Fall 2014 Edition

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Meet Our Providers

Robin J. Fowler, M.D.

Allen H. Hord, M.D.

Rhee W. Miller, M.D.

David J. Rosenfeld, M.D.

Ramon D. Espinal, M.D.

Naureen M. Adam, M.D.

Pickens A. Patterson III, M.D.

CONDITIONS TREATED

- Hip Pain – Degenerative Disc Disease
- Neck Pain – Spondylosis
- Back Pain – Disc Herniations
- Occipital Headaches
- Nerve Root Impingements
- Vertebral Compression FX
- Spinal Cord Injury nerve pain
- Radiculopathy/Sciatic – Cancer
- Reflex Sympathetic Dytrophy RSD/CRPS
- Diabetic Neuropathy
- Facet Pain – SI Joint Dysfunction
- Trigger Point Injections

NON-SURGICAL TREATMENTS

- Epidural Steriod Injections/Discograms
- Selective Nerve Root Blocks/Facet Blocks
- Diagnostic Nerve/Lumbar sympathetic blocks
- Radiofrequency Ablation
- Major Joint Injections/Stellate Ganglion Block
- SI Joint Injections/Medial Branch Blocks
- Peripheral Nerve Blocks
- Celiac Plexus Blocks/Spinal Cord Stimulator
- Occipital Nerve Blocks
- Hypogastric Plexus Blocks
- Vertebroplasty/Kyphoplasty

kledet@spinepains.com

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"I Already Had A Cortisone Shot"

By Pickens A. Patterson, III, M.D.

I often hear this phrase from patients presenting to me at initial consultation in my practice as an interventional pain physician. When I ask what type of cortisone injection I am often greeted with blank stares. Patients and even healthcare providers are relatively unaware of the vast array of interventional procedures used to treat chronic painful conditions. A clear understanding of the procedures performed by interventional pain physicians is essential to being an active participant in a patient's recovery.

Cortisone is but one type of steroid that is used in injections used to treat painful conditions. However, many patients use cortisone injection as a synonym for epidural steroid injection. In reality, various steroids are used to inject inflamed joints, nerves, and soft tissues. There are three commonly performed types of epidural steroid injections: caudal epidural steroid injections, translaminar epidural steroid injections, and transforaminal epidural steroid injections. All of these injections should be performed with fluoroscopic guidance. A translaminar injection is often used when a patient has not had surgery and more than one nerve root or disc is involved and the interventionalist needs to spread the steroid across more than one level. A transforaminal injection targets a single nerve root or foramen. Additionally, a transforaminal injection allows access to the anterior epidural space, placing the medication, usually consisting of a steroid and local anesthetic closer to the inflamed area. In a caudal epidural injection, the needle is passed through the sacral hiatus.

This type of injection is frequently performed in patients that have had prior back surgery. It is important that an interventionalist be comfortable in not only performing the various types of epidural steroid injections, but in selecting appropriate candidates for each type of injection.

Another common injection performed in an interventional pain clinic is called lumbar facet joint injections or medial branch blocks. These injections can be diagnostic or therapeutic. Facet injections are used to treat facet arthropathy or inflammation of the facet joints. The spine contains facet joints from the cervical and lumbar region. The joints frequently become inflamed or degenerated due trauma or the aging process. Pain from facet joints is often described as aching and aggravated with bending and twisting movements such as sweeping or vacuuming. The pain may travel into the hips and thighs but rarely travels below the knee. Inflammation or degeneration of the joints may or may not be visible on imaging, making an accurate history and physical examination imperative. Diagnostic facet blocks are generally performed by injecting several cc's of a local anesthetic around or in the facet joints or medial branch nerves (the nerves that supply the facet joints). A positive test is achieved when a patient receives 50% or greater relief from their pain for the expected duration of the local anesthetic. A therapeutic injection includes steroids in an attempt to achieve longer pain relief.

When a positive result is achieved with facet blocks or medial branch blocks, many interventionalists will proceed with radiofrequency ablation (RFA). RFA is a procedure that uses heat transmitted through a needle to destroy the sensory nerve (medial branch nerve) to the facet joint. Great care is taken to avoid injury to a motor nerve and to properly identify the sensory nerve, both visually and electrically. Patients undergoing an RFA following a successful facet or medial branch injection can expect to achieve pain relief for 6 to 18 months, at which time the procedure can be repeated.

Sympathetic blocks are also frequently performed in an interventional pain clinic. These blocks are often used to treat complex regional pain syndrome (CRPS). Lumbar sympathetic blocks are used to treat sympathetically mediated pain or CRPS of the lower extremity and involve injecting local anesthetics around the sympathetic chain near the lumbar vertebral bodies under fluoroscopic or CT guidance. For CRPS involving the upper extremities stellate ganglion blocks are performed. The stellate ganglion is generally located at the level of a tubercle on the transverse process of C6. The sympathetic blocks are often repeated, initially as frequently as every few days, when attempting to control the symptoms and progression of CRPS. They are always performed in conjunction with physical therapy, arguably the most important treatment for CRPS.

Several other injections are often performed in an interventional pain practice including joint injections for joint pain and arthritis, trigger point injections for myofascial pain, and a variety of injections for abdominal and pelvic pain including celiac plexus blocks, and superior and inferior hypogastric nerve blocks along with a variety of peripheral nerve blocks. If all other treatments fail and a patient is not a surgical candidate, a select group of patients benefit from spinal cord stimulation or intrathecal pump implantation.

The interventional procedures at the disposal of a well trained and experienced interventional pain physician is extensive and often accelerate an injured patient's recovery. It is important that all healthcare workers be aware of the various treatment options and available interventions. With proper patient and physician selection these procedures are often an integral part of recovery.

WH WORKPLACE HEALTH

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Editor-in-Chief:
Garlana H. Mathews
President

Managing Editor:
Jeri Gale

Director of Sales:
Michelle Wilds

Contributing Partner:

P.O. Box 55801
Macon, Georgia 31208
1-800-991-4716
specialtydevelopment@gmail.com

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The Application Of An Intrawound Antibiotic Powder During Spine Surgery Significantly Reduces The Rate Of Post-Operative Infection And Results In Large Cost Savings.

By Dmitri Sofianos M.D.

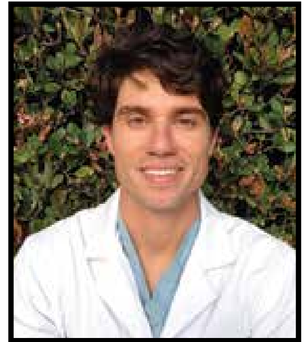
Despite modern improvements in infection prevention, surgical site infections remain a significant problem in all types of surgery. In the spine surgery population the rates of infection have been reported to be anywhere from 1 to 15 percent. The impact on patients and cost of treating such infections is profound. In an attempt to combat this problem researchers began to use a local delivery of antibiotics directly to the wound at the time of surgery. Vancomycin, a common type of antibiotic, is now manufactured in a powder form that is easy to apply by the surgeon. This powder has been found to be effective in animal and human studies as an adjunct to systemic or intravenous antibiotics in surgical site infection prevention.

Three years ago researchers at Vanderbilt University Medical Center published a paper focusing on the use of this intrawound antibiotic powder to prevent infection. In their study they looked at patients who underwent posterior spine fusions for traumatic injuries over a 2-year period. The clinical outcome they looked for was the incidence of either superficial or deep postoperative wound infections. They looked at 110 patients overall. One group (control group) received standard systemic prophylaxis only, whereas another (treatment group) received Vancomycin powder in the surgical wound in addition to systemic prophylaxis. The control group had 54 patients and treatment groups had 56 patients and both were statistically similar. A statistically significant difference in infection rate was found between the treatment group (0%) and control group (13%) without any adverse events. Importantly, no adverse effects were noted from use of the Vancomycin powder.

