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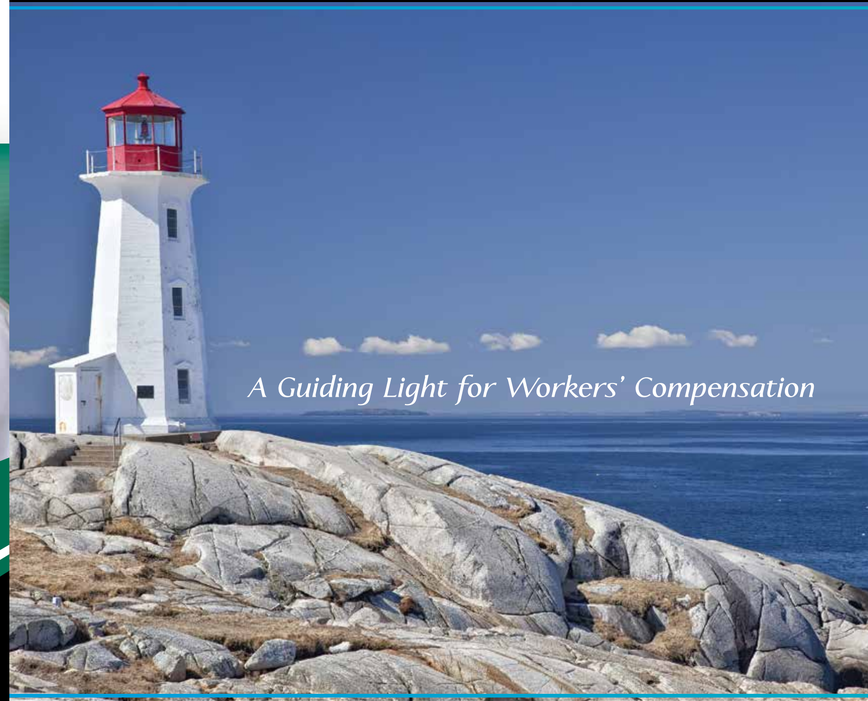
Summer 2014 Edition

WH Workplace Health



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What is Pain Management?

Pickens A. Patterson, III, M.D.

A pain specialist is a physician who has dedicated their practice of medicine to the relief of pain and suffering. It is important to understand what a true pain specialist is, and is not. In short, any physician may classify herself as a pain management specialist if that classification is based on the fact that they treat patients who have pain. With a definition so broad, almost any physician is a "pain specialist" at some point in their career. A primary care physician may choose to focus their entire practice on the treatment of chronic pain, yet they are not pain specialists. Because they have not had formal training in the entire scope of pain management, this generally consists of prescribing medications, and sometimes utilizing non-interventional techniques to manage chronic pain. In addition, other specialists may choose to practice under the broad title of pain management again by primarily providing medications and performing or directing other simple procedures. Unfortunately, a few unscrupulous physicians have employed yard signs and billboards announcing "Pain Management" along with a phone number. Many of these doctors have no formal training in pain management. This type of advertising is akin to an anesthesiologist placing yard signs exclaiming "Brain Surgery!" along with a phone number. As ridiculous as this analogy sounds, the similarity is almost identical.

The vast majority of practicing pain specialists have completed a residency training program along with a subspecialty fellowship in pain management. In general, these sub-specialists have training first in anesthesiology, physical medicine and rehab, or neurology. Because pain management is considered to be included in the residency training of an anesthesiologist, there are some pain practitioners who have training in anesthesiology alone. These pain specialists are trained in not only the complexities of medication management, but also in interventional techniques such as epidural steroid injections, nerve blocks, sympathetic blocks, interventional spine procedures, and some surgical procedures related to the management of chronic pain. Pain management is a recognized subspecialty by the American Board of Anesthesiology.

The specialty of pain management should not be considered a last resort for patients in pain when nothing else is working for them. In fact, early treatment by a pain specialist is likely to decrease the long term and debilitating consequences of chronic pain. A pain specialist will develop a plan for treating a patient's pain with clearly defined goals. In addition to the obvious goal of pain reduction, an improvement in function and quality of life are extremely important. When a patient is suffering from a work-related injury, the goal of returning the patient to a pre-injury level of functioning is the ultimate goal.

Interventional pain specialists often use injections to help to eliminate or reduce pain and to eliminate or reduce the need for narcotic pain medications. No single therapy whether that be injections, medications, or other adjuvant therapies should be used in excess or in isolation. Only with the skilled implementation of a variety of treatment modalities will the patient obtain the most optimal outcome and have the greatest opportunity to return to an optimal quality of life.

There are many styles of practitioners within the pain community. It is important to identify a pain specialist that has proper training and experience in the management of pain patients and to find a practitioner that uses a balanced approach to treating pain in order to get the best and most cost-efficient outcome for your patient. Pain management should not be viewed as a "black hole" that draws a patient into a never ending cycle of injections or medications without clearly defined goals, nor should it be viewed as a specialty of last resort. The specialty should be considered an integral part of maximizing a patient's function and improving their quality of life.

INTERVENTIONAL SPINE & PAIN MANAGEMENT

Pickens A. Patterson, III, M.D. is Double Board Certified in Anesthesiology and Pain Management Medicine. He has eight years of experience in practicing Interventional Pain Management in South Carolina and Georgia.

Dr. Patterson attended the United States Naval Academy and received a Bachelors degree in biology from Hampton University. He graduated from the Medical College of Georgia and completed his residency in anesthesiology at Vanderbilt University where he was awarded "Best Bedside Manner" by the director of his fellowship program.

WH Workplace Health

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WH Contents

Relieve Pain... Restore Life

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Board Certified in Pain Medicine
and Physical Medicine
and Rehabilitation

Redefining Pain Management : **Radiofrequency Ablation**

Pain isn't a shared experience. Many people suffer from pain, but how they experience it—its severity, its location, and its impact on their lives—can be so different for each person.

