Fall 2013 Edition

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We believe that communication between the patient, employer, case manager, insurance adjuster and all medical personnel is critical to the most thorough, cost-effective service. To ensure consistency and open lines of communication for all involved parties, **Pinnacle Orthopaedics** has a dedicated Workers' Compensation Coordinator in each division.

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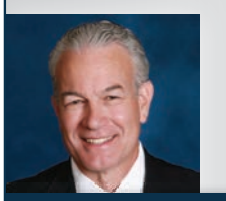

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Prevention & Treatment of Lower Back Pain

Almost everyone will experience lower back pain at some point in their lives. It can be the result of a specific movement such as lifting or bending. Age also plays a role in many back conditions, causing degenerative changes in the spine that can start in the early 30s or even younger.

Those suffering from lower back pain may experience some of the following:

- Back pain with bending and lifting, or prolonged sitting
- Pain when standing and walking
- Back pain that comes and goes, and often follows an up and down course
- Pain that extends from the back into the buttock or outer hip area
- Sciatica, including buttock and leg pain, numbness, tingling or weakness that goes down to the foot.

Prevention

It may not be possible to prevent lower back pain as we can't avoid the normal wear and tear on our spines that goes along with aging. There are ways to lessen the impact of lower back problems:

- Lift heavy items with your legs, not your back. Rather than bending over to lift, keep you back straight and bend at the knees.
- Combine aerobic exercise, like walking or swimming, with specific exercises to keep the muscles in your back and abdomen strong and flexible.
- Maintain a healthy weight. Being overweight puts added stress on your lower back.
- Avoid smoking. Both the smoke and the nicotine cause your spine to age faster than normal.
- Good posture is important for avoiding future problems.

Nonsurgical Treatment

Medications like aspirin or acetaminophen can relieve pain with few side effects. NSAIDS like ibuprofen and naproxen reduce pain and swelling. Pain medications, such as codeine or morphine, may also help. Steroids, taken either orally or injected into your spine, deliver a high dose of anti-inflammatory medicine.

Physical Therapy may include application of heat or ice, massage, ultrasound, and electrical stimulation. Active therapy consists of stretching, weight lifting, and cardiovascular exercises. Exercising to restore motion and strength to your lower back can be very helpful in relieving pain.

Braces are often used, the most common of which is a corset-type that can be wrapped around the back and stomach.

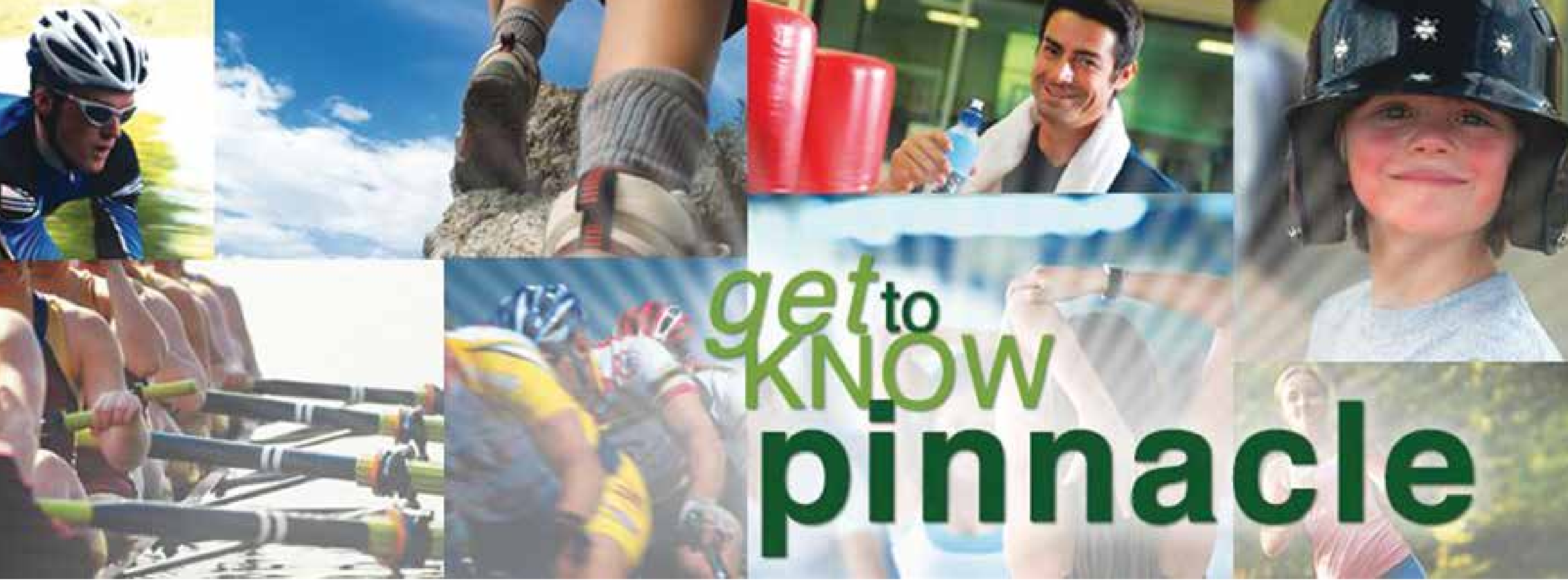
Other exercise-based programs, such as Pilates or yoga are helpful for some patients.

Surgical Treatment

Surgery might be an option when a disc problem or other lower back issue causes pain prevents you from doing everyday tasks. Consider surgery only when other non-surgical options have been exhausted.

With proper treatment, resuming normal or modified activity, including work, is a typical and expected part of treatment and recovery from lower back pain.

*Only your surgeon can help you decide what treatment is best for your lower back pain or other condition. Talk to orthopedic surgeons Dr. Lex Kenerly and Dr. Matt Valosen and the staff at the **Bone & Joint Institute of South Georgia** if you have questions about the best treatment for your condition, or visit **BJISG.com***



Shoulder Pain

Shoulder pain is one of the most common complaints of patients presented to an orthopedists office. There are many possible sources, but I will discuss the five most common causes here.

