabilitation program for injured workers with severe pain that will help them to recover and restore function and control their pain, while decreasing reliance on opioids and medical interventions. The program incorporates physical reconditioning, medication tapering, and cognitive-behavioral therapy within an ultramodern free-standing rehabilitation facility in the metropolitan Atlanta area. For more information, please contact ***info@RizorInstitute.com.***

Paul Mefferd, D.O., a partner with The Physicians Spine & Rehabilitation Specialists, received his undergraduate degree in Biology from the University of South Carolina and his medical degree from the University of Health Sciences, College of Osteopathic Medicine. He is a member of the American Academy of Physical Medicine and Rehabilitation, The International Spine Injection Society, The North American Spine Society, The American Osteopathic Association, and numerous other national and regional associations.

Randy Rizor, M.D., a founding partner of The Physicians Spine & Rehabilitation Specialists and founder/medical director for the Rizor Institute, graduated Phi Beta Kappa from Bates College and received his Doctor of Medicine from the University of Toledo School of Medicine. He is a member of the Chairman's Advisory Council of the Georgia State Board of Workers' Compensation and serves on the Board of Directors of the Medical Association of Atlanta.

Beyond the Human Resources Army

Rushe Hudzinski

This saying has been quoted many times over, but it rings true:

> *"To start a movement, you need an individual,*
> *but to change a culture, you need an army."*

Human Resources (HR) often gets assigned the job of an army, while often only consisting of a few individuals. They must work together to represent the company to the employees at every level. However, what does not bode well for a company's success is the knee-jerk reaction organizations regularly take to fix their turnover ratio, thinking it's merely a stone instead, it's a boulder. Sound familiar?

Situations requiring reactive measures to show good faith efforts on behalf of organizations are always difficult to navigate. Generally, a detrimental event has occurred which caused severe negative connotations or repercussions via media. Organizations deploy their HR army of a few personnel to fix the predicament with professional training and development sessions appearing punitive and corrective in nature. Essentially, this merely creates unrest, frustration, and resistance among employees moving from one negative into another, resulting in an endless downward spiral instead of a productive outcome. The reality check is this process was doomed from the start.

The question unfolding is how to take a detrimental event affecting stakeholders and turn it into a desired productive outcome. The truth is, HR tactics are sound, but the implementation is languid. HR needs the support of the full organizational army to prevail. An overall positive approach for improvement will always secure a genuine conclusion with a measurable return on investment. For example:

- An issue of diversity and tolerance: Approach solutions from an area of acceptance and good will.
- An issue of bias and anti-bias: Focus on fairness and collaboration.
- An invite to extend options instead of demand employee participation: Conduct sessions on global mindedness and communication.
- An issue of conflict resolution: Strategize with discussions and forums awareness.

Encouraging synergistic pathways within the organization to exchange ideas naturally generates brainstorming and creativity. Discussions of perception and interpretation will interject in the process to establish mutual understanding and trust. The true army then begins to form, tangible change is activated, and productive outcomes occur.

HR can always be a catalyst for supporting a company's needs; however, it is imperative for the business to provide the cornerstone forces to reach transformations.

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.

The Importance of Risk Management

Gregory Scott

Risk management processes are in place to assure any risks or threats to the company that might affect the bottom line and the health/welfare of all employees. These can be issues of financial or legal matters, but they can also put a spotlight on possible threats to the well-being and/or safety of workers.

Organizations are not much different than our own family unit. In fact, many of us refer to our colleagues and co-workers as our "work family." It is our duty to protect this "work family" as we would protect our own. If we accept this responsibility, we not only strengthen the organization, but ourselves, too.

Processes are cold and uncaring, by nature, and leave out the most important thing: caring and concern. In order to be a good risk manager, it is necessary to handle such issues with care and concern. In fact, we should pattern our behavior after the first risk manager we encountered in life… our mother. Mothers go through risk management processes and apply the proper techniques before their "team" (children) are allowed to do anything with the goal of preserving the safety and security of the family. The application of the process went from: "you can't do that" (avoidance); to "be careful" (mitigation); to "I'll take you" (transfer); and finally to "be back by midnight" (acceptance).