A comprehensive pain management program focusing on treating different types of pain for different people is essential. Those suffering from work related injuries, headaches, pain in the joints, or pain from a sports injury have as many options for treatment as those who suffer from more common pain conditions when using a comprehensive approach.

Radiofrequency ablation is just one of the many treatment options available within a comprehensive approach to pain management. Radiofrequency ablation is a procedure where radio waves are used to produce an electrical current that applies heat to targeted nerve tissue. It can be used to relieve symptoms associated with various types of chronic pain. When the heat is applied, it causes a semi-permanent disruption of pain signal transmission from the spinal column to the brain by impairing or completely destroying nerve tissue.

This nonsurgical procedure was first discovered as an effective method for relieving chronic pain in 1931 when it was used to treat a case of trigeminal neuralgia, a condition that affects nerves located in the face. This condition can cause excruciating jolts of pain. Ever since the initial successful radiofrequency ablation procedure was performed, it has become increasingly popular amongst both patients and physicians, especially over the last fifteen years, due to its documented benefits.

Various reports have shown that the disruption of nerve function through radiofrequency ablation has led to larger improvements in spine-related pain than conventional treatment methods.

Additionally, several reports suggest that pain relief may be maintained for six to twelve months after radiofrequency ablation is performed. Additional benefits related to this procedure have made it the treatment method of choice for many patients, as well as physicians. These benefits include optimal precision during needle insertion, the ability to repeat the procedure if necessary, and the ability to perform it in an outpatient setting.

There are two basic types of radiofrequency ablation, known as continuous radiofrequency and pulsed radiofrequency. Both methods are found to be effective at hindering the transmission of pain signals from specific nerves, thereby reducing or eliminating chronic pain. It is well documented that the heat-induced nerve damage is mainly responsible for radiofrequency ablation's effectiveness, however, some reports have also suggested that improvements in reported pain symptoms may also be attributed to the impact the electric field has on gene expression within neurons that are responsible for processing pain.

Currently, radiofrequency ablation is commonly utilized to treat pain that originates in the facet joints. Facet joints are structures that connect the vertebrae along the spine. Networks of medial branch nerves are located within facet joints and these tiny nerves transmit pain signals to the brain when nerve tissue becomes damaged or inflamed. When the pain becomes chronic, radiofrequency ablation is often performed in order to destroy the medial branch nerves and reduce or completely alleviate the pain.

This procedure is successfully utilized to treat additional conditions such as work related injuries, arthritis-related pain, low back pain, and cervical facet pain.

Pain management is critical, whether a patient is suffering from acute, chronic, or end-stage pain. By redefining what pain treatment means, this specialty aims to reach a wider variety of patients in pain helping them return to a more active lifestyle.

Injury Prevention: The Role of the Certified Athletic Trainer

Brett Moore, M.S.S., A.T.C

For many years professional sports teams and collegiate athletic programs have employed Certified Athletic Trainers to handle the medical needs of their athletes. Injury prevention, early injury assessment, injury treatment, and post-surgical rehabilitation are just a few of the responsibilities of this licensed and well educated medical professional known as a certified athletic trainer. Many leading companies in the United States, both large and small, are now employing athletic trainers to help keep their employees healthy and productive, greatly lower healthcare costs, and significantly improve overall safety results.

Athletic trainers are employed by companies in the airline, pulp and paper, and food preparation industries; along with the United States Military, just to name a very few. All of these organizations have three very basic reasons for hiring the services of athletic trainers. Uninjured, healthy employees are safer and more productive. Healthcare costs for injured employees and their employers are only getting more outrageous. Soft tissue and musculoskeletal recordable injuries and lost work days can be prevented with very simple action steps in place.

Injury prevention and employee health education is the first action step and a great starting point. Athletic trainers provide and implement excellent, easy to understand employee education programs. These programs can be tailored to meet the needs of each specific facility. One facility might have issues with diabetes, arthritis, and back injuries that are costing them lost work days and decreased productivity. Another facility may see chronic issues with foot pain, high blood pressure, and shoulder (rotator cuff) injuries. Athletic trainers have the ability and education to share information with employees to help them help themselves or know when to ask for medical assistance. While education is a great starting point to allow employees to get to know and feel comfortable with the athletic trainer, there are other steps to be taken. These other action steps are more hands-on and start the process of lowering healthcare costs, improving safety statistics, and getting employees healthy very quickly.

The next step in this process should be the establishment of an early symptom reporting protocol. While this sounds really in-depth and involved, it is not. Simply put, do employees have a place to go to report work and non-work related musculoskeletal and soft tissue issues? Is there a medical professional there specifically trained to evaluate these issues and provide proper instruction to the employee? Please note; this program is for work- and non-work related issues. Many times non-work related issues that can be easily treated are left to worsen by the employee and are aggravated at work thus becoming a work-related injury. This is frustrating to all involved. The vast majority of these non-work related issues could have easily been treated and healed. By doing so, the employee is well and the company would not have a non-work related issue become a work-related recordable injury. Early symptom reporting is imperative to handling these issues.

Another component to the role of the athletic trainer is directly beneficial to a facility's safety record. All too often, an employee has a minor work related soft tissue injury (sprain/strain/contusion, etc.) that simply has no way of being properly evaluated on site. Athletic trainers have the ability, under the direction or standing orders of a physician, to evaluate the injury. Many times the minor injury can be treated right there and kept at a first-aid case. The employee is properly treated, returns to work, and followed up with as needed. Too often the employee is sent directly to an Emergency Room for evaluation and any of a number of medical treatments is performed resulting in a recordable injury that could have been properly treated with OSHA first-aid measures.

When it comes to evaluating and assessing these types of injuries, let there be no mistake, while athletic trainers are well educated, 70% with Masters Degrees, they do not pretend to play the role of physicians. Athletic trainers work under the direction of licensed physicians. Athletic trainers and physicians of many specialties work very closely together thus allowing more industrial facilities to enjoy these services that provide excellent care for their employees.