In a more recent study from 2013, researchers compared the rate of infection with and without the use of Vancomycin powder application during posterior cervical instrumented surgery. They had 112 patients in their study and again showed a significant decrease in infection rate in the intervention group (0%) compared with the control group (15%) in this high-risk population. Again, no adverse events were noted in the intervention group associated with the use of Vancomycin powder. This study supports the growing body of evidence that Vancomycin powder placed in the wound can reduce the incidence of postoperative wound infections.

To elucidate cost savings associated with the use of intrawound Vancomycin powder, researchers looked at data from 303 patients who underwent surgery over two years. In the treatment group there were 96 patients who received prophylactic intrawound Vancomycin powder in addition to normal intravenous (IV) antibiotic prophylaxis. This left 207 patients in the control group who received just routine IV antibiotic prophylaxis. Patients requiring repeat surgical procedures for infection were identified, and the costs of these additional procedures were elucidated. The total reimbursement received by the health care facility was used to model the costs associated with repeat surgery, and this cost was compared with the cost of a single local application of vancomycin costing about $12. Of the 96 patients in the treatment group, the return-to-surgery rate for SSI was 0. In the group without Vancomycin, seven patients required a total of 14 procedures for infection. The mean cost per episode of surgery, based on the reimbursement, the health care facility received was $40,992 (range, $14,459–$114,763). A total of $573,897 was spent on 3% of the 207-patient cohort that did not receive intrawound Vancomycin, whereas a total of $1,152 ($12×96 patients) was spent on the cohort treated with Vancomycin.

This study showed a reduction in surgical site infections requiring a return-to-surgery —with large cost savings— with use of intrawound Vancomycin powder. In this one study population, the cost savings totaled more than half a million dollars!



In conclusion, the use of vancomycin powder in surgical wounds reduces the incidence of infection in patients undergoing spine fusion. Applying Vancomycin powder to surgical wounds is one way to prevent costly and harmful postoperative wound infections in high-risk populations.

Dmitri Sofianos MD
Chatham Orhopaedic Associates
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Do your fingers catch or lock?

Michael S. Shuler, MD

Trigger fingers is a painful condition associated with fingers catching or locking when a tight fist is made. It may feel like a finger is dislocating or popping in and out of joint. Pain may be more noticeable in the morning, after fingers have locked during sleep and remain in a flexed position. People often relate this to arthritis or old age, but fingers catching and locking is not a normal occurrence. The good news is that it can usually be treated easily and without significant recovery periods.

What is trigger finger/thumb and why does it happen?

The tendon that flexes or bends the last joint of the finger runs through a series of tunnels along the course of the finger starting in the palm and extending to the tip of the finger. The tunnel at the base of the finger where the palm meets the finger can tighten, causing a buildup of fluid on the tendon. The fluid buildup, or ball, moves with the tendon and can sometimes be felt moving under the skin at the base of the finger. When the finger is flexed to make a fist, the ball hits the tunnel and does not want to enter the tight tunnel. If pulled hard enough, the ball slips into the tunnel and gets stuck causing the finger to lock down. In advanced stages, freeing the finger may require pulling on it with the other hand.

The cause of trigger fingers is not completely understood. Diabetics tend to suffer from trigger fingers more often than non-diabetics. However, having trigger finger does not mean you have diabetes. In some instances, overuse and heavy manual labor may contribute to the development of trigger fingers. The exact cause is usually difficult to determine.

What can be done about trigger fingers?

In most cases, therapy does not help because overuse may make the symptoms worse. Splinting can be valuable in the early stages of catching or triggering. Additionally, a steroid shot in the palm of the hand may help resolve the problem by shrinking the ball of fluid so it glides in and out of the tight tunnel more easily. Shots work at least temporally in about half of the instances. The longer the triggering has been occurring and more severe the locking, the less likely the shots will work. There is no down side from trying a shot (except the pain associated with the shot) and a shot is usually tried prior to surgical intervention. A second shot can be attempted if the initial shot helps but does not resolve the problem completely. If shots are not effective, surgery may be considered.

Surgery involves a small incision in the palm about a half inch in length. The tight tunnel is released and the tendon is freed from constriction. Once released, the triggering in that finger should not reoccur. However, releasing one finger does not mean other fingers cannot develop triggers. In some cases all 10 fingers require surgical release over a period of time. Surgery takes about 5-10 minutes per finger and can usually be performed without general anesthesia. Recovery involves modified use for a period of a couple days to weeks. Surgery is performed in an operating or procedure room on an out-patient basis, and requires about 3 stitches per finger to close the wound. After surgery, patients are encouraged to use the finger as much as possible to prevent stiffness and scarring.

What to remember?

Finger locking and catching is not normal. Simple interventions like a shot or splint can help. If conservative measures do not work, a small 5 minute surgery can resolve the problem permanently. Recovery typically takes several days to a couple weeks.

FOR MORE INFORMATION, CONTACT:
Jennifer Herring, CWCP at (706) 549-1663 x3259

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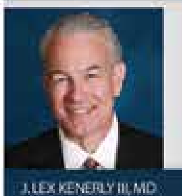
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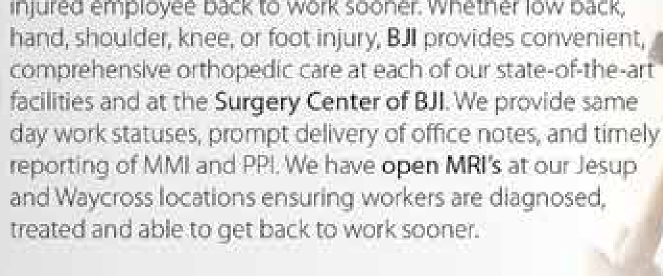

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Treatment of Rotator Cuff Disease

Rotator cuff disease can be defined as any damage to the rotator cuff, and is one of the most common causes of shoulder pain in people over 40. It begins with inflammation (impingement and/or bursitis), progresses to small partial tearing, and can progress further to full thickness tear. The incidence of rotator cuff damage increases with age and is most frequently caused by degeneration of the tendon that can take years to progress, rather than injury from sports or trauma.

Symptoms of rotator cuff disease

Pain in the shoulder, and weakness or inability to lift the arm are the most common symptoms of rotator cuff disease. Night pain is also very common. Pain is initiated by excessive or unusual activity, or injury. Reaching overhead or upwards pinches the rotator cuff so if the rotator cuff is already inflamed, this pinching increases or causes pain.

Treatment of Rotator Cuff Disease

Treatment depends on the severity of the injury and the patient's underlying condition. Even with complete rotator cuff tears, the standard treatment is to start with conservative measures. Rotator cuff tears generally don't heal well with time, but even for complete rotator cuff tears, the standard treatment is to start with conservative measures, usually non-operative means such as physical therapy, anti-inflammatory medications, steroid injections and activity modifications. While the size of the tear may not change with conservative treatment, the symptoms often diminish. In some cases (such as traumatic rotator cuff tear in a younger patient) early surgery may be recommended.

Surgical treatment

For simple shoulder impingement, subacromial decompression is a good option. This outpatient arthroscopic procedure is performed using instruments inserted through 2 or 3 small incisions, each approximately 1/2 inch long. A small portion of the bone (acromion) and its bursa, which overlies the rotator cuff, are removed, relieving pressure on the rotator cuff to promote healing and recovery.

The three most common surgical procedures for rotator cuff treatment are:

Open Repair: Prior to the use of the arthroscope, rotator cuffs were repaired by looking directly at the torn tendon through an incision about 2-4 inches in length. An advantage is the rotator cuff tendons are easily seen by this method, but the incision is large, and the recovery can be longer and more painful.

Mini-Open Repair: This method of repairing a rotator cuff involves using an arthroscope and a short incision to gain access to torn tendon. By using the arthroscope, the surgeon can also look into the shoulder joint to clean out any damaged tissue or bone spurs. The incision is about 1-2 inches, and the recovery typically requires less time and therapy than the open cuff repair.