1. **Impingement syndrome** - This is an umbrella term that encompasses a number of different ailments: Bursitis, Rotator cuff tendonitis, and Rotator cuff tears. In the instance of impingement, there is swelling of either the cuff or bursa. This causes these structures to pinch under the acromion and causes pain. The pain is on the side of the shoulder and often radiates down toward the elbow. It is usually treated with Physical Therapy, medications and icing with occasional injections. The majority of people improve with these treatments and without surgery.
2. **Labral tears** – The labrum is a cartilage ring which attaches around the edge of the socket of the shoulder. It is important for stability of the shoulder joint and as an attachment for the biceps. A tear in this region is usually caused by wear and tear or by a fall landing on an outstretched arm. This type of tear will cause pain on the front of the shoulder. It is usually treated with therapy and medications, if that doesn't work then it may require repair.
3. **Acromioclavicular joint pain** – The AC joint is the joint between the end of the collar bone and the inside part of the acromion which is the roof of the shoulder. This joint can be injured by a fall or when someone is tackled to the ground landing on the top of the shoulder. The more severe forms are treated with surgery to rebuild the ligaments of the AC joint. The second cause of AC joint pain is arthritis. This is caused by wear and tear and occurs to just about everybody, but most people do not get pain from it. Arthritic pain is treated with medications and injections. If this fails then the end of the collar bone is removed to stop the grinding in the joint which relieves the symptoms.
4. **Frozen Shoulder** – This is the most mysterious of the ailments. For reasons which are unknown the soft tissue capsule around the joint becomes inflamed. As it becomes inflamed the capsule starts causing a lot of pain and then the capsules starts forming abundant scar tissue. As the scar tissue forms the shoulder becomes more and more stiff or "frozen." The treatment is a process of stretching to break up the scar tissue. In most cases this will take anywhere from 6-18 months.
5. **Neck Pain** – The last of the causes is referred neck pain. Many people with an arthritic neck or with a neck injury will present with shoulder pain. The reason for this is the muscles which support the neck attach to the shoulder and the nerves coming out of the neck supply all the muscles around the shoulder. If the neck is painful, the pain will radiate out toward the shoulder and give people the sensation of shoulder pain. This is usually treated with therapy and medications. If this fails injections into the neck are often done and rarely surgery.

While there are many causes of shoulder pain, I have discussed the most common. It can be difficult sometimes to sort out all the causes, but the good news is that most patients do very well with non surgical measures.

By Richard Maguire, MD

Dr. Maguire is an orthopaedic surgeon at Pinnacle Orthopaedics. Get to know Pinnacle. Call 770-944-3303 or visit www.pinnacle-ortho.com for a complete list of services, physicians and locations near you.

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A great time was had by all at the May 2013 Spring Georgia Workers' Compensation Association Conference at Calloway Gardens!

(Formerly known a the GSIA- Georgia Self Insurance Association)

Education is a major focus for GWCA. Through education, employers have the tools to continuously improve their programs. During the Spring Conference the new organization held its first Employer's Roundtable Session.

"I strongly believe that an informed employer is going to be an industry leader," said Kathy Oliver, a spokesman for GWCA. "By joining GWCA you not only stay informed but you are also able to meet other strong leaders who can help you improve your entire workers' compensation program."

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Get Down Tonight!

One of the favorite networking events at the Georgia State Board of Workers' Compensation Educational Conference each year is the ride on the Fur Bus to Johnny's Hideaway. This evening of dancing and relaxing is a perfect time to catch up with WC folks from all over the state.

We'd like to thank the sponsors who generously provide support for the evening!

The Fur Bus is courtesy of Chatham Orthopaedic Associates, P.A.!

Fur bus Schedule August 26, 2013

8:00PM - Leaves from Hyatt Regency Atlanta for Johnny's Hideaway and returns at 9:00, 10:00 and 11:00. Return transportation is sponsored by AccessOn Time and will provide additional transportation at 8:30, 9:30, 10:30 and 11:30.

The last return bus leaves Johnny's Hideaway at 12:30 PM

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Thumb Amputations

Loss of the thumb significantly impairs hand function. The injured patient may lose the ability to pinch, grip, write or operate machinery. The remaining hand is marginally effective without a stable thumb of adequate length. Occupational thumb amputations are common and may be due to crushing, lacerating, or injection injuries. Primary management and late reconstruction may significantly improve hand function.

Amputations of the thumb are described and managed based upon the level of injury. The thumb is composed of three joints and four bones. The joint closest to the thumb tip is the interphalangeal joint between the distal phalanx and the proximal phalanx. The middle joint is the metacarpophalangeal joint and is the articulation between the proximal phalanx and the first metacarpal. The saddle joint at the thumb base is the first carpometacarpal joint and is the articulation of the first metacarpal and the trapezium, a small wrist bone.

Impairment is due to the level of thumb loss. The 5th. Edition of the AMA's "Guides to the Evaluation of Permanent Impairment" suggests that an amputation at the most distal joint represents a 50% loss of thumb function, 20% of hand function, and an 11% whole person loss. An amputation at the metacarpophalangeal joint or proximal represents 100% thumb loss, 40% hand loss, and a 22% whole person loss. The loss of the thumb proximal phalanx doubles the whole person loss. Therefore, maintaining or restoring thumb length is the primary objective in managing thumb amputations. The surgeon avoids the sacrifice of precious thumb length.

An amputation at the interphalangeal joint or distally may require skin coverage with a local flap rather than shortening the bone and repairing skin over a foreshortened skeleton.

Sharp amputations with little crush component proximal to the interphalangeal joint may be amenable to replantation which can be very effective management in this setting.

When replantation is not an option or fails, wound coverage is obtained and a variety of reconstructive options are available to increase length and restore function. Injuries proximal to the middle of the proximal phalanx generally require reconstructive surgery. Deepening of the first web with tissue rearrangement such as Z-plasty or skin graft may serve to functionally lengthen the thumb. Injuries that retain the first metacarpal are amenable to bone lengthening using an external device that may provide several centimeters of length but does not add joints or restore the nail. However, the procedure may be done without sacrifice of a distant functional body part which may represent an attractive option in many settings.

Free microvascular transfer of a toe is a major undertaking that requires partial foot donor tissue and may significantly improve thumb and hand function.

Generally, transfer of a toe demands that sufficient bone length and soft tissue are present to accept the toe on the hand. Very proximal thumb amputations may require a pollicization procedure in which the index finger is transferred to the thumb position and the remaining digits oppose the repositioned index finger.
Advances in tissue transplantation add further potential thumb reconstructive options.