Companies across the United States are also seeing their employees delay retirement and keep working. Many of these employees are undergoing major orthopedic surgeries and face long-term disability as a result. Their extended time away from work is a big concern for the employers. Hip replacement, knee replacement, spinal fusion (lumbar/cervical), and rotator cuff repair can lead to months of time away from the facility.

These types of surgeries require healing time and rehabilitation time. How about having the services of an athletic trainer cut this time dramatically? How about having a basic facility at work that will allow the majority of this rehabilitation to be done at work? Many facilities allow employees to return, when cleared by their physician, to perform approved duties and to take 30 to 60 minutes per day for proper rehabilitation. Employees enjoy this benefit because they are back to a fairly normal work life and have quality rehabilitation at no cost to them. There is no insurance billing for these athletic trainer services. No co-pays or deductibles for the employee, and the company has the valuable employee back much sooner. A win – win for all involved.

On a personal note, I have worked in the industrial setting for nearly twenty years. My company has provided athletic trainer services for large facilities (over one thousand employees) and small organizations (fewer than one hundred employees). Not all facilities need full-time athletic trainer coverage. A good rule of thumb is about fifteen hours of coverage per week per one hundred employees. The starting point and type of coverage will vary from organization to organization. Safety records and healthcare costs can dramatically improve. Organizational leadership and employees alike have to get serious and stay committed in order to keep employees safe and well. The role of the certified athletic trainer is a key component of this protocol.

Injury Prevention
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For more information, current statistics, and organizations that employ certified athletic trainers, please visit our website at:
moorewellnesssytems.com

When it's Hot, Hot, Hot!

Robert E. Vazzi, CIH, Area Director: USDOL-OSHA Savannah Area Office

After a long cold winter, we look forward to another hot, humid, Georgia summer. How can you and your workplace be better prepared for the heat of the day? What can you do to prevent your employees from being overtaken by heat and becoming ill?

Check out the Occupational Safety and Health Administration's Heat Illness Prevention webpage **(http://www.osha.gov/SLTC/heatillness/index.html)** to learn effective ways to teach your employees how to work safely under hot conditions.

In 2011, thousands of workers in the United States became ill from excessive heat on the job and more than 60 workers died. These illnesses and fatalities can be prevented by some simple precautions following these three simple steps:

Water: Drink plenty of water throughout the day – every 15 minutes. Don't wait until you feel thirsty.
Rest: Rest breaks help your body recover.
Shade: Resting in the shade or air-conditioning helps you cool down.

New employees need to become acclimatized over a period of time to hot working conditions. As the temperatures and heat index increase, more time is needed to drink water, rest and cool down.
Know the signs and symptoms of Heat-related Illness. Acting quickly can prevent more serious medical conditions and may save lives.

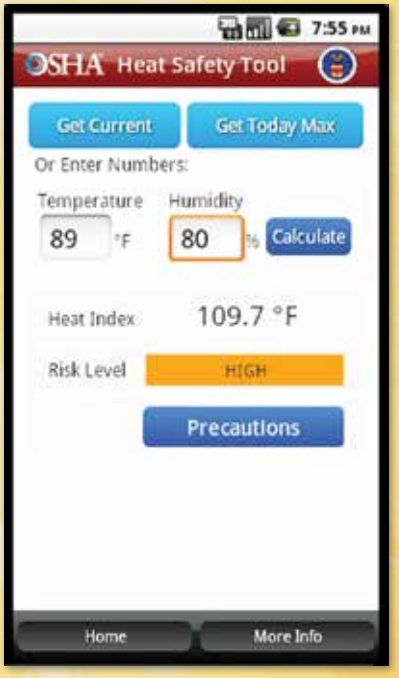
• Heat Stroke is the most serious heat-related illness and requires immediate medical attention. Symptoms include: confusion, fainting, seizures, very high body temperature and hot, dry skin or profuse sweating. CALL 911 if a coworker shows signs of heat stroke.

• Heat Exhaustion is also a serious illness. Symptoms include: headache, nausea, dizziness, weakness, thirst and heavy sweating. Heat fatigue, and heat rash are less serious, but they are still signs of too much heat exposure.

If you or a co-worker has symptoms of heat-related illness, tell your supervisor right away. If you can, move the person to a shaded area, loosen his/her clothing, give him/her water (a little at a time), and cool him/her down with ice packs or cool water.

How do you know when hot is too hot? Download and use OSHA's Heat Safety Tool App on your Android or iPhone from the directions given on their webpage. The App allows workers and supervisors to monitor the heat index and determine precautions to take to protect themselves under hot conditions.

The OSHA Heat Safety App lets you get the current conditions and calculate the heat index under those conditions. It will also allow individuals to get the precautionary measures that they should follow to prevent them from becoming ill due to the heat by simply pressing the **"Precautions"** button.
Under the **"More Info"** button at the bottom, you can look up the symptoms and first aid meaures.



OSHA can help. Visit **www.osha.gov** for worker fact sheets, worksite posters, and other resources on preventing heat-related illness, in both English and Spanish. If you have questions, call OSHA. It's confidential.
Call 1-800-321-OSHA (6742) or visit www.osha.gov to learn more about staying healthy in the heat.

Methicillin-resistant Staphylococcus Aureus

Suzanne Tambasco, RN, BSN, CCM, CRRN, COHNS/CM, NCLCP, LNCC

Background: Methicillin-resistant Staphylococcus Aureus (MRSA) infection is caused by a strain of staph bacteria that's become resistant to the antibiotics commonly used to treat ordinary staph infections.

MRSA infections began with a very specific strain of the staph bacteria now defined as HA-MRSA or healthcare acquired MRSA. It is associated with patients who have been hospitalized and or have had invasive medical procedures, such as surgery or implanted medical devices.

The first United States hospital outbreak of MRSA occurred 1968. By 1995 the rate had increased to 22% by 1995, and by 1997 the percent of HA-MRSA had reached 50%.