Arthroscopic Repair: An arthroscopic repair is done with an incision approximately 1/2 inch long by the surgeon looking through a small camera to watch the repair on a television monitor, and generally lasts between one and two hours.

Recovery

Recovery time depends on several factors, including level of strength before the operation, and the severity of the rotator cuff disease/tear. For rehabilitation following a subacromial decompression, patients are placed in a shoulder sling following surgery and can begin shoulder motion quickly. In some cases, strengthening can begin within a few weeks, and sports can resume after the swelling subsides. After the rotator cuff is repaired, physical therapy begins more gradually and with caution, beginning with gentle therapy, followed in 4-6 weeks with more active lifting. Approximately 8-10 weeks after the rotator cuff repair, physical therapy intensifies in an effort to strengthen the rotator cuff muscles. Complete recovery usually takes 4-6 months.

Only your surgeon can help you decide what treatment is best for your rotator cuff disease or other condition. Talk to orthopedic surgeons Dr. Lex Kenerly, Dr. Matt Valosen, Dr. Christopher Swanson & 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**

Using Social Media In Claims Investigations

By Tarrence L. Callins, President CISS, INC

There are various investigative uses for social media including:

- Surveillance cases (photos, habits, activities)
- Locating witnesses, insured, claimant
- Background information like character, habits, activities, financial information
- Identifying relationships and/or accomplices

Incriminating Posts:

The Internet has been around long enough that most claims handlers now use it routinely to check everything from court dockets to statistical information about the venue of a lawsuit, but "social media" can often provide a much more detailed and candid look at a claimant than can be found in those dry statistics. At the very least, these sites can tell you a little bit more about the type of person with whom you are dealing. In the best case, you might find the incriminating photo or other information that completely contradicts the claims being presented before a settlement is reached.

Information available on these types of websites can include not only photos such as "Tom" doing the double black diamond trails, but also comments from his friends (for example, "can't wait for skiing this weekend!"), current status reports from the claimant himself ("having a great time on the slopes!"), and even videos (maybe showing the claimant and friend après ski).

The most popular of the "social media" or "social networking" sites is Facebook, which was founded by Harvard undergraduate students in 2004. In July 2010, Facebook boasted 500 million users. Facebook, Inc., now based in Palo Alto, Calif., employs some 1,700 people and reports projected revenues of more than $1 billion for 2010.
Facebook allows users to post photographs and personal information, write messages on other users' "walls," and announce their status, or what they are doing at that moment. Depending on the user's privacy settings, this information may be restricted to "friends" whom he or she approves, or made more widely available to friends of friends or even the general public.

Other similar, but less popular sites include Myspace and Friendster, while Linked-In is more of a business networking site. Twitter provides short (140-character or less) bursts of instant news called "tweets" sent to a member's "followers." YouTube, founded in California in 2005 and now owned by Google, is a video exchange site that includes everything from TV commercials, professional music videos and movie segments, to grainy personal home videos. Craig's List, which has been on the Web since the mid-1990s, is the online version of a newspaper's classified ads, which allows users to list personal ads, jobs, and sales among other things.

Other Online Clues:

Although not technically "social media," other online resources helpful for investigating a claimant are their own personal web pages and blogs and the websites of any organizations to which they might belong. (For the uninitiated, a "blog," short for "web log" is an online diary.) These may provide documentation of a person's regular activities, which could be helpful in evaluating the effects, if any, of his injuries.

These online resources can provide a veritable treasure trove of information about claimants and witnesses. You might find that a claimant who says he can't walk is boasting via Twitter about having just completed a 10-mile training run. A Facebook photo could be useful if you need to conduct surveillance. (If you are fortunate enough to catch a claimant in a blatant misrepresentation of his injuries, then you probably won't need surveillance.) A video on YouTube of a supposedly injured person doing any physical activity could mean the difference between a win or a loss, and a person's business activities on Linked-In may suggest he has exaggerated his economic claims.
In addition to learning more about your claimant, you may be able to locate others who can be helpful to your investigation. One way you might do this is by uncovering the identity of the claimant's friends or business acquaintances who might be frank about his condition. Sometimes plaintiffs exchange information on their blogs or pages about their accidents, or even their lawsuits.

Imagine this exchange on the Facebook "wall" of a claimant: "How's your lawsuit going?" asks a friend. "Pretty good," replies the plaintiff. "My lawyer says I'm going to get a lot of money." Although this may sound farfetched, it does happen.

You can usually locate a person's blog, Facebook, and other relevant pages with a simple run of their name through a search engine such as Bing or Google. It's even possible to do a search for the person at a specific website to see if he or she is a member.

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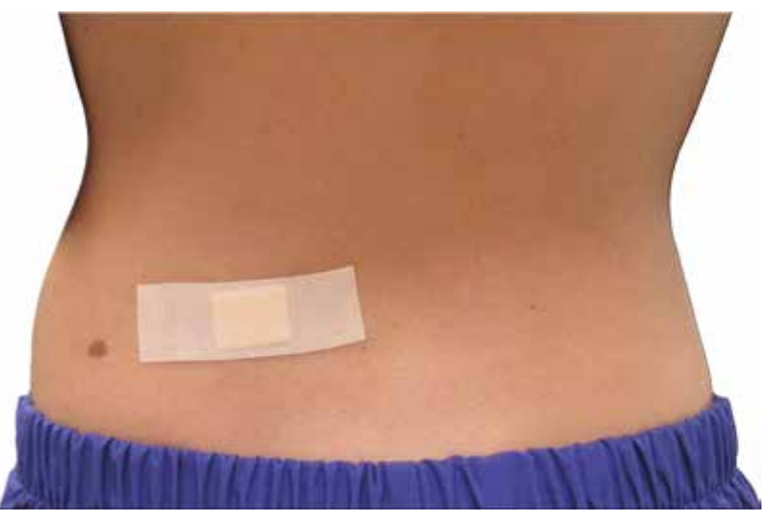
What Does “Minimally Invasive” Mean and Why is it Important in Workers’ Compensation?

For some healthcare providers, the term “**Minimally-Invasive**” is more than an adjective, it is a philosophy. A physician committed to a minimally invasive medical philosophy is focused on maximizing effectiveness while minimizing surgical trauma. Minimally invasive procedures use either smaller incisions or alternate entryways that avoid tissue and muscle damage. This means less pain and often dramatically shorter recovery periods for patients.

WHY THE WORKERS’ COMP INDUSTRY SHOULD PAY ATTENTION:

1. **Less Pain.** Overall the patient experiences less pain and requires less pain medication (if any).
2. **Less Risk.** Smaller incisions and less trauma allow for less risk of infection.
3. **Shorter Recovery Period.** With less tissue damage, patients are able to get back to their daily lives much quicker. This reduces the amount of time they are away from work, which increases their likelihood of returning to the workforce.



The incisions in most of the endoscopic spine procedures are so small they can be covered with just a household bandage.

MINIMALLY INVASIVE PROCEDURES TO WATCH

All Endoscopic Spine Surgeries >> Dr. Kevin Stevenson is the only surgeon in Middle Georgia offering comprehensive endoscopic spine procedures. Many of his spine patients are able to walk around the same day as the surgery.

The Direct Anterior Approach to Hip Replacement >> Dr. Bill Barnes was one of the first surgeons in Middle Georgia to use the direct anterior approach to hip replacement. This approach avoids cutting or damaging certain muscles as with the traditional route.

Endoscopic Carpal Tunnel Release >> The endoscopic method involves a puncture rather than a long incision. Many of our patients report returning to daily activities in less than half the time.

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Anterior Cruciate Ligament

By Dr. David Ryan

One of the most commonly injured structures in the knee, and one of the most notorious for athletes of all ages, is the anterior cruciate ligament (ACL). Frequently these injuries are managed surgically and there are over 100,000 ACL procedures performed annually in the United States. It has grown to become one of the more predictably successful operations that orthopedic surgeons can offer patients. It is quite remarkable that with current surgical techniques, a patient can undergo an ACL reconstruction and essentially be back to full function from an athletic standpoint within 8 months.