Workplace thumb amputations are common. Both impairment and management are guided by the amputation level. Functional restoration is frequently an available option for these crippling injuries.

By Waldo Floyd III, MD, OrthoGeorgia

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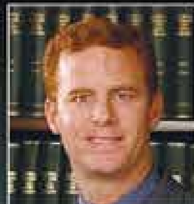
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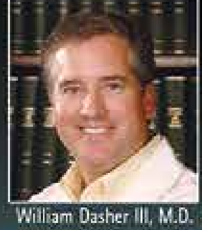
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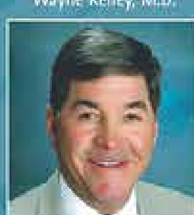
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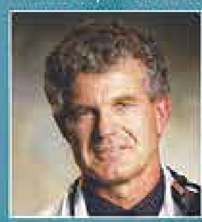
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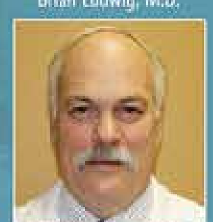
Todd Kinnebrew, M.D.

A message from the Chairman of the GA State Board of Workers' Compensation

It is an exciting time at the State Board of Workers' Compensation. We have a completely new Board of Directors appointed by Governor Nathan Deal starting with the appointment of Judge Elizabeth Gobeil on November 01, 2012 followed by my appointment as Chairman on March 01, 2013 and Judge Harrill Dawkins' appointment on May 31, 2013. The three of us also serve as the three judge panel for the Appellate Division and hear all of the appeals of the hearing decisions. Our goal is to continue to find ways to improve our workers' compensation system which has served employers and employees well in our state. Georgia continues to remain one of the very best states in the nation in which to do business and our workers' compensation system is a key component in the business equation.

The 2013 Georgia Legislative Session passed House Bill 154 in the House and Senate and has been signed by the Governor and will take effect July 01, 2013. The most significant change is a 400 week cap from the date of injury on medical benefits for accidents occurring on or after July 01, 2013, except in cases qualifying for catastrophic designation. OCGA §34-9-240 regarding formal offers of light duty work was amended to require an employee to attempt the offered light duty job for at least "8 cumulative hours or one scheduled work day, whichever is greater" in order to meet the good faith effort requirement. The maximum temporary total disability benefit rate for accidents occurring on or after July 01, 2013 was increased from $500.00 to $525.00 per week and the maximum temporary partial disability rate was increased from $334.00 to $350.00 per week. The time for reimbursing employees for their mileage was decreased from 30 days to 15 days for all compensable claims. The interest rate for advanced lump sum payments decreases the present-day value discount interest rate from 7% to 5%. Also of note, is that effective January 01, 2014 Board rule 104 will require the filing of a Board form WC-104 with the supporting medical report within 60 days from the date the employee was released to work with restrictions by the employee's authorized treating physician in order to unilaterally convert the employee's income benefits from temporary total disability benefits to temporary partial disability benefits pursuant to the provisions of OCGA §34-9-104 (a) (2).

Most prognosticators predict the 400 week cap on medical benefits will have the largest impact on Georgia's workers compensation claims. However, this statutory change is predicted to have a cost saving impact over time. It is predicted to reduce the cost of those claims requiring a Medicare Set Aside Allocation.

In April and May the State Board travelled to Columbus, Tifton, Savannah, Athens, and Kennesaw for its Annual Regional Education Seminars. The State Board with the assistance of its Public Education Committee discussed numerous workers' compensation topics including a case law and rules update, injury prevention, claims handling, and litigation vs. mediation tips. Each seminar concluded with audience participation and a game show format similar to "Jeopardy" with various workers' compensation topics as the categories. Prizes were awarded to the winners. The State Board is currently finalizing its preparations for the Annual Educational Seminar to be held this August 26th through the 28th at the Hyatt Regency Hotel in downtown Atlanta. We look forward to seeing many of you at the Annual Seminar.

By Frank R. McKay, Chairman

STATE BOARD OF WORKERS' COMPENSATION

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The Painful Foot

Do you suffer from these common yet painful conditions of the foot and ankle? What options are available for relief?

Ankle sprain: These are rated Grade I, Grade II or Grade III based on the severity of the injury to the lateral ligaments. There is pain upon weight bearing, swelling then bruising. Treatment ranges from R.I.C.E. (Rest, Ice, Compression and Elevation) and anti-inflammatory medications to a cast, boot or brace and 4-6 weeks of physical therapy.
Ankle fracture: A fracture is treated with a cast or boot. If the injury is unstable, surgery may be required followed by 10-12 weeks of physical therapy.
Plantar Fasciitis: As many as 10% of the population gets plantar fasciitis. It is the most common cause of heel pain. It is a degenerative process at the plantar fascial insertion onto the heel bone. Pain is common with the first steps out of bed in the morning. Approximately 80% of all heel pain is caused by plantar fasciitis and 90% of patients are improved in 9 months. Stretching the calf muscles is paramount. Surgery is almost never indicated.

Achilles Tendonitis: Occurs when the tendon (Achilles tendon) that connects the back of your leg to your heel becomes swollen and painful near the bottom of the foot .Pain, redness and swelling with pain are noticed on push-off as when climbing stairs. Treatments are stretching, NSAIDS (Advil, etc.), ice and surgery.
Flatfeet: There are 2 types of flatfeet: those you are born with and those you acquire over time. Congenital flatfeet (those you have at birth) can be treated with inserts and arch supports if they become painful. Painful flatfeet that are acquired are likewise fitted with shoe inserts or braces. Occasionally surgery is required to reconstruct the arch of the foot.
Bunion: The painful prominence over the big toe known as a bunion can cause quite a bit of pain and disability. It is NOT a new growth of bone but rather a slow dislocation of the big toe joint over time due to genetics or narrow footwear. Initial treatment is always footwear modification to limit pressure over the painful bump. Surgery is sometimes required to realign the great toe to alleviate pain.