Another strain of MRSA that appeared 1981 in the community in the intravenous drug population that was later defined as CA MRSA or community acquired MRSA. At the same time the health care community was working hard to stabilize the rise of Hospital Acquired MRSA, the newest strain or CA-MRSA was continued to rise. This trend continues today.

About two people in 100 are carriers of MRSA. Healthy people can be carriers without any symptoms of the disease and without knowing. Transmission is person to person through hand to hand contact.

For employers and claims adjusters, understanding how MRSA, both hospital and community acquired, is critical for managing your claims. An MRSA infection is physically and financially costly and potentially life threatening. The average cost of an MRSA infection is about $14,000. This is due to the increased cost of the newer and multiple antibiotics required to treat the infection.

MRSA, especially the community acquired strain, has an affinity for the skin, brain and meninges. As a result, untreated MRSA that begins as cellulitis has been known to cause MRSA Meningitis which can lead to stroke if untreated or spinal abscesses that can lead to spinal cord injury.

CA-MRSA often starts as a boil, or abscess that is more often than not mistaken for a bug bite. Many employees will report to their employee and occupational health physicians that they must have been bitten by a spider given the appearance of the abscesses. Many MRSA infections have been incorrectly diagnosed and treated resulted in increased morbidity and even mortality. Inappropriate diagnosis leads to costs being inappropriately shifted to worker's compensation and contributes to the public misunderstanding that spider bites cause MRSA. Employers and providers must be keen to understand that the report of an unwitnessed "spider bite" cannot be considered a spider bite and the differential diagnoses of MRSA must be considered. Most public health officials and medical boards have alerts posted on their respective websites as these misdiagnoses are quite prevalent.

Employers also may want to take the extra step at the initial evaluation to have the employees nares swapped for MRSA colonization as to assist with the establishment causality of the infection. Because this is a community based disease that is also acquired by medical care, it is critical to a claim to understand if the patient infected themselves or it was acquired as a result of treatment for a work related injury. This is doubly important if in fact the wound in question originates as an abscess and is not associated with medical treatment.

Employers that work closely with the public such as daycare workers, prison workers, EMS, healthcare providers, nursing home employees, and other jobs where there is close personal contact with potentially infected individuals are at risk for occupationally acquired MRSA. It is again critical to be able to have a good infection control and reporting plan in place so that you can identify active cases and potentially employees exposed.

Return to work: When properly treated with the necessary antibiotic medication, most employees can work with MRSA infection barring other physical limitations. Maintaining good hand and body hygiene especially after exercise/sweating is critical. Wounds should be kept clean and covered until healed.

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Anterior Cervical Discectomy and Fusion (ACDF)

Dr. Raphael Rey Roybal, MD, MBA

Anterior Cervical Discectomy and Fusion (ACDF) has been a gold-standard treatment for Cervical Spine Pathology including spinal stenosis and herniated cervical discs with corresponding radiating arm pain (radiculopathy). Since at least the 1950s, ACDF has been an efficient, reproducible, and safe treatment for pinched nerves, spinal cord compression, and even cervical myelopathy, characterized by severe neurologic deficit. The anterior approach to the spine, which is entry from the front as opposed to the back of the neck, is also characterized by a muscle sparing, gentle blunt dissection which was minimally invasive before its time. Accordingly, patients throughout the years have enjoyed quick recoveries and return to full activity and function. However, the procedure involves removing completely the pathologic disc thereby requiring the replacement of that disc which has been traditionally a fusion device rendering that segment of the spine immobile.

Interestingly, the cervical spine often accommodates one through three levels of fusion in the cervical spine without loss of total cervical spine motion. Additionally, no clear cut evidence exists for the occurrence of increased degeneration adjacent to fused segments. However, there remains a theoretical and philosophical appeal for preserving motion when possible in the cervical spine.

Within the last few decades, Total Disc Arthroplasty (TDA) or artificial discs have become an increasingly popular and researched alternative to cervical fusion after decompression of the cervical spine via an anterior approach. Numerous FDA studies have been conducted that demonstrate an equivalent efficacy of TDA compared to ACDF, which are both very good. There have been additional studies that show a clear improvement of TDA vs. ACDF in terms of a quicker return to work and function. However, the majority of these studies have been limited to single disc disease as all available disc replacements have been limited by the FDA to single levels.

In the last year, a pivotal prospective randomized study was completed comparing 2 level ACDF to 2 level TDA in the cervical spine. It is important to know that both groups did very well, meeting extraordinarily strict criteria defining surgical and clinical success. However, the TDA group significantly out-performed the fusion group in terms of less need for additional surgery after the index procedure as well as overall neck pain and disability. Although the single level ACDF and single level TDA in this same study had equivalent excellent results, the addition of the second level demonstrated this significant difference.

Why is that? Historically, single level cervical fusions fuse with almost 100% certainty. When attempting to fuse 2 levels, the fusion rate begins to drop. Therefore, symptomatic patients with a failed fusion (termed a pseudarthrosis) often require a second revision surgery to achieve successful arthrodesis (fusion). With a Total Disc Arthroplasty, the surgical goal is to preserve motion and fusion is definitely not required or even desired for surgical technical success.

One has to hypothesize why the two study groups (2 level ACDF vs 2 level TDA) exhibited such a difference in overall neck disability and pain measured by the NDI (neck disability index). Hypothetically, preserving motion may spare the other non-operative segments from extra or excessive forces needed to compensate for a fused segment in the cervical spine. Because 1 level ACDF and TDR produce equivalent and excellent NDI's, the extra level fused in 2 level ACDF may cause the clinical difference explaining the better NDI in 2 level TDR.

It is important to remember that both 2 level surgeries reliably and excellently relieve radicular arm pain, improve quality of life, and earn high marks for patient satisfaction. When two levels are pathologic in the cervical spine, 2 level TDR may provide an even more excellent outcome with less residual neck pain and less risk of a need for revision surgery at the index surgery. Consistent with recent comprehensive literature review and research, this study once again confirmed that even fusion of the cervical spine does not increase the risk of adjacent level degeneration or pathology. This would indicate that for single level pathology, ACDF or TDR is an equivalent excellent option. On the other hand, if the patient meets strict indications for disc replacement, 2 level TDR seems to be a superior option for 2 level pathology.