The anterior cruciate ligament (ACL) is one of four major ligaments that stabilize the knee joint. The primary function of the ACL is to prevent rotation and forward translation of the tibia (shine bone) with relation to the femur (thigh bone). Typically, ACL injuries occur while playing sports when the knee is stopped abruptly or is planted/twisted with enough force to tear the ACL. The classic report of "twisting the knee and feeling a pop" is what the majority of people will report when they have an ACL tear. This is usually followed by substantial pain and swelling that dissipates over the next few days. For the vast majority of young patients that sustain an ACL injury, surgical correction is the best option.

Modern day ACL reconstructive surgery is performed via an arthroscopically assisted technique which means that it is minimally invasive and done through very small incisions under the guidance of a high definition video camera. The surgery is performed to reconstruct (replace) the torn native ACL by taking a graft, either from a tendon around the knee or from a cadaver, and securing it in place where the torn ACL had been. The surgery is typically done on an outpatient basis meaning that the patient goes home after the surgery and a stay in the hospital is not necessary. After the surgery, patients are able to walk with crutches immediately and perform the majority of everyday tasks typically right away. However, return to full function takes several months and patients are guided through a rehabilitation process during this time. The typical time frame to return to athletics is around 8 months and patients can expect a full recovery.

As a fellowship trained sports medicine and arthroscopic surgeon, I feel as though I am on the cutting edge of ACL reconstruction as over the years the improvements in techniques have led to faster recoveries and better outcomes. I am happy to be able to offer my patients all of the benefits of the most novel techniques of ACL surgery.

Dr. David Ryan
Athens Bone and Joint Orthopedic Clinic
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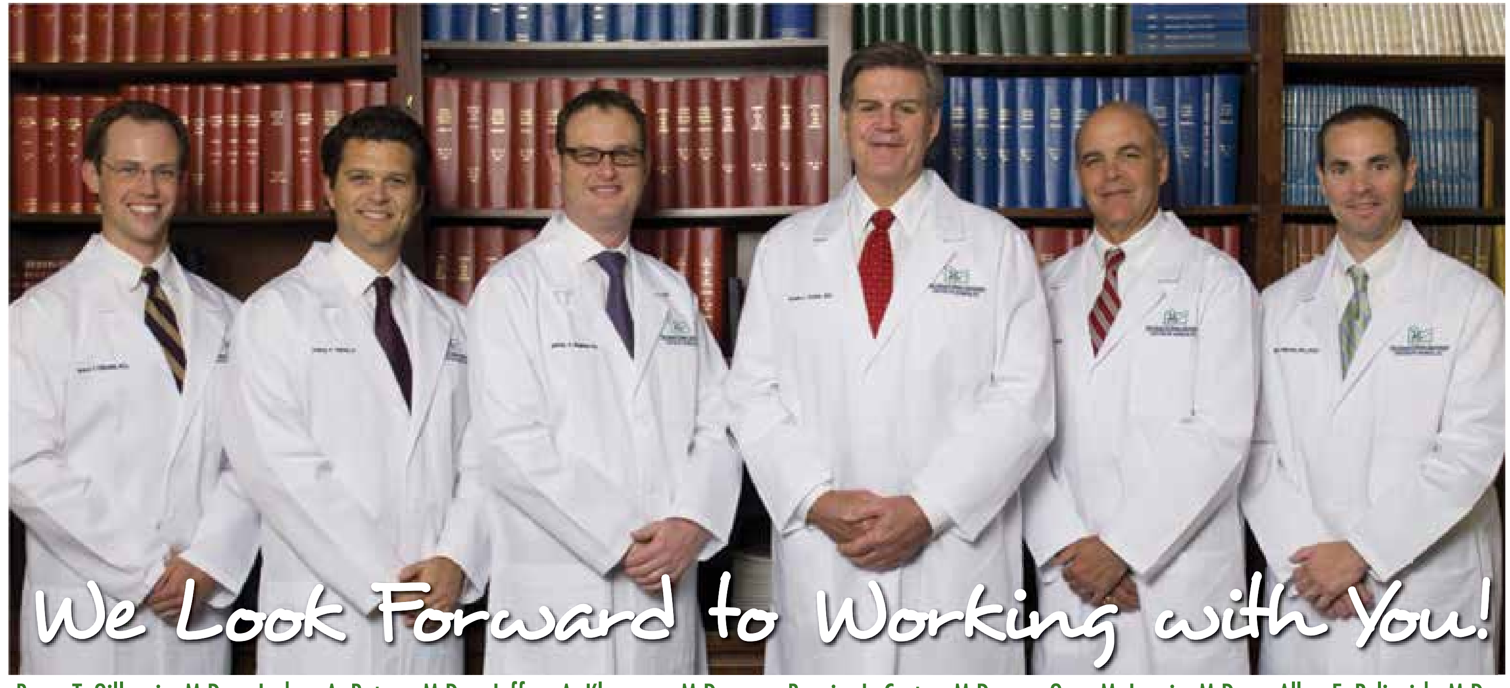

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Repetitive Motion

By Amrish Patel, M.D.

The proverbial "straw that broke the camel's back" that is what repetitive motion injuries can be viewed as. Repetitive motion/stress injuries, according to the OSHA website up to 1 of every 3 dollars spent on worker's compensation injuries is due to a repetitive motion injury and one in four days lost from work. The risk factors that increase occurrences of repetitive motion injuries include awkward positioning, increased forces, heavy lifting, repeated activities and a combination of these activities. Steps have been taken to try to prevent injuries yet the rate of repetitive motion injuries remains a high cost to employers and even higher cost to the injured employee.

The rate of injuries has gone down in many centers that have implemented changes that address ergonomics, work weight lifting limits, and speed of production. The use of consulting firms and ergonomic evaluations can help start the process of injury prevention. Prevention can be a key to limiting injuries and reduce time lost and healthcare dollars spent on worker's compensation claims. The use experienced personnel to evaluate work place and work stations to optimize the ergonomics for the individuals at that station can prevent injury.

Another factor that is often ignored is the length of time one works in a certain position. Observations of repetitive stress injuries in sports have led to pitch counts and training methods to allow endurance in the structures that are at the greatest risk for injury to help prevent time lost from sport. Often injuries in sports occur when fatigue has set in and biomechanics are altered. The same can be reflected in work place injuries. However, in work related injuries we often find that people don't "train" for work. This is where it is of vital importance to address the workplace and workstation to help lower the risk of injury to employees and educate the staff and employer's on preventable factors to reduce loss of time from work.

Here at OrthoGeorgia, our goal is not to only help people get back into the work force but to also help find way to prevent injuries. With our healthcare team consisting of athletic trainers, therapists, nurses, and physicians we are working towards finding and helping prevent injuries where we can. Our athletic trainers and therapist are educated in postural re-educations, ergonomics and proper lifting techniques. For those that are injured our physician services and therapist strive to get people back to work safely and in a timely manner to reduce the time lost from work. The key to work related injury is prevention and after an injury preventing re-occurrences will take a team approach and ergonomic optimization.

Having worked at OrthoGeorgia for a few years now another venue that is often not addressed with work related injuries are head injuries. The rate of concussions has dramatically increased, but more because of recognition of symptoms post injury that has led to better diagnosis. Concussion injuries are brain injuries and as such should be treated as any physical injury. Diagnosis is key and treatment by providers familiar with head injury and concussion so that injured workers are not returned to work too early. Again prevention is key diagnosis and treatment is vital, if a worker is returned to early they are at greater risk for further length of time to recovery. IMPACT testing is one tool that can help monitor recovery and treatments to help assure safe transition back to work. As an IMPACT test provider OrthoGeorgia has the tools to help make sure we don't return cognitively impaired worker's back to work too soon. As a team trying to prevent injuries and continue to promote productivity at work, hopefully we can keep help prevent "the straw that broke the camel's back".