Hallux Rigidus; Hallux Rigidus (or big toe arthritis) is Latin for "stiff big toe". Treatment includes wearing stiff soled shoes to limit painful motion through the arthritic joint. Surgery can be done to trim away bone spurs or to fuse the big toe joint if the arthritis worsens.
Gout: A very painful condition involving the toes, ankles, elbows or knees is called gout. This can be familial or diet-related. Uric acid crystals form in the joints that are away from the core of the body where the temperature is decreased, i.e big toe, elbow, or hands. To prevent Gout episodes, limit alcohol, meat, fatty foods and purine-rich foods such as oils, salty fish (anchovies, herring, and sardines), gravies, legumes, mushrooms, spinach, asparagus, and cauliflower. Treatment for gout is usually with medicines: anti-inflammatory drugs (indomethacin), colchicine and steroids. Allopurinol can be used to prevent recurrent attacks.
Hammer Toes: Painful deformities of the toes such as hammer toes, claw toes and mallet toes cause corns and calluses to develop. This causes difficulty with wearing shoes and pain about the prominent bones of the toes. Footwear modifications and cushioned sleeves should be used. Surgical realignment is a last resort.

By J.T. Prather, MD, Orthopaedic Foot and Ankle Surgery, Chatham Orthopaedic Associates, P.A.

Athens Orthopedic Clinic – Personalized care with a longstanding tradition of excellence and service

Since 1966, Athens Orthopedic Clinic has provided personalized patient care across the entire spectrum of orthopedic surgery and rehabilitation. From urgent care to consultation, from surgery to rehabilitation, Athens Orthopedic Clinic's professional network of physicians and physician assistants provide exceptional orthopedic treatment and care. To accommodate the needs of their growing patient base, Athens Orthopedic Clinic has expanded to offer a total of nine convenient locations throughout Northeast Georgia, while staying committed to meeting the individual needs of each and every patient.

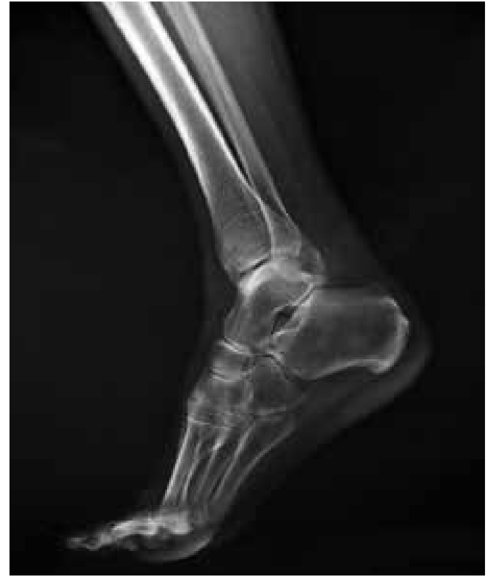
The growing practice also offers a variety of specialty centers. Athens Orthopedic Clinic's highly-respected team of physicians, physician assistants, trainers, and therapists provide specialized care in many different areas of orthopedic expertise. Members of each team work toward one common goal - to provide patients with individualized orthopedic care. Athens Orthopedic Clinic's specialty centers include: Orthopedic Urgent Care, Ambulatory Surgery Center, AOC Therapy Center, Spine & Scoliosis Specialists, Hand & Upper Extremity Specialists, Total Joint Center, Foot and Ankle Center, Sports Medicine Center, Interventional Pain Management, and Occupational Health Center.

Athens Orthopedic Clinic's dedicated Occupational Health Center provides employers with an individualized approach to the treatment of injured employees. Their mission is to provide expeditious and professional services to employees and employers with specific goals of returning employees to work in a safe working environment and provide positive outcomes. Dr. Joseph M. Savitz, board certified in Physical Medicine & Rehabilitation, serves as the medical director of the Occupational Health Center, and Jennifer Herring, CWCP, is the Director of Workers' Compensation and both are available to discuss all workers compensation questions or concerns.

Jennifer Herring believes that communication and education are the keys to reaching a positive outcome. Jennifer explains, "In my 9 years at Athens Orthopedic Clinic, I have had the privilege of helping to foster the growth of the Workers' Compensation division into what it is today: a multi-faceted extension of AOC that gives specialized care to patients and personalized service to all parties involved in each case. Our dedicated Workers' Compensation department is committed to ensuring that each case runs as smoothly as possible."

Whether you want to get back to work, get back on the field, or just get back to living a happy and healthy life, Athens Orthopedic Clinic is here to help you reach your goal.

For more information, please visit www.AthensOrthopedicClinic.com or call 706-549-1663.



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Now you can earn 30 minutes (.5 hours) credit toward the CWCP & MPWCP Recert for reading through this edition of Workplace Health magazine. If you are registered for the CWCP or MPWCP Recert, simply log on to the training portal and you will find a set of questions associated with the content in this edition.

Best Practices in Workers' Compensation

Adam Cobb, a professor at Wharton, said "My loyalty to the firm is contingent on my firm's loyalty to me… But there is one party in that exchange who has tremendously more power, and that is the firm." When you are involved in the management of a workers'compensation claim you are "the firm". According to NCCI (National Council on Compensation Insurance), claims frequency continues to decline, but the cost per claim for lost time claims is rising.

I believe a major factor influencing the increase in claims costs is the continued deterioration of the employer/employee relationship. The "silver bullet" in claims handling has more to do with employee engagement (or the lack of) than it does with Board Forms. It is the quality of the relationship between an employee and his or her manager that determines the overall level of employee engagement.

Good companies will develop a growing list of great managers over time. It is the local level teams and how they are connected together by leaders and managers that have the most impact in successful resolution of lost time claims. Training on a pre-claim basis is a proven strategy to reduce post-claim costs.