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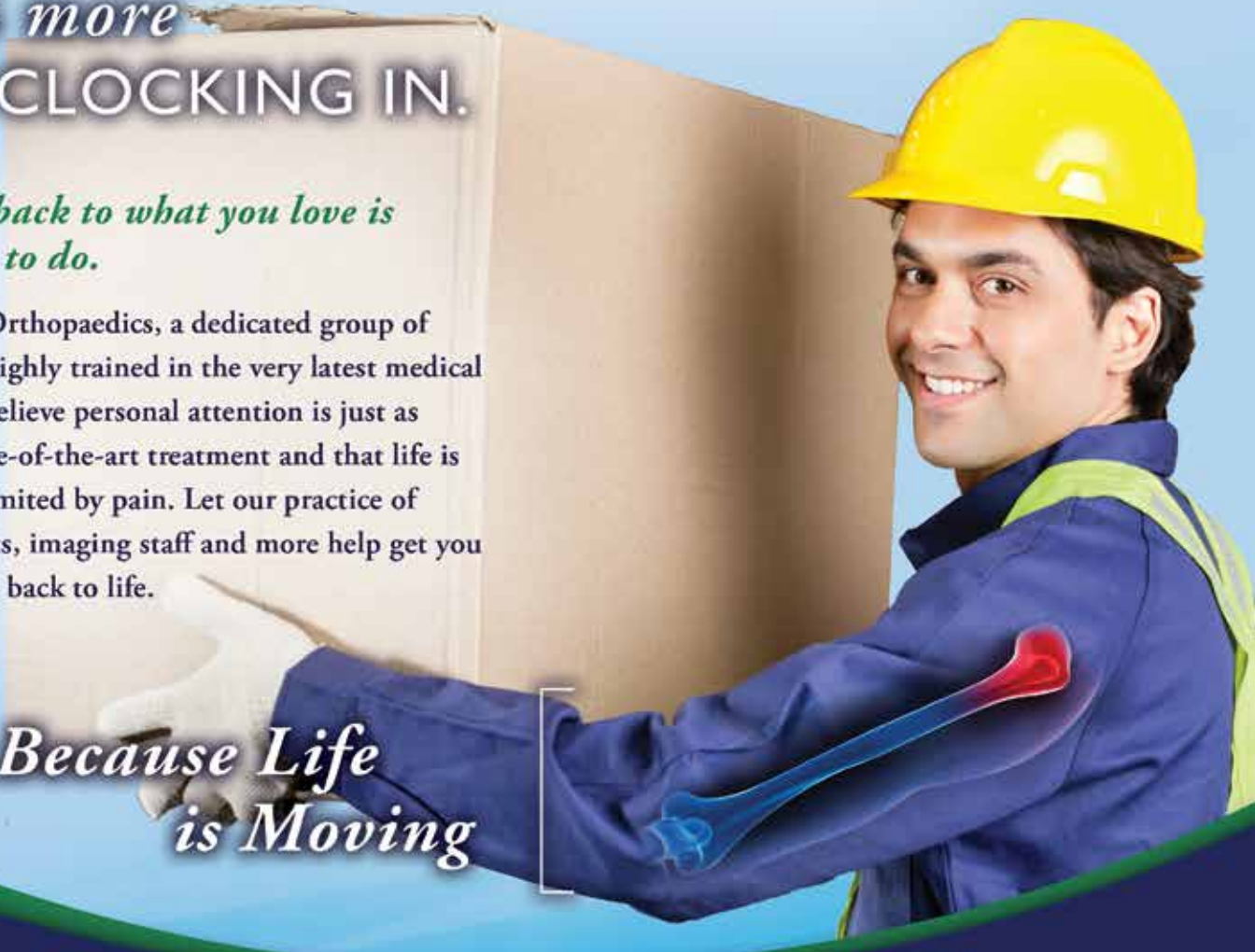
SOMETIMES GETTING BACK TO WORK MEANS *more* THAN CLOCKING IN.



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"Coverage B"– Employer/Carriers Beware!!!

M. Kemmerly Thomas, Partner

Generally, there are four types of insurance coverage for Employers:

(1) General Liability Insurance;
(2) Workers' Compensation Insurance, Part I (Coverage A);
(3) Employer's Liability Insurance, Part II (Coverage B); and
(4) Employment Practices Liability Insurance.

Section 440.11, F.S., immunizes an Employer in Florida from suit by an injured employee in connection with a work place injury, with limited exceptions. Likewise, O.C.G.A. Section 34-9-11, provides a Georgia Employer the same immunity with similar exceptions. Unfortunately, this "protection" from additional liability, in addition to and apart from payment of workers' compensation benefits, is under attack.

A recent development in Florida is the recognition of a new tort springing from the claims handling of a workers' compensation case. A workers' compensation claim is handled under Part I of the WC portion of the policy (also known as "Coverage A"), but the "springing tort", if the Employer is again named as the defendant, would be handled under Part II ("Coverage B"). These "springing torts" can be more costly for the insurer than the underlying workers' compensation case due to cost of defense and policy limit considerations. "Coverage B" provides coverage not encompassed within the Employer's general liability policy - i.e., coverage for bodily injury or disease caused by an accident to an employee. "Employees" are excluded from coverage under the GL policy. Historically, "Coverage B" has been so rarely used that class actions across the United States have been filed to enjoin state funds from writing the coverage and charging an insured a minimal premium for the coverage. See Selkirk Seed Company v. State Insurance Fund, 135 Idaho 434(Idaho 2000). However, the Plaintiff/Claimant's bar is now focusing on the ambits of "Coverage B" as a potential untapped source of damages.