Risk management processes follow the same steps, even though the phraseology may vary business to business. These standard methods work together to provide easy and effective solutions:

Step 1: Identify, investigate, and acknowledge any risks that might had an adverse effect on the project, business, team, and/or individual employee.
Step 2: When the risk is discovered, analyze the probability and significance of the risk. Develop knowledge of the risk and how it could possibly influence the project, business, team, and/or individual employee.
Step 3: Once the risk is identified and analyzed, determine the extent of the consequences and/or results of that risk and evaluate/rank if it is something the project, business, team, and/or individual employee can withstand or manage.
Step 4: To treat the risk, it must be reviewed properly and a plan put in place to avoid and/ or manage the results. Craft risk mitigation strategies and plans addressing how to prevent or work through those issues.
Step 5: Take the time to monitor/review how the organization has handled risks in the past and how they plan to manage them in the future. Having a clear, concise plan benefits the project, business, team, and/or individual employee.

There is a great deal of uncertainty when it comes to risk. By thinking ahead of all possible situations, consequences, actions and/or reactions, an organization can either plan for the risk or avoid it all together. Knowing the risks of any project or task can actually help all involved employees in executing it risk-free.

Gregory A. "Greg" Scott, Sr. is the Risk Manager for Chatham County, Georgia. With thirty-six years' experience, Greg handles complex claims involving policy and coverage issues. He is a graduate with a Master of Business Administration from Savannah State University

Advancement in Thumb Carpometacarpal Arthroplasty: Faster Healing and Less Invasive

By: Michael Shuler, MD

Carpometacarpal (CMC) arthritis of the thumb, also known as basal thumb arthritis, is very common and occurs in roughly 1 in 4 women and 1 in 12 men. While identifying the specific causation of such a common disorder, CMC arthritis can be associated with work injuries or as a result of wear and tear.

CMC arthritis results in a painful thumb especially in axial loading activities such as pinching, turning a key, holding a plate/book and opening a jar. A painful prominent bump is often seen at the radial base of the thumb and is a result of laxity in the anterior oblique ligament. This laxity allows the metacarpal to sublux dorsal and radially on the trapezium resulting in a malpositioned joint (Figure 1). Similar to a set of tires, if they are malaligned, the treads wear out and the tires need to be replaced. If the joint is malaligned, the abnormal pressures result in cartilage loss and the development of painful arthritis.

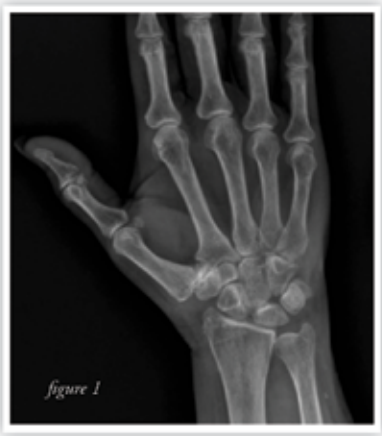


figure 1

As with other degenerative arthroplasties, conservative measures include splinting, NSAIDs, and corticosteroid injections. Surgical consideration should be given when conservative measures are not effective and symptoms limit patient function on a daily basis, including their ability to work.

The traditional surgical method is trapeziectomy (removal of the arthritic trapezium), ligament reconstruction and tendon interposition. This procedure removes one side of the joint, thereby relieving the pain, stabilizing the thumb metacarpal by reconstructing the incompetent anterior oblique ligament. It typically requires cutting of a functional tendon as a graft and six weeks of post operative casting. The extended casting results in a stiff thumb and significant occupational therapy to improve motion and function.