By Steve Heinen, President ,Risk Management Inc.

http://www.rmitraining.net/

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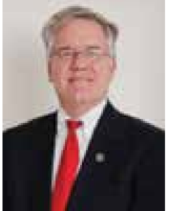

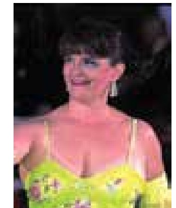
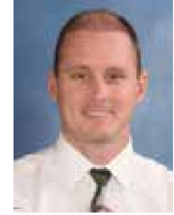

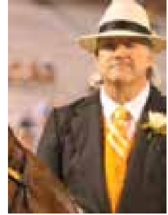
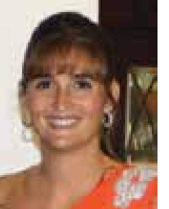

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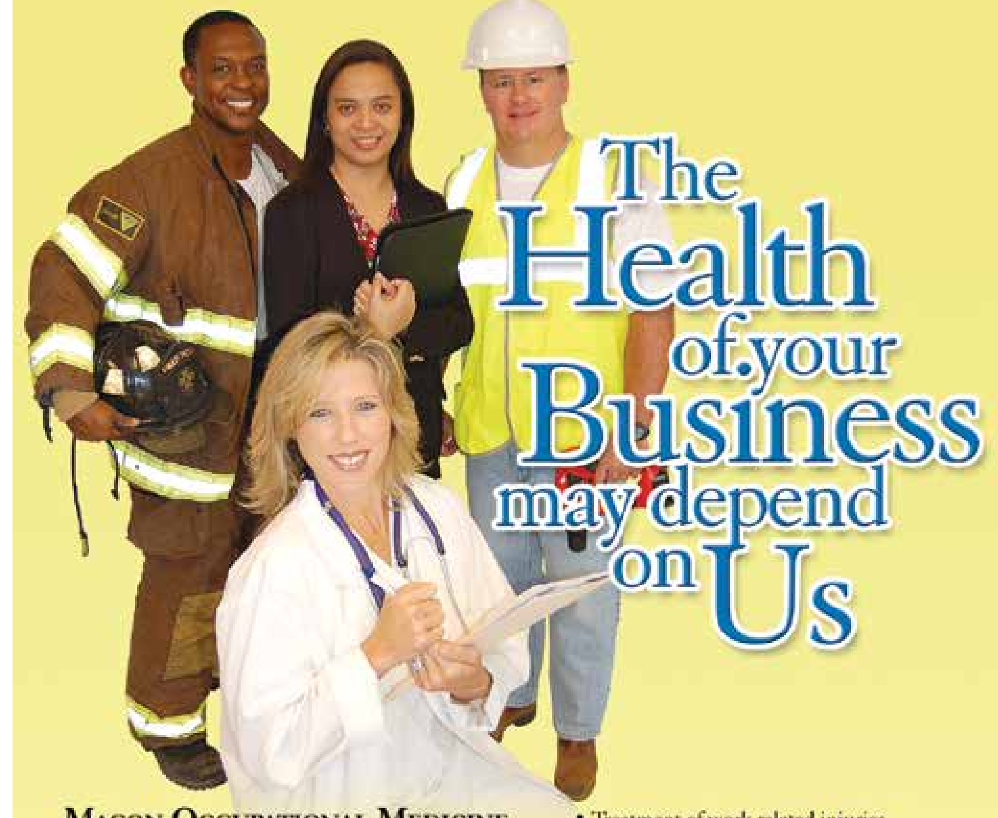
Improve The Safety of Your Workforce

Is your workforce fit to work safely without undue risk of injury?

Consider these questions as well: Are you making sure your new hires are physically fit to do a specific job description without risk to himself or to a coworker? What if they have already been injured? Is your employee ready to work again safely? Companies are starting to hire better and lower their injury rates by doing a few screenings that lower their risk.

Post Offer Placement Evaluations in addition to pre-employment physicals and drug screens can dramatically improve the safety of all your workers. You do not have to risk of discrimination because of age, race or gender - all workers have to pass agility, lifting, pushing, pulling test to evaluate whether they are physically fit to do a specific job description successfully. As an independent medical facility, at Macon Occupational we can let you know up front if someone is not physically fit to do the job before you have an avoidable injury claim affecting your workers' compensation rates. If an employee has been out for any reason, we can do a "return to work" physical also known as a "fit for duty" physical. This will evaluate if the employee's health and physical capacity are ready for the job description they will be doing. This physical can dramatically lower the risk of injury or aggravation to a previous injury.

Macon Occupational Medicine will be happy to help you assess your screening process and make recommendations for ways to improve the safety of your workforce. As they say, "an ounce of prevention is worth a pound of cure!"



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At The Physicians, all of our doctors hold primary certification through ABMS in Anesthesiology or Physical Medicine and Rehabilitation. Our physicians also hold subspecialty certification in Pain Medicine through the ABMS. This is considered the highest standard in pain medicine certification. A helpful tool in determining whether your provider is appropriately certified by ABMS is through the website certificationmatters.com. Selecting an ABMS Board Certified physician ensures your provider keeps abreast of the latest advances in pain medicine and demonstrates best practices when it comes to patient safety and ethics.

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What Should You Expect From Interventional Pain Management?

It seems as though most people feel that pain management is a "black hole"- a place from which the claimant will never return. Some pain management practices may fit such a description. However, all pain management practices should not be painted with such a broad brush.

A common misconception is that pain management is the last place to refer an injured worker; after all other treatment has failed. The truth is if we could treat these patients earlier, before they are started on schedule 2 narcotics, especially when they have pain that is not sensitive to narcotics, then we would have many more treatment options. Most of the time strong narcotic medication is not appropriate and NSAIDS, muscle relaxers, neuropathic medication and physical therapy will suffice. If the origin of the pain is the back, then conservative measures should be tried first. It is also important to know that treatment with narcotics prior to tests may block the pain generator and make it difficult to determine the actual cause of pain.

A common thought is pain management patients become dependent on narcotics. That is not the case with interventional pain management physicians who also practice addiction medicine. The goal is to screen patients for risk factors regarding narcotics BEFORE prescribing them. Efforts should also be focused on reasonable prescription regimens, with strong reinforcement that narcotics will be used sparingly and only with other modalities. If a physician is prescribing narcotics, their plan should also include an estimated length of time for the use along with preparations for ending the narcotics.

It is fair to expect a care timeline from the treating physician. The care plan must outline the steps needed to diagnose, carry out the plan, and an alternative protocol for other possibilities that may be met during the treatment.

We are all aware there are abusers of the Workers' Compensation system. Finding physicians who are experienced at recognizing and treating this type of person and who can identify potential addiction problems is vital. Quick diagnosis and short treatment times are beneficial to all involved with the claim. In all of the years I have been treating pain patients, I have never seen patients that needed multiple diagnostic blocks, or continuous therapeutic epidurals. If the first few did not work, it does not help to continue the same treatment.