The "Coverage B" or Part II - Employer Liability Insurance provisions most often provide as follows:

The Employers Liability Insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.
1.) The bodily injury must arise out of and in the course of the injured employees employment by you;
2.) The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page;
3.) Bodily injury by accident must occur during the policy period; 4.) Bodily injury by disease must be caused or aggravated by the conditions of your employment....

The "Exclusions" portion of "Coverage B" usually details twelve or more exclusionary scenarios. For example, common exclusions are, "Any obligation imposed by a worker's compensation, occupational disease, unemployment compensation, or disability benefits law or any similar law" and "bodily injury intentionally caused or aggravated by you." Arguably, "Coverage B" falls within the statutory scheme of worker's compensation because it applies to "bodily injury by accident or bodily injury by disease" which "arises out of and in the course of the injured employee's employment". A plain reading of the verbiage of "Coverage B" indicates no language supporting application to any persons other than employees. The argument now being raised is that Coverage B provides additional coverage for damages not covered by the WC policy. i.e. remaining one-third of lost wages, pain and suffering.

Part I ("Coverage A") and Part II ("Coverage B") technically both provide workers' compensation insurance. However, each provides coverage under different conditions and are mutually exclusive. Arguably, when read as a whole, Part I functions as the policies omnibus clause in providing worker's compensation insurance to Employers. Part II applies in only limited circumstances, and the exclusion of any obligation imposed by worker's compensation law serves only to preclude operation of Part I in the event the terms and conditions of Part II have been met. Case law has recognized that Part II/Coverage B clearly contemplates coverage for an Employer brought before a forum other than a Judge of Compensation Claims and provides payment or defense for the liability incurred by an

Employer as a result of an injured employee.
If the compensation carrier refuses to cover and defend a tort action, the Employer is free to defend the case and is free to settle with the claimant/plaintiff. In that circumstance, the plaintiff may take an assignment of the Employer's right to obtain indemnification from the insurer. In the action against the carrier to collect the settlement or judgement, the carrier loses any real defense to the action other than the settlement was excessive or that there existed fraud in the process. See Wright v. Hartford Underwriters Insurance Company, 823 So. 2nd 241 (Fla. 4th DCA 2002). Arguably, the Employer has the ability to bind the carrier to the defense of a "Coverage B" claim just as the carrier has the ability to expose the Employer to excess liability. A mere oral statement by a Florida Employer to an employee indicating the Employer does not have "full worker's compensation coverage" is potentially enough to allow the injured worker to avoid the exclusive remedy and sue in tort. Generally, the limits of liability for "Coverage B" are fixed and start at $100,000.00 per person.

The exact issue of an Employer/Carrier's exposure under "Coverage B", in addition to liability for W.C. benefits, is currently under review by the Supreme Court of Florida. In Morales v. Zenith Insurance Co., 714 F.3d 1220 (U.S. 11th Cir. 2013), an employee was killed while performing landscaping duties and his widow received Florida W.C. death benefits. The estate then filed a wrongful death action against the Employer under Coverage B asserting negligence with no assertion of intentional conduct on the part of the Employer/Insured. The WC carrier, Zenith, agreed to defend the Employer in the Coverage B action asserting the civil action was barred due to receipt of WC benefits. The Employer did not assist in the defense and the attorney hired by Zenith to defend the Employer ultimately withdrew. The civil case proceeded to trial and the Employer did not appear. The jury awarded the estate $ 9.525 million in damages. While the wrongful death action was ongoing, the WC case was settled. The estate filed an action in Florida against Zenith asserting it breached its' insurance policy by failing the pay the tort judgment on behalf of the Employer. Zenith defended, among other argument, that the estate had elected a remedy by settlement of the WC case and Coverage B exclusions applied to bar coverage. The estate argued that Zenith's withdrawal of counsel for the Employer resulted in a failure to preserve defenses and that the exclusions of Coverage B did not operate as a bar to its' claim for the judgment award. Ultimately, the 11th Circuit determined that there exists "unsettled Florida law" regarding the issue and certified the following questions to the Supreme Court of Florida:

(1) Does the estate have standing to bring its breach of contract claim against Zenith under the Employer Liability Policy ("Coverage B") ?

(2) If so, does the provision in the Employer Liability Policy which excludes from coverage "any obligation imposed by W.C. law..." operate to exclude coverage of the estate's claim against Zenith for the tort judgement ?

(3) If estate's claim is not barred by the W.C. exclusion, does the release in the W.C. settlement agreement otherwise prohibit the estate's collection of tort judgment ?

The insurance industry will be anxiously awaiting the opinion issued by the Supreme Court of Florida in the Morales case. Without question, this case is on the radar for Plaintiff/Claimant attorneys in Florida and Georgia. The impact of this decision will be tremendous in terms of expansion of liability, pleading and defense strategies and the increase in litigation expenses resulting from a carrier's duty to defend.

Kemmerly Thomas is the managing partner of the Thomasville, Georgia office of McCounnaughhay, Duffy, Coonrod, Pope & Weaver, P.A.

She concentrates her practice in the areas of workers' compensation defense, employment issues, lien resolution and carrier audit litigation throughout Florida and South Georgia. She is Board Certified in Workers' Compensation law in Georgia and Florida. She is an annual speaker on workers' compensation issues at the Florida Workers' Compensation Educational Conference and Georgia State Board of Workers' Compensation Annual Educational Conference, as well as numerous other seminars around the southeast.

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Job Hazard Analysis – An Overview

Developing a Job Hazard Analysis (JHA) is the centerpiece of a safety process. A JHA is a tool to focus on a specific job, define the steps required to do that job, and ultimately define each task required to perform each step.