Dr. Amrish Patel, M.D.
Ortho Georgia
3708 Northside Dr, Macon, GA 31210
(478) 745-4206
www.orthoga.org

What Is Hip Arthroscopy?

By James. W. Duckett III, MD

The arthroscopic treatment of hip disorders has gained popularity in recent years as technological advancements have allowed for better visualization of and access to the hip joint. Arthroscopy utilizes a small telescopic camera to visualize the internal structures of the joint and arthroscopic instruments to correct these disorders. This allows for much smaller surgical incisions, less pain, and faster recovery.

Hip arthroscopy may relieve painful symptoms of many problems that damage the labrum, articular cartilage, or other soft tissues surrounding the joint.

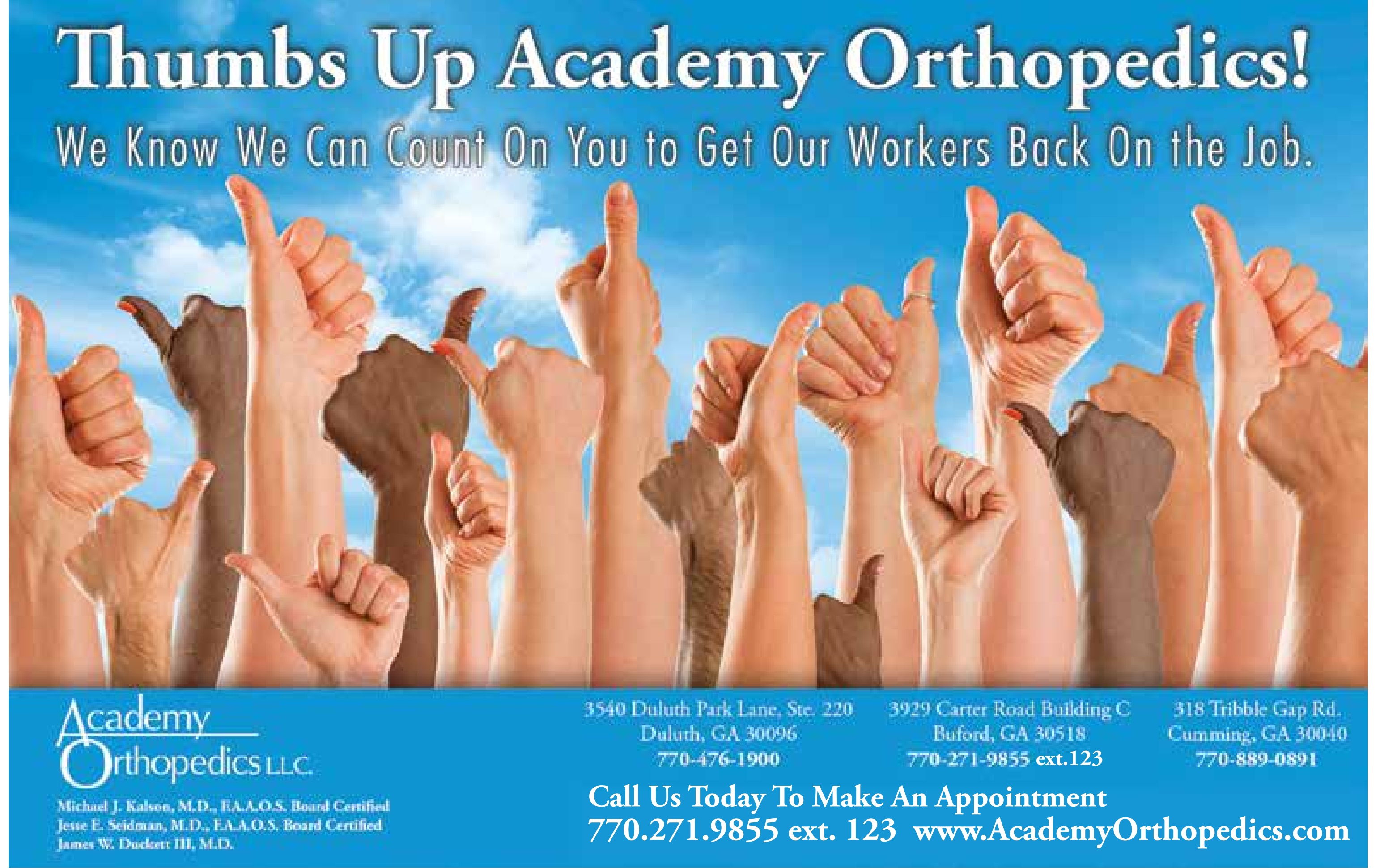
Commonly treated conditions include:

- Labral tears
- Femoroacetabular Impingement (FAI)
- Snapping hip syndromes
- Trochanteric Bursitis
- Hip Dysplasia

Accurate diagnosis is made through a combination of thorough patient history, physical examination and diagnostic imaging such as x-ray and MRI. Occasionally intra-articular injection or CT scan can confirm a suspected diagnosis.

Initial treatment is conservative with options including rest, activity modification, physical therapy, NSAIDs and intra-articular injections. Many of these hip disorders can be successfully treated with conservative measures.

When conservative treatment methods fail to improve function and symptoms, surgical options may be considered.



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Why Certification Matters When Selecting A Pain Management Physician

By Emilie Gastley, MBA, MHA

With endless options and so much at stake when it comes to your health and medical treatment, how can you be sure you're selecting a qualified physician dedicated to providing high-quality care? Beyond basic medical licensure, it is critical to select a Board Certified physician, ensuring he or she has met nationally recognized standards for experience, skills and continuing education. While there are many boards and certifications that may sound impressive, the American Board of Medical Specialties (ABMS) is universally considered the "Gold Standard" in board certification.

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.org. Here you can search by location and specialty to find out if your doctor is Board Certified. 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.

Emile Gastley, MBA, MHA
The Physicians
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A Word From The Chairman

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

As the fall edition of "Workplace Health" magazine rolls out, the State Board will be at the Atlanta Hyatt Regency for the Board's Annual Seminar. The 2014 Seminar will be held August 25 – 27. Our Steering Committees have worked very hard throughout the year planning and developing this year's program which I anticipate could be our best one yet. We are especially excited this year to have some outstanding speakers including a special guest appearance from Georgia Governor Nathan Deal. We will also hear inspiring and motivational speeches from Coach Vince Dooley and Amie Copeland. In addition, we will hold our "live" Appellate Division Oral Arguments and for the first time ever we will have a "live" cadaver surgery.

In May, the Board concluded its Annual Regional Educational Seminars in six different cities across Georgia. The Public Education Committee of the Advisory Council chaired by Sy Jenkins, worked diligently to develop an entertaining and educational program. The Board went to Dalton, Augusta, Oakwood, LaGrange, Savannah, and Jonesboro and had 570 attendees representing business, medical, insurance, and legal fields. These seminars are important because statewide Georgia is seeing economic development under the Governor's initiatives in the form of record numbers of new jobs due to existing business expansion and new business location. Georgia has been designated the number one state in the nation to do business and the most competitive state by both CNBC and the leading authority on business site selection. The stability and fairness of our workers' compensation system plays a vital role in economic development and that is good for everyone.

The 2014 legislative session could be described as a quick one where only critical legislation was introduced due to the primaries being scheduled earlier in this election year. Under these circumstances, we did not have any workers' compensation legislation this year. However, even though there was no legislation this year concerning workers' compensation, the legislative committee of the Advisory Council continues to discuss legislative issues and has been monitoring a number of cases in the appellate courts. Of note, on April 7, 2014, oral arguments were held by the Georgia Supreme Court in the MARTA v. Reid case. The issue presented in this case is whether the Georgia Court of Appeals erred in ruling that a claim for late-payment penalties made more than two years after the last payment of income benefits (in this case close to ten years after the fact) is not barred by the statute of limitations under O.C.G.A. §34-9-104(b). We anticipate a decision by the Georgia Supreme Court later this year.