Our goal is to help injured workers return to work quickly and safely and arm them with skills to avoid re-injury. Our wish for them is to work safely, productively and positively for the remainder of their career.

By D. Janene Holladay, M.D.
Spine Care & Pain Management
Board Certified:
American Board of Anesthesiology
American Board of Pain Medicine
American Board of Addiction Medicine

You can find out more about Dr. Holladay and her practice at www.TameYourPain.com.

Developing a Custom Job Placement Assessment

Since 1990, SouthernAG Carriers has grown from a handful of employees to nearly 300 today. In fact, just five years ago the company had 165 full time employees and now process up to 65 applications and 15 hires a month. "There is not a time anymore where we are not taking applications", says Dexter Murphy, SouthernAG Carriers' Driver Personnel Manager. Murphy is now an HR specialist that deals solely with the hiring of new employees on a daily basis. With success came change on how the company handles operations internally and two years ago a decision was made to examine possible changes within the company's hiring process. Hugh Nall, CEO of SouthernAG Carriers, assembled a team to take a look at all aspects of personnel recruitment. This was a simple task for Nall. Having coached football in the SEC for twenty years, he understood the need to consult with specialists in the legal and medical field in order for this change to be effective.

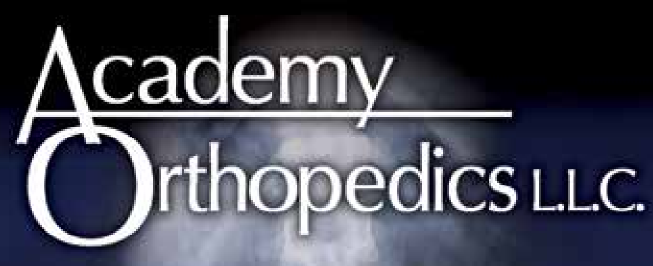
Workers' Compensation Defense Attorneys Nathan Levy and Buck Burriss of Levy and Thompson, LLC and Occupational Medicine physician Dr. Kevin Smith of Phoebe Putney Corporate Health of Phoebe Putney Occupational Medicine were consulted. After an examination of SouthernAG Carriers' hiring process, several legal and medical changes were adopted. SouthernAG Carriers committed to the use of a Post-Offer Medical Questionnaire for their conditional hires. From a legal perspective, this document allows an employer to obtain key medical information after an offer of employment has been made and within the stringent requirements of the ADA. The questionnaire also allows SouthernAG Carriers to ensure that any health issues are discussed that are of a concern in the heavily regulated trucking industry. "Safety has always been our top priority", says John Yordy, SouthernAG Carriers' Safety Director. "We want our employees safe and certainly take seriously the safety of the general public who use our nation's highways."

The post-offer medical questionnaire also assists Dr. Smith in his role in the hiring process. Dr. Smith and his staff at Phoebe Corporate Health set aside 4 slots each week for SouthernAG Carriers' new hires. "We partnered with SouthernAG Carriers to provide new hires with a comprehensive physical examination and assessment of the employee's medical history", says Dr. Smith. "Once the employee passes the physical examination, a job placement assessment, or JPA, is administered. The JPA was developed specifically for SouthernAG Carriers by Phoebe East Industrial Rehabilitation and includes activities specifically tailored for the trucking industry." When an employee passes the JPA and physical examination, they can hit the road. The examination pinpoints a new employee's ability to perform all of the essential functions of the job for which they are hired and also identifies all pre-existing conditions that need to be addressed.

What began as just an idea in early 1990 became a reality in December of that same year when Henry H. Griffin, Owner/CEO, of SouthernAG Carriers, Inc. put together the purchase of a small private fleet of 5 tractors and 10 dry van trailers serving customers in the peanut processing industry in Georgia, Alabama, & North Carolina. Since December of 1990, SouthernAG Carriers has grown to operate a fleet of 250 company owned tractors and over 1000 trailers serving a wide array of customers across 27 states. SouthernAG Carriers now meets the daily needs of customers in just about every business sector, having moved beyond their initial ag based business model. A business model based on long-term relationships and a constant commitment to on-time, claims free service has made SouthernAG Carriers a successful and growing business.

With the new program in place, SouthernAG Carriers has met with immediate positive results. "We now know for certain that our employees are safe to go about their tasks of satisfying our customers", says Janice Pollock, SouthernAG Carriers' Assistant Safety Director. SouthernAG Carriers' commitment to change the hiring process has involved a tremendous amount of dedication and hours of consultation. but the hiring process is now fit with the exponential growth of the business. SouthernAG Carriers is now positioned to continue to meet customer demands, continue to grow and to do so with healthy and safe employees.

It Takes a Committed Team to Create a Great Program.



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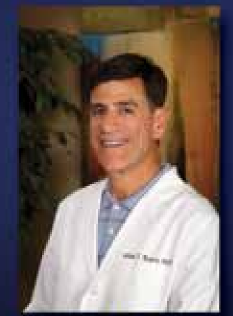

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See you in August!

Repetitive Stress Injuries in the Workplace

What Are RSIs?

Occupational RSIs, or repetitive stress injuries, comprise more than one hundred different types of job-induced injuries and illnesses resulting from wear and tear on the body. RSIs are one of the fastest growing workplace injuries, and can result any time there is a mismatch between the physical requirements of the job and the physical capacity of the human body. Specific risk factors that can cause RSI's include repetitive motion, force, awkward posture, heavy lifting, or a combination of these factors.

Warning Signs of RSI:

There are no clear ways to alert a worker that they are headed for an RSI. Often, by the time an employee realizes that something is wrong, damage has already been done. Employers should encourage workers to pay attention to the following warning signs:

- Pain
- Tingling or numbness
- Fatigue
- Weakness or clumsiness

So What Can Be Done About RSI's?

Improper ergonomics is the primary cause of RSI's across many kinds of jobs. Ergonomics is the study of how people interact with their physical environment. It uses scientific knowledge about objects, systems, and environments (like work stations) to maximize productivity and minimize injuries. So ergonomics play an important role in the cause and prevention of work-related cumulative trauma injuries.

As an employer, what can you do to reduce RSI's? Be proactive; take steps to protect your employees from carpal tunnel syndrome and other RSI's. For example, by upgrading equipment, training employees on improved work techniques, or modifying the layout of work stations. And always listen to your employee; this may help reduce the severity of RSI's.