The JHA focuses on the interaction between:

- The employee
- The job as a whole unit
- The tasks that are defined in each step
- The tools, materials, and equipment being used
- Existing and potential hazards
- Potential at-risk events associated with each task
- Existing policies and procedures
- The nature of the physical environment that the job is completed within

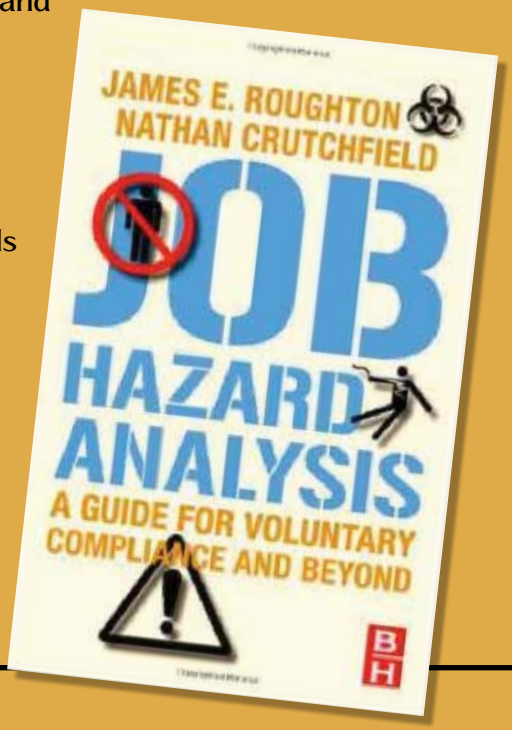
"Hope is not a strategy" – Rick Page

Parts of the analysis include clear and detailed definition of statements, policies, responsibilities, codes and practices for both management and employees. These must be crafted specific to the site and job specific. Other requirements are Safety Discipline Policies and Personal Protection Equipment evaluations.

Human behavior must always be a factor for consideration. Employees who participate in the process are more likely to support and use the safety programs. They should be included in problem-solving as they are the closest to the action. Employees will also have a full understanding of the job.

A Job Hazard Analysis (JHA) identifies the basic job steps and tasks and their associated hazards and risks, and then develops safe operating procedures and hazard controls based on this analysis. In this book, James Roughton and Nathan Crutchfield argue that the JHA should be the centerpiece of any risk control and occupational safety and health program and a methodical analysis is required for the new American safety and health management standard ANSI/AIHA Z10. However, the traditional JHA has potential problems in gathering and analysis of task data and, with its focus on the sequence of steps, can miss the behavioral effects and the systems interactions between tools, equipment, materials, work environment, management and the individual worker.

The authors present a new and improved concept for the JHA incorporating elements from Behavior-Based Safety and Six Sigma. They take the reader through the whole process of developing tools for identifying workplace hazards, developing systems that support hazard recognition, developing an effective JHA, and managing a JHA based program and fitting it into occupational safety and health management systems, allowing businesses to move from mere compliance to a pro-active safety management. The book is supported by numerous examples of JHAs, end of chapter review questions, sample checklists, action plans and forms.



A HANDY LIST OF ACRONYMS COMMONLY USED IN SAFETY LITERATURE

ABSS: Activity-Based Safety System
AHA: Activity Hazard Analysis
AIHA: American Institute of Hygiene Associate
ANOVA: Analysis of Variances
ANSI: American National Standards Institute
BBS: Behavior-Based Safety
BMP: Best Management Practice
C&E: Cause and Effect Matrix
CPI: Continuous Process Improvement
CRM: Continuous Risk Management
DAMIC: Define, Analyze, Measure, Improve, and Control
DPMO: Defects per Million Opportunities
DOE: Design of Experiment in Six Sigma
DOE: Department of Energy, Government
DOT: Department of Transportation
EEO: Equal Opportunity Objectives
EPA: Environment Protection Administration
FAA: Federal Aviation Administration
FMEA: Failure Mode and Effect Analysis
FTA: Fault Tree Analysis
HAZOP: Hazard and Operability Studies
IH: Industrial Hygienist
JHA: Job Hazard Analysis
JSA: Job Safety Analysis
KSA's: Knowledge, Skills, and Attitudes/Abilities
MSDS: Material Safety Data Sheet
OJT: On-the-Job Training
ORM: Operational Risk Management
OSHA: Occupational Safety and Health Administration
OIR: OSHA Incident Rate
OSH: Act Occupational Safety and Health Act
OSPP: OSHA's Strategic Partnership Program
PCA: Process Capability Analysis
NR: Non-routine
POA: Plan of Action
PDCA: Plan-Do-Check-Act
PDC: Professional Development Course
PHA: Process Hazard Analysis
PPE: Personal Protective Equipment
PSM: Process Safety Management
RA: Risk Assessment
R&R: Gauge Repeatability & Reproducibility
ROI: Return on Investment
RR: Residual Risk
SPC: Statistical Process Control
SOP: Standard Operating Procedure
TCIR: Total Case Incident Rates
THA: Task-specific Hazards Analysis
TQM: Total Quality Management
VOE: Voice of the Employee
VPP: Voluntary Protection Programs

Hand Lacerations – Preventing Infection

Among the most common reasons for hand surgery consultation after a work-related accident is a hand laceration. The complex anatomy of the hand makes even a seemingly simple cut a potentially serious injury. While urgent evaluation by an emergency room or urgent care center is recommended, subsequent follow up with a physician experienced with the detailed examination of the injured hand is essential.

Initial management should always include infection prevention. Wounds should be irrigated to eliminate contamination. Antibiotics and tetanus prophylaxis are given when indicated. In the event of excessive bleeding, pressure is applied to the wound either by hand or with a reinforced bandage. Uncontrolled bleeding or gross contamination may be an indication for prompt surgical care. When possible, a thorough examination to assess tendon function, nerve function, and vascular status should be performed. Findings should be documented. Wounds should be covered with non-stick dressings and loosely placed bandages.

If there is concern about injury to structures deep to the skin, prompt (within 2-3 days) evaluation by a hand surgeon is required. Early recognition and treatment of hand injuries is an important predictor of successful outcomes. Delayed treatment in the case of tendon and nerve injuries complicates surgical care and compromises rehabilitation.

Surgical management and rehabilitation of patients with hand injuries requires the expertise of those specially trained in the field. Hand surgeons and certified hand therapists have completed specialized training to ensure accurate diagnosis, skilled surgical and non-surgical management, and optimized patient outcomes.