The Rules and Medical Committees of the Advisory Council made a number of recommendations to the Board in 2013. Of particular importance, effective January 1, 2014, under Board Rule 104, when serving a Form WC-104 upon an employee and their attorney, this form now has to be filed with the Board on the front end. In addition, Board Rule 240(c) was amended to reflect the statutory change in O.C.G.A. §34-9-240(b)(2) regarding a good faith attempt by an employee when offered a light-duty job. Finally, on the medical front, as of May 1, 2014, an updated Medical Fee Schedule is available. This is the culmination of many hours of work by board employees as well as committee members who volunteer their time to assist in enhancing and strengthening the workers' compensation system in Georgia. All of this is greatly appreciated by the Board.

As a practicing lawyer for over 20 years, I valued the Board's foresight in going paperless with ICMS in 2005. I enjoyed being able to view a file, along with filing documents instantly. ICMS revolutionized the practice of workers' compensation. To this end, when I first became Chairman, I noticed our technology infrastructure was aging. Over the past year, under the steady guidance of our Executive Director, Delece Brooks, we hired a number of technical experts to assist us in modernizing our infrastructure. This included upgrading outdated hardware and "virtualizing" our environments. With these upgrades, for both our internal and external users, we have achieved a reliable, real time work environment for everyone. In addition, the processing time of EDI filings has improved by close to 50%. These recent upgrades in technology will assist the Board with the development and upcoming implementation of ICMS-II, which we anticipate will be in 2015. The Board continues to emphasize the requirement to file the WC-1, WC-2, WC-3, WC-4, and WC-6 Board Forms.

We look forward to seeing many of you at the Annual Seminar in Atlanta.

Frank R. McKay, Chairman

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Complete Occupational Health - What You Need To Know

By Dr. Lawrence Goren

Onsite Occupational Health involves the treatment of work-related injuries and illnesses, as well as all health aspects of the employee at work. Complete occupational health also includes the adjustment of work to the employee and the adjustment of the employee to the job.

Onsite Occupational Health physicians should be immediately accessible to an injured worker and should provide the most effective, yet least invasive treatment. Practitioners of occupational medicine should have a thorough knowledge of the industries that they serve. This will allow them to comfortably utilize the employer's return to work policy.

This knowledge also creates trust on the part of the employee since the practitioner demonstrates understanding of the nature of their job and work place. Furthermore, understanding the nature of the workplace, occupational medicine physicians are uniquely qualified to identify ergonomic issues within the workplace. These physicians collaborate with onsite Safety Professionals, Human Resources, Claims Representatives and Nurse Case Managers during the life of a claim.

They are patient advocates who use their unique position to help the employee return to work and full function quickly and effectively. It is not mutually exclusive to be an agent of the employer and a patient advocate at the same time.

Onsite Occupational Health entails a significant preventive aspect through the utilization of surveillance physicals. These are performed to assess a worker's health in order to detect and identify any abnormality that might affect their longevity and/or workplace hazards. There are other significant aspects of the preventive portions of occupational health which include overall wellness, productivity, ergonomic analysis, physical training and job coaching.

Historically, manufacturing facilities have utilized onsite occupational medical clinics. These older facilities were not as flexible as they are today. Full scope onsite clinics are essentially patient-centered medical facilities for all employees. Because of the presence of the Clinicians, they will work with Safety professionals to target injury prevention and to develop proactive educational and ergonomic programs. Their focus on prevention and in treating and managing illness and injury make them a valuable partner in the workplace and the surrounding medical community.

Onsite Occupational Health is a unique specialty that will continue to grow and change as the needs of the employers and employees grow and change.

Dr. Lawrence Goren
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What Is Cognitive Rehabilitation?

By Cynthia Bailey, PhD

Cognitive rehabilitation is the process by which professionals utilize evidence-based activities to improve the thinking and memory skills of persons who have sustained brain injury. The most commonly affected areas of cognition are attention, executive functioning, communication, and both short-term and prospective (remembering to do something in the future) memory.

There are two basic types of cognitive rehabilitation:

- Restorative therapy enables the person to develop a lost function through specialized computerized programs or manual exercises. Attention, information processing speed, basic memory skills and executive functioning are the most commonly treated by this type.
- Compensatory therapy helps the person to develop and make habitual the use of aids and tools to overcome the impairment. These aids and tools can be either internal or external.
- Internal aids/tools included self-regulation and metacognition (thinking about thinking) and are very effective for goal management and time pressure management.
- External aids include objects or manipulating the environment. These may include written instructions, electronic devices or checklists. These are effective for both short-term and prospective memory.

Basic assumptions are made in developing and using cognitive rehabilitation.

- Cognition cannot be isolated
- An eclectic approach must be used: One size does not fit all
- The relationship of the impairment to the person must be conceptualized
- Current knowledge from the fields of cognitive psychology and neuroscience must be applied.
- The individual's cognitive strengths and weaknesses and personality style must be considered.

The basic principles of cognitive rehabilitation include:

- The person affected must participate in a collaborative and active fashion
- Treatment is goal-oriented and builds on strengths
- The primary focus is on education, empowerment, self-control and efficacy

Cognitive rehabilitation consists of structured sessions, and the goals may include both cognitive and behavioral goals. It assists the individual in achieving a more accurate understanding of strengths and weaknesses and a better adjustment to impairments.

How do we know it works? Cognitive rehabilitation has been shown to be of greater benefit than conventional therapy in 94% of studies.

Why? Because it is evidence-based. "Evidence-based" means that we utilize the most effective known treatment for each type of deficit. A strategy is considered to be the Treatment Standard if at least one randomized study with a large number of participants and further support from other studies, and should be used. A Treatment Guideline is based on a randomized study without a good control group and well-designed other studies. A Treatment Option has been shown to be effective with single case studies or studies that had no control group.

So what does this mean? When working with clients with brain injury, it is considered unethical to withhold treatment in a clinical setting, so it is often difficult to have randomized studies. So often less restrictive study methods are used. But, when enough studies indicate that a treatment works, it becomes imperative for clinicians to use that study.

Currently, there are Standard Treatments for attention, memory and gestural therapy. There are Standard Guidelines for visual scanning, executive functioning, and visual perceptual deficits.

Cynthia Bailey, PhD
Touchstone Neurorecovery Center
1-800-414-4TBI (4824)
www.TouchstoneNeuro.com

A Call To Arms

By Nazario Villasenor, M.D.

As a new graduate from a pain medicine fellowship program in Detroit Michigan, I thought that I had seen it all. But I was amazed at the degree of prescription pain medicine abuse in the state of Georgia where I newly resided and worked.

I was no stranger to illicit drug use. Before embarking on the road of medicine I was a police officer for several years in North Chicago. At that time, crack cocaine and heroin were kings on street. Drug dealers and gang members fighting for every inch of profitable space. But now a new enemy is confronting us and lives in our offices. The very medicine that we use daily as anesthesiologists and pain medicine specialist to help our patients are now becoming the new wave of illicit drug use.

It was in frustration that I turned to an e-mail that was sent to me by the American Board of Addiction Medicine. It was asking for individuals to become certified in the field of addiction medicine. I laughed at the thought of trying to help these patients that I did not want in my clinic to begin with. But as I reflected on my initial thoughts, I came to realize what a great opportunity it would be to help individuals that are afflicted with prescription pill abuse. Many of them had true pain etiologies. As I researched the different options of helping these addicted patients, I came to realize that my pain clinic was like a light to moths.

I then decided to go to the American Society of addiction medicine conference in Atlanta and instead of becoming frustrated at this addiction issue, I became more educated on the subject matter. I realized I did have treatment options for these patients who lost their way.