Medicare Set Aside Review

We have completed the first year with the new review contractor and as expected the process for review time has improved significantly. MSA turnaround time has greatly increased response back to insurer. Allocators are gaining a better understand of expectations from CMS. Although not perfect, there is a consistency of reviews and outcomes far from what we experience in prior years. Long term objective is for CMS and allocators to use evidence based medicine to guide the review of allocations. Knowing what specific guidelines are being used by CMS to establish projections and costing of drugs will help to improve accuracy. Committees within our national organization (NAMSAP) are working on legislative initiatives to address MSA practice and standards with CMS.

Effective July 1, 2013 Georgia HB154 will cap medical benefits at 400 weeks for accidents occurring on or after July 1, 2013. Allocations for the State of Georgia after the effective date should not project past 7.7 years. Allocators should attach HB 154 to CMS submission to prevent a counter higher and over funding of MSA. CMS should comply with state ruling.

In summary, CMS has agreed to re-review allocations where you disagree with a decision if there was an obvious mistake, mathematical error, failure to recognize medical records or if you have additional evidence not previously considered. Follow the re-review process in any case where you have supporting documentation. Withhold settlement until WCMSA is approved by CMS.

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To check on status of electronic WCMSA go online to: https://www.cob.cms.hhs.gov/WCMSA/login or for paper or CD submissions contact WCRC at

855-280-3550.

Transportation for Your Injured Worker – Liability & Service

Transportation is made available when injured workers cannot facilitate the function themselves. It will help facilitate a faster return to work of the claimant by:

- Insuring that safe, reliable transportation is available to the claimants to get them on time to significant appointments.
- Eliminate the excuse of missed appointments due to not having reliable transportation, thus prolonging the claim.
- Limit additional risk of people outside the claim becoming injured in facilitating the transportation.
- Documenting claimant's compliance.

The most often type of transportation requested is ambulatory transportation (80%). Wheelchair is estimated at 10% and all other modes (stretcher, ambulance) at 10%.

The provider you utilize should carry insurance coverage that layers on top of the network vendor to assure coverage that would meet the levels that insulate the client that retains the services. This normally is a policy referred to as "Hired and Non-Owned" that covers only the injured worker being transported for liability related to injuries incurred and for the other vehicle involved if applicable. It layers on the commercial vendor's coverage and starts at "dollar-one" for the Independent (their insurance is personal and therefore would not cover "for hire" services).

By Melven (Mel) Nehleber President & CEO of AccessOnTime
For more information visit www.accessontime.com

Practical Ergonomics in the Workplace

Industrial Preventive Rehab is troubleshooting problems for injury prevention. There are ergonomics by definition and then there are Practical Ergonomics.

Practical Ergonomics is about safety and productivity and taking care of the folks who work with you. An Employee with painful feet, back or neck is not a stable, safe or productive employee! Low level chronic pain decreases employee concentration, productivity and safety.

Why does my back hurt when all I do is sit?
There are four types of back/leg pain and they all require different exercises. There is no one exercise for all back pain. Exercises for back patients need to be patient specific; an exercise that decreases and/or centralizes their symptoms: **The four types are:**

- Symptoms are worse sitting, but better walking
- Symptoms are worse walking, but better sitting
- One sided symptoms that are better walking and worse sittings
- Those with symptoms that never change

Why do my feet hurt when I'm on concrete, even when I'm wearing shoes?
The human foot contains 26 bones, 33 joints and over 100 tendons, muscles and ligaments that change over time!

- Pronators, when not supported, and high rigid arches are supported on sand and grass. Pronators pinch the structures on the outside of the ankle and stretch the structures on the inside of the ankle; both cause pain.
- Flat rigid surfaces offer no support to either.
- Stress, in those with pronators and those with high arches, is put on the midfoot causing the small muscles of the foot to work harder trying to maintain the arch and balance.

To understand the pain/condition of any individual, you must take into account their work station, posture and work requirements. Other factors include if they have degenerative or herniated discs, whether the pain is one-sided and if they have had proper foot evaluations recently. A visit to the workplace by a professional trained to recognize how to prevent injuries in the workplace with ergonomics is supported by the savings in employee health costs. Safety includes evaluating all the situations in which your employees perform – including those at a desk or computer.

By Tommy Williamson, Physical Therapist, Certified McKenzie Therapist, Director of Rehabilitation, Forsyth Street Orthopaedics

Ergonomic Tips

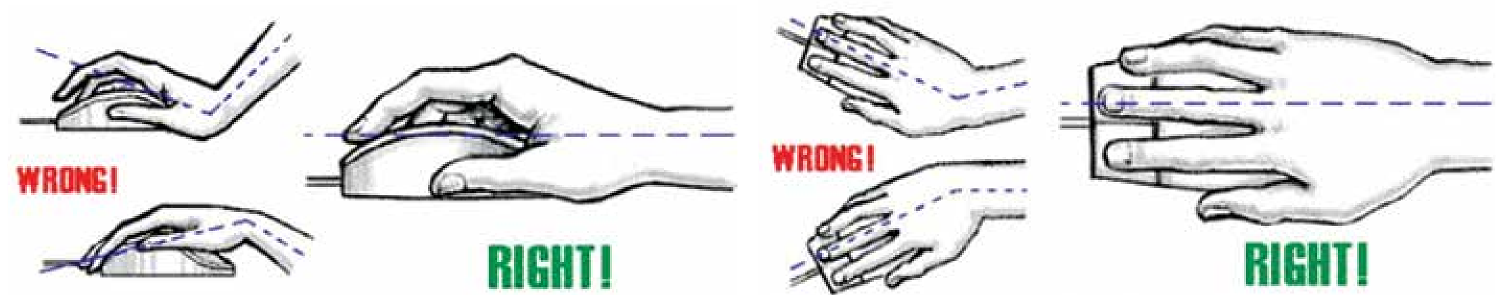
Work Station Posture:

Chair Set-Up: Your chair is usually the most adjustable piece of equipment in your work station. Become familiar with all of its available adjustment sites. Adjust the height so that the upper legs are parallel to the floor. This will ensure that the hips are at 90 degree angles. Your feet should be supported on the floor or a footrest. Many chairs can also be adjusted for low back support. A lumbar roll can be used as a support if the chair does not have this feature. A good lumbar support will help facilitate good posture.