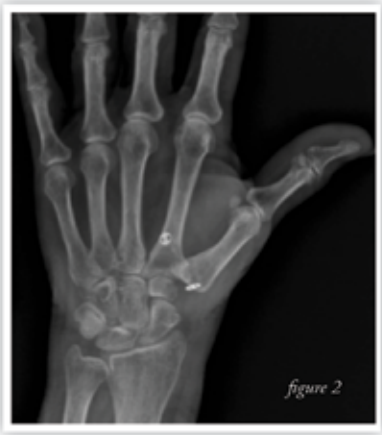


figure 2

With the application of a suture bridge to stabilize the thumb, the need for a tendon autograph is obviated. A suture bridge construct utilizes two metal or suture buttons with stout suture running between the buttons. The suture between the buttons is used to pull the bones towards each other and to stabilize the otherwise unsupported thumb. With CMC arthroplasty specifically, the buttons prevent proximal migration of the thumb metacarpal while pulling the thumb metacarpal back in towards the index metacarpal base (Figure 2). Additionally, more stable fixation is obtained with the suture reconstruction; thereby, allowing for decreased casting and faster mobilization. Reduced immobilization allows for faster return to work and less occupational therapy visits.

Early clinical data has been limited to small population sizes and short-term follow up. Our long-term data from 242 subjects, with an average follow up of 48 months, has shown promising results. Outcomes data showed minimal post-operative pain and excellent patient reported functional outcomes. A 6% complication rate was found with only 3% requiring additional surgeries. When compared to a historical complication for LRTI of 9-22%, the suture bridge suspensionplasty shows significant promise in the management of a common hand ailment affecting both the workers' compensation population as well as the non-workers' compensation population.

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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Web Address: www.downeymedicalconsultants.com
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PHONE: 470-242-7584 ext 101
FAX: 470-443-9230

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309 W. Washington St. Suite 200
Chicago, IL 60606

Contact: Bennie Jones, President
Email: bjones@rmsoa.com
Direct Line: 312-960-6200
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Web Address: www.rmsoa.com
PHONE: 470-242-7584 ext 101
FAX: 312-960-1920

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Sunrise, Florida 33325

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Email: info@teampostop.net
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Christina Anthony and Katie McNamee
Direct Line: 912-358-1515
Email: OccMed@WeAreUrgentCare.com
Web address: OccMed@WeAreUrgentCare.com

Physicians

J. David Carson, MD
Robert Mazur, MD

Physician Assistant

Catherine Grant, PA-C

Georgia Bone and Joint

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

4000 Shakerag Hill, Suite 100
Peachtree City, GA 30269

Workers' Compensation Coordinator

Vickie Calhoun
Direct Line: 770-502-2152
Email: vcalhoun@gbandj.com
Web address: www.gbandj.com
PHONE: 770-502-2175 FAX: 770-502-2131

Physicians

Jack H. Powell III, M.D.
George M. Ballantyne, M.D.
Michael P. Gruber, M.D.
Chad M. Kessler, M.D.
Michael V. Cushing, M.D.
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MD Pain Care

1301 Sigman Road Suite 100
Conyers, GA 30012

333 Alcovy St. Suite 3
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Workers' Compensation Coordinator

Cheryl Keenan
Direct Line: 470-444-1665
Email: Cheryl.keenan@mdpaincare.com
Web address: www.mdpaincare.com
PHONE: 770-760-9360 FAX: 770-760-9303

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Roy L. Talley, M.D.

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Donna Malcom (Northside, Macon)
Email: dmalcom@orthoga.org
Direct Line: 478-254-5388 FAX: 478-832-6509

Jan Carroll (Northside, Macon)
Email: jcarroll@orthoga.org
Direct Line: 478-254-5302 FAX: 478-832-6509

Amanda Mangham (Spine Center)
Email: amangham@orthoga.org
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Wendy Stamper
Email: wcreferrals@painphysiciansofatlanta.com
Direct Line: 770-391-3979
Web Address: www.painphysiciansofatlanta.com
PHONE: 770-391-3979 FAX: 770-391-0020

Physicians

Shazad Wada, M.D.
Ken Joel, M.D.
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Pain Institute of Georgia

3356 Vineville Avenue
Macon, GA 31204

Workers' Compensation Coordinator

Lori Carr
Email: wcreferrals@paininstituteofga.com
Direct Line: 478-476-9247
Web Address: www.paininstituteofga.com
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Physicians

Carlos J. Giron, M.D.
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5673 Peachtree Dunwoody Road Suite 825
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Workers' Compensation Coordinator

Nanci Joya
Email: Njoya@perimeterortho.com
Direct Line: 404-574-1872
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