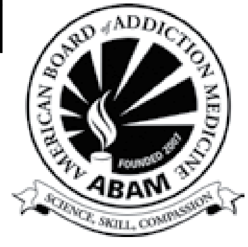
Recently my colleagues at the practice I am with and I have taken the addiction medicine board exam and have become board-certified. We are now only a handful of anesthesiologist/pain medicine specialists that are certified to practice addiction medicine.

So I ask of other pain specialists and Anesthesiologists to help in this battle against prescription pain medicine abuse. It is by the sheer nature of using opioids that changes the brain chemistry. In fact, pain and addiction both use the same prefrontal cortex regions involved in the reward pathway. Our field of anesthesiology has allowed us to become experts in the pharmacology of opioids. Let us use this great knowledge base to help with detoxing of addictive patients and help educate the community and other physicians on narcotic use.

One key way to begin this process is to contact your local chapter of your American Society of Addiction Medicine. Possibly this will spark your curiosity into becoming board-certified in addiction medicine but more importantly this will allow you to get into contact with other providers that are concerned with prescription drug abuse.

By the nature of our job we are surrounded with opioids and this will continue to attract individuals with addictive characteristics. We as a field need to arm ourselves with knowledge and treatment plans to combat this formidable foe.

Nazario Villaseñor, M.D.
Board Certified:
American Board of Anesthesiology;
sub-specialty Pain Medicine
American Board of Addition Medicine



Are You Throwing Money Away? If You Fail To Diligently Maintain A Valid Panel Of Physicians, Then You Are!

By Rodney McColloch, Partner

The number one way to control your exposure to medical benefits in a workers' compensation claim in Georgia is to ensure that you maintain a valid, updated Panel of Physicians. The failure to do so can result in an injured employee invalidating the Panel and, as a result, he or she is free to treat with any doctor of their choice at the employer's expense, along with also being afforded the opportunity to make one additional change to another doctor at a later date. Claimant's attorneys, recognizing this, will often ask the employer for a copy of the Panel in the initial correspondence after a workplace accident in an attempt to invalidate the Panel and gain control over the injured employee's medical treatment. This Article will explore the proactive steps you can take to ensure that your Panel is valid and you do not lose control of the medical treatment in your next workers' compensation claim.

What You Can Do to Maintain an Updated and Valid Panel:

The following are just a few proactive steps you can take to ensure that your Panel is valid and you do not lose control of the medical treatment in your next workers' compensation claim.

1. Always list more than the required number of physicians on the Panel (at least 8 is recommended)

2. Check quarterly to see if the physicians and addresses listed on the Panel are still valid and that they accept workers' compensation claims.

3. Explain the Panel to newly hired workers and show them its location

4. Have new employee's sign a form stating that the purpose of the Panel has been explained and that they understand the function of the Panel and their rights thereunder

5. Post the updated Panel at all business locations, preferably near a time clock or employee bulletin board

6. Make sure that you provide a copy of the Panel to the worker at the time of injury

The following are just a few proactive steps you can take to ensure that your Panel is valid and you do not lose control of the medical treatment in your next workers' compensation claim.

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Fraud- What You Need To Know

By Todd Ross

We are all well aware of the ever present possibility of fraud within the workers' compensation system. Fraud presents itself in many forms. However, this article shall focus on one specific example of employee fraud. The case involves a self-insured multi-national corporation located in Dublin, Georgia and an employee living in the same city. The employee brought a workers' compensation claim for an alleged right rotator cuff injury. Employee alleged that the injury occurred at work as a result of lifting a bucket of silicone. However, the claim was initiated only after he had to have surgery, after his six month's salary continuation expired and after his three month's short term disability had all expired. Until the flow of money stopped, the employee had consistently told: (1) his immediate supervisor, (2) the Environmental Health and Safety Manager, and (3) the HR department that he was NOT injured at work and that he did not know how he had hurt his shoulder. When the employee obtained counsel and filed for hearing nine months after his newly alleged work injury, the employer denied the claim and litigation ensued.

So, where's the fraud in these facts? Well, the employer became aware that the employee was actually working at a BBQ stand while he was seeking workers' compensation benefits. By relaying that information to me as defense counsel, I was able to coordinate a proper response to written discovery, engage surveillance and obtain the employee's deposition. These events were carefully coordinated to comply with discovery requirements, ethical obligations, and yet still prove the fraud. We e-mailed written discovery responses on a Tuesday, investigative surveillance was initiated on Wednesday and Thursday and I obtained the employee's deposition on Friday. These events all occurred in the same week. By the time we commenced the employee's deposition on Friday, we had two days of solid surveillance showing extensive work activities. The surveillance video clearly showed the employee: arriving at the BBQ stand at 8 am and unlocking the doors, cooking at the BBQ pit located outside the back of the restaurant, tending to customers throughout the day, going to the grocery store to purchase supplies for the business, as well as closing and locking the restaurant at 9:30 each night.

However, during the course of his deposition, the employee denied any work activities. He did claim he was a "volunteer" at a family member's BBQ stand but that he did not work there. He claimed very few hours of volunteerism and insisted he left each day between 12:30 and 1:00 o'clock. He claimed that his only compensation was gas money reimbursement for running a few insignificant errands for the business. This was the fraud. The perjury. The false swearing.

The WC case was litigated before the ALJ who denied any work injury had occurred, denied all benefits and made the rare determination that the employee was not credible. However, the ALJ also denied the employer's request for judicial referral to the Enforcement Division. The employee appealed and the employer cross-appealed seeking a judicial referral to the Enforcement Division. The Appellate Division also denied the claim but DID refer the case to the Enforcement Division. A field investigator reviewed the deposition and hearing testimony in comparison with the surveillance video. A warrant was obtained and the employee was arrested for workers' compensation fraud. Best part?? Well, the Enforcement Division issued a press release about the case. The local newspaper in Dublin, GA splashed the story across the front page. The employee was named, the employer was named and the prosecution ensued.

Some claims need litigating, some need settling and some need a referral to the Enforcement Division for investigation of fraud. We are a workers' compensation defense firm and can assist you with your claims.

Completing an Employment Certificate Online For Minors Under Age 18
(Instructions for Employers)

To access the online employment certificate (work permit) system, go to our website at www.dol.state.ga.us.

- Select "Child Labor", listed under "Quick Links".
- Select "Get a Youth Employment Certificate (Work Permit)".

SECTION B (To be completed by the Employer)

Upon receipt of a data sheet from the minor, the employer:

- Selects the **"Employer"** option on the online work permit system.
- Enters the employer's telephone number and selects "Submit".
- If the employer information is already in database, selects "Start New Employee".
    1. Enters the Minor Security Key (MSK) and selects "Submit".
    2. Selects the correct date to complete Section B.
       (Select the most recent date if there is more than one date displayed.)
- If the employer information is not already in the database,
    1. Enters the Minor Security Key (MSK) and selects "Submit".
    2. Selects the correct date to complete Section B.
       (Select the most recent date if there is more than one date displayed.)
    3. Enters employer name, physical worksite address, telephone number, etc.
- Selects "Industry" and "Job Duty" from drop down box.
  (If job duty is not listed, select "Other" and enter description of duties in the section provided.)
- Enters maximum work hours per day/week and earliest start and latest end time for when school is in and out of session.
- Enters name and title of company official completing form; verifies information & selects "Submit".

The employer should retain a copy of the confirmation page displaying the MSK & the ESK (Employer Security Key) in order to print a "Completed Work Permit" after section C has been completed by an issuing officer. The ESK is only active for 30 days after the completed work permit has been issued.

NOTE: An authorized issuing officer is:

1. Superintendent of schools or his/her designee (Each school usually has designated issuing officers).
2. Principal Administrative Officer of a licensed private school or his/her designee.