Keyboard: The keyboard and mouse should be close enough to your body so that your elbows are at a 90 degree angle with your arms at your side. Your wrists should be straight in a neutral position in line with your elbows. Your shoulders should be relaxed.

Mouse Tips:

Placement: The mouse should be close enough to your body, so that your elbows are at a 90 degree angle.
Hand/Wrist Position: Lightly grip the mouse with the wrist straight. Do not use a wrist rest or pad. If available, choose a mouse that fits your hand and is as flat as possible. This will help decrease wrist extension.
Movement: Move the mouse with your elbow and not your wrist or fingers.



Important Update to Florida Workers' Compensation Law - Westphal takes us back 20 years

In February of this year, the First District Court of Appeal held a portion of Florida law, specifically Section 440.15(2)(a), unconstitutional and further held the standard found prior to 1994 was the appropriate constitutional standard. Essentially, an injured worker is now entitled to Temporary Total Disability (TTD) benefits for up to 260 weeks.

Mr. Westphal was a firefighter who was injured in the line of duty. He suffered severe injuries that resulted in a five level fusion. As a result of his injuries, he was placed on a no-work status throughout his medical recovery, which extended past the 104 week limitation mandated by Section 440.15(2)(a). Due to still needing further surgeries and still recovering from his injuries, he was not placed at maximum medical improvement at the time that his TTD benefits were exhausted. As a matter of fact, Mr. Westphal was still not at MMI nine (9) months after his benefits exhausted. As a result, Mr. Westphal went for an extended period of time with no monetary benefits. This time period is generally known as the "temporary permanent total" period, which is not defined nor recognized by the Florida Workers' Compensation system. The Court noted that it was unreasonable and unfair for an injured worker to not be entitled to benefits after 104 weeks of benefits, despite the fact that he was at that time totally disabled, incapable of engaging in employment, and ineligible for any compensation under Florida's Workers' Compensation law for an indeterminate period.

The Court was very detailed on how indemnity benefits have been cut by the legislature throughout the past 50 years at the detriment of injured workers. In 1968, an injured worker had 350 weeks of TTD benefits available, then reduced benefits to 260 weeks of TTD in 1991, and then shortly thereafter again reduced benefits to 104 weeks in 1994. The DCA went as far as calling it a draconian reduction.

So where does this leave us? An injured worker is now entitled to 260 weeks of TTD benefits. But what about temporary partial disability (TPD) benefits, are they limited to 104 weeks, or will the Claimants' Attorneys' also argue for 260 weeks as per the pre-1994 standards? Or, is 260 weeks the maximum for both TTD and TPD benefits? The language in the opinion seems to indicate that a worker who is able to work, albeit with work restrictions, would not fall under the Westphal analysis. Therefore, until the Florida legislature passes new legislation to clarify this matter, it appears that a Claimant will be entitled to 104 weeks of TPD benefits, and 260 weeks of TTD benefits, increasing the Employer/Carrier's exposure on each claim.

By Carla C. Wester and Lourdes M. Sancerni-Fulton
Moore, Ingram, Johnson & Steele LLP

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Occupational Health Nurses: The Gate Keepers of Treatment

The ideal candidate for an Occupational Health Nurse (OHN) will be a LPN or RN in good standing within the state of practice, experienced in occupational health, urgent care, and/or emergency medicine and OSHA training (10-hr minimum). The work-site OHN must juggle the best interest of the patient, the business relationship with the employer and always maintain acceptable ethical and medical practices. Duties can include Off-Site or On-Site Industrial Medicine Nursing and Worker's Compensation Case Management.

On-Site (Industrial Facility) duties:

- Random Drug Screening
- Breath Alcohol Testing
- Respiratory Fit Testing
- Pulmonary Function Testing
- Strength/Fit/ Endurance
- Immunizations
- Wellness Education
- Health Fair Participation

And always the OHN must document, document, document because:

-OSHA is watching
-State Board of Worker's Compensation is watching
-Joint Commission is watching
-WC attorneys are watching

By Sequoyah (Quorry) Brown, RN, BSN, OHN
Disability Case Manager
Georgia Power Company

Workers' Compensation Case Management

Work-Site	Third Party
• Initiate care	• Claims management
• May do first report of injury/incident reports	• Schedule and attend appointments
• Submit Claims	• Usually works for insurance company
• Follow up evaluations	
• Schedule and attend appointments	

The Employer's Perspective

Desirable Outcomes	Undesirables
• Health and recovery of the injured worker	• Loss of human capital
• Minimal direct/indirect costs	• Excessive direct/indirect costs
• Non-recordable injury	• Injuries resulting in OSHA recordables of LTAs
• Avoid lost time accident status	• OSHA investigation
• Avoid litigation	• Litigation

A Skin Infection May Very Likely be MRSA

The Centers for Disease Control encourages you to consider MRSA in the differential diagnosis of skin and soft tissue infections (SSTIs) compatible with S. aureus infections, especially those that are purulent (fluctuant or palpable fluid-filled cavity, yellow or white center, central point or "head," draining pus, or possible to aspirate pus with needle or syringe). A patient's presenting complaint of "spider bite" should raise suspicion of an S. aureus infection.

Recent data suggest that MRSA in the community is increasing. The spectrum of disease caused by MRSA appears to be similar to that of Staphylococcus aureus in the community. SSTIs, specifically furuncles (abscessed hair follicles or "boils"), carbuncles (coalesced masses of furuncles), and abscesses, are the most frequently reported clinical manifestations. The role of MRSA in cellulitis without abscess or purulent drainage is less clear since cultures are rarely obtained.

Recently recognized outbreaks of MRSA in community settings have been associated with strains that have some unique microbiologic and genetic properties compared with the traditional hospital-based MRSA strains, suggesting some biologic properties (e.g., virulence factors) may allow the community strains to spread more easily or cause more skin disease.

Environmental cleaners and disinfectants should not be used to treat infections. The EPA provides a list of EPA-registered products effective against MRSA.

To learn more about Methicillin-resistant Staphylococcus Aureus (MRSA) Infections, please see the source of this information at http://www.cdc.gov/mrsa/index.html

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