All minors, including home schooled minors, minors not attending school, and minors from out-of-state, must have their certificates issued by one of the above sources. These minors should take their birth certificate to the issuing officer. After the issuing officer has certified the employment certificate online, he/she will print a completed copy from the system and present it to the minor. The minor takes the computer generated copy of the online certificate to the employer. **The employer must maintain this copy of the employment certificate at the work site as long as the minor is employed.**

NOTE: Minors 16 & 17 years of age that are issued a permanent identification card (Form DOL-4102) should retain the card themselves. Minor should present their first employer with the original copy of the employment certificate. On subsequent employment, minor should present the ID card to the employer. Employer should make a copy of the ID card for minor's personnel file and return the original to the minor. **The employer keeps a copy of the ID card on file at the work site as long as the minor is employed.**

DOL- 4114 (10/08)

CHILD LABOR SUMMARY SHEET

When there is a difference in state, federal or local law regarding child labor, the law providing the most protection to the minor takes precedence.

Below are the more restrictive requirements for employing a minor.

		JURISDICTION
MINIMUM AGE	14 Years of Age	FEDERAL
EMPLOYMENT CERTIFICATE (Work Permit) (Includes home schooled minors & minors from out-of-state working in Georgia)	17 Years of Age & Under Obtained from Georgia School attended OR County School Superintendent	STATE
HOURS OF WORK Minors 14 & 15 Years of Age	3 Hours (school day) 8 Hours (non-school day) 18 Hours (school week) 40 Hours (non-school week) Not during normal school hours. Not before 7 a.m. Not after 7 p.m. (Evening hours extended to 9 p.m. June 1 to Labor Day).	FEDERAL
HAZARDOUS OCCUPATIONS Minors 17 Years of Age & Younger	Manufacturing & storing explosives; motor vehicle driving & outside helper; coal mining; logging & sawmilling; power-driven woodworking machines; exposure to radioactive substances; power-driven hoisting apparatus; power-driven metal-forming, punching, and shearing machines; mining; slaughtering; meat-packing, processing or rendering; power-driven bakery machines; power-driven paper products machines; manufacturing brick, tile, & kindred products; power-driven circular saws, band saws, & guillotine shears; wrecking; demolition, & shipbreaking operations; roofing operations; excavation operations.	FEDERAL
ALCOHOLIC BEVERAGES	May not: Dispense, serve, sell or take orders for alcoholic beverages. (EXCEPTION: Where alcohol is sold for consumption OFF the premises). NOTE: Local law may be more restrictive.	STATE
PROHIBITED OCCUPATIONS Minors 15 Years of Age & Younger	Machinery; motor vehicles; equipment; food process; fixtures; railroads; unguarded gears; vessels or boats; dangerous gases or acids; communication or public utilities; freezers; meat coolers; loading and unloading trucks, railroad cars, conveyors, etc.; warehouses; scaffolding or construction; mines, coke breaker, coke oven, or quarry.	STATE
	Manufacturing; mining; public messenger service; construction; work in/about Boilers or Engine Rooms; cooking; (Includes power mowers or cutters - including weed eaters).	FEDERAL
MINORS IN ENTERTAINMENT	Requires special application and certificate of consent. Certificate of consent must be issued by Georgia Child Labor Section prior to minor beginning work.	STATE

NOTE: Minors working for a parent/guardian who owns the business are exempt from all but the hazardous/prohibited occupation restrictions.

Page 26 and 27- Courtesy of Jenifer Enterante Cummings
Of Counsel
Licensed in Georgia and Louisiana

Study Finds Obesity Tips Scales As Prevalent Workplace Health Challenge

By Josiah Pritchard, MHA Mayo Clinic Vice President, Florida Association of Self Insureds

A recent study confirmed that obesity remains one of the top employee health problems in America, and is now estimated to cost employers almost $73 billion a year in higher health care bills. The Northeast Business Group on Health, a group of large national employers and other organizations that chart health care costs, released the study, entitled "Weight Control and the Workplace" in early November.

In light of new insurance provision mandates under the Affordable Care Act, employers have become more concerned about the health of their employees, and are working to unveil incentives to reduce costs and increase the physical activity of employees.

Researchers have observed that obesity has reached epidemic proportions in the U.S., with one-third of all adults considered overweight. Five years ago, health care spending directly resulting from obesity was as high as $210 billion, or 21 percent of total health spending. When indirect costs were included, this bill more than doubled to more than $450 billion.

The Centers for Disease Control and Prevention have estimated that chronic diseases accounted for 75 percent of national health care expenditures. If these trends continue, health care costs could double by 2030, the CDC estimates.

The report by the Northeast Business Group pinpointed a number of critical components to a successful workplace weight-loss program, starting with support from top executives and prize incentives. While these items have had success at encouraging employees to increase their exercise, the sensitive nature of initially approaching overweight employees has proven to be a challenge due to the stigma associated with being overweight or obese. Much of the stigma is connected with documented workplace health problems among obese employees, who outnumber thinner co-workers 2 to 1 in the number of workers' compensation requests filed, and averaging six to nine more sick days than their comparators.

To combat obesity, employers have unveiled wellness programs that have included healthier cafeteria options, free workout classes and prizes for those who make the most progress in the battle of the bulge.
A 2012 study by the Rand Corp. found that 58 percent of employees think incentives are important for participation. When incentive programs were put in place, program participation rose 30 percent.

The report can be downloaded at:
http://www.nebgh.org/resources/NEBGH_SC_WeightControlFINAL10%2031%2013.pdf

Josiah D. Pritchard, MHA Mayo Clinic Vice President, Florida Association of Self Insureds

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Direct Line: 478-254-5387
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Beverly Jackson (Griffin)
Email: bjackson@orthoga.org
Direct Line: 478-254-5331

Donna Malcolm (Milledgeville)
Email: dmalcolm@orthoga.org
Direct Line: 478-254-5388

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Workers' Compensation Coordinator

Roxanna Fredrick
Email: r.fredrick@handcenterga.com
Direct Line: 404-255-0226 x 130
Web Address: handcenterga.com
PHONE: 404-255-0226 FAX: 404-256-8968

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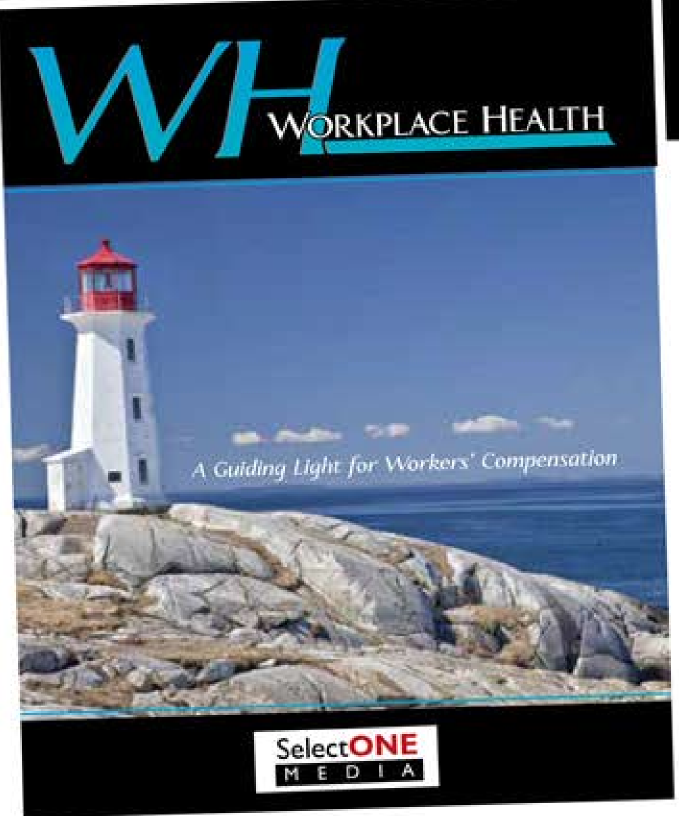

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The deadline for submitting advertisements and articles is March 1, 2015. The Spring 2015 issue will be published in early April 2015.

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