Athens Orthopedic Clinic

BACK TO BASICS

THE MANAGEMENT OF BACK AND NECK PAIN in the employee can be somewhat challenging. While most patients with back or neck injuries recover in 4–6 weeks, others can develop chronic symptoms, lasting 3 months or longer.

Athens Orthopedic Clinic's Occupational Health Center is committed to the prompt treatment and care of musculoskeletal injuries and to the safe and pain-free return of workers to the work environment. Our dedicated Occupational Health Center team provides employers with an individualized approach to the treatment of injured employees.

Some of the risk factors associated with neck and back pain include:

- Manual lifting/bending/twisting
- Improper mechanics
- Poor body composition/deconditioning
- Past history of back pain or injury

With each patient, prompt evaluation and treatment is necessary to avoid a poor outcome. Most patients can be treated with conservative means, such as anti-inflammatory medications and muscle relaxants, as well as physical therapy. Occasionally, selective injections may be needed. Employee safety, education and ergonomic programs may help to reduce the occurrence of work-related back injuries. If the patient is physically able to do modified work, remaining active and productive while recovering from the injury can be a benefit to both the patient and employer.

While returning the patient back to work as safely as possible is one of our top priorities, it is equally important for our team to educate the patient and employer on reducing the risk of future injury.

At Athens Orthopedic Clinic, we take pride in the conservative spine care programs we offer. Sometimes, however, work-related injuries do not result in neck or back pain. To treat other types of orthopedic injuries, we have many specialty orthopedic and fellowship-trained surgeons on staff. Additional services offered at Athens Orthopedic Clinic include: Spine & Scoliosis specialists, Sports Medicine Center, Hand & Upper Extremity Center, Foot & Ankle Center, Physical, Occupational & Aquatic therapy, EMG/NCV, MRI, CT, IME, PIR and an Ambulatory Surgery Center.

As an added convenience for patients, we offer a dedicated Internal Case Manager who works closely with our Workers' Compensation clients to ensure optimal care and attention. Having our own case manager allows for frequent and effective communication among employers, nurse case managers, adjustors and attorneys, resulting in prompt care and more positive outcomes.

If you would like to discuss the care of your employees, or if you have questions about any of the services we offer, please call Dr. Joseph Savitz, Medical Director of the Occupational Health Center, or Jennifer Herring, Director of Workers' Compensation/Internal Case Manager, at (706) 433-3259.

Joseph Savitz, D.O.

WORKERS' COMP INJURIES?

Athens Orthopedic Clinic's board-certified physicians are trained to diagnose and treat workers' compensation injuries with a caring, personal approach.

We provide care for all types of orthopedic problems and aim to return each patient to work quickly and safely.

FOR WORKERS' COMP, CONTACT:
JENNIFER HERRING, CWCP at (706) 549-1663 x3259

www.AthensOrthopedicClinic.com

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Workers' Compensation Claims Protocol

Accurate initial reports are critical to the claims process!
(Superficial Lacerations/Contusions, Minor Animal/Human Bites, Corneal Abrasions, Dermatitis, Lacerations Requiring Sutures)

1. Learn all of the circumstances

- Date & time of accident
- Exact Location of accident
- Body part(s) injured
- How did injury occur?
- Witness (co-workers, customers)
- Weather conditions (If outdoors)

2. Post-accident drug screen

3. Talk with the individual making the accident report

- His or her source of information
- Photos
- Verbal & written statements

Roberta S. Mike, WCLA, FCLA
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Worker's Compensation Field Adjuster
Strategic Comp Services

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Wes "Dahmer" Sharp
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Steve Hawkins, Tennessee OSHA
Featured Speaker

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Osteoarthritis

Waldo E. Floyd III, M.D.

Osteoarthritis (OA) is the "wear and tear" form of arthritis that we all suffer with age. The saddle joint at the thumb base is the most common site of OA in the hand. The condition is known as basal joint OA or OA of the first carpometacarpal joint. The condition is more common in women than in men but it is present in significant numbers in both genders. Over a third of women over the age of forty years will have x-ray changes of basal joint OA but not all of these individuals will develop symptoms.

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

The diagnosis is made by physical examination of the involved joint and x-rays. The condition is frequently in both thumbs and there may be a familial predisposition.

Treatment is tailored to the patient's symptoms. Patients having little pain despite deformity and severe x-ray changes usually do not require medical intervention.

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

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

Most patients experience significant long term pain relief and increase in pinch strength.

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

Why You Should Include a Pain Physician on Your Posted Panel

Emilie Gastley, MBA, MHA.

Employers are often reluctant to include pain management physicians on their posted panels. Although the idea may seem counterintuitive, including a trusted pain physician or group can help control costs in the long run.

Contentious cases will frequently end up in pain management at some point. It is better to control the case from the beginning, with a carefully selected panel, rather than risk your employee being referred to a disreputable pain doctor down the line. In addition, pain management outcomes will generally be much better when treatment is initiated soon after injury.

A responsible pain doctor will often treat with less (if any) narcotics and avoid the use of long-term opioids whenever possible. Also, a good pain doctor will drug screen and keep the medications under control, particularly if they fear diversion could be an issue.

Having an experienced pain doctor properly diagnose the source of pain early can often eliminate unnecessary surgery which may stem from misdiagnoses. For example, acute inflammatory conditions can often be effectively treated by a pain doctor, eliminating the need for surgery altogether.

Having a trustworthy pain doctor on your panel can be a great strategy in controlling a case. The right doctor will work with you to get the patient functional and back to work as soon as possible.

– Emilie Gastley, MBA, MHA

The Aging Workforce and Combating Degenerative Disc Disease

L. Anita Cone- Sullivan, M.D.

The American population is aging along with the workforce. A number of physiological changes occur with increase age, such as, cardiopulmonary changes, decrease visual and hearing senses, lean muscle mass, strength, balance, and flexibility and degenerative disc disease.

Degenerative disc disease is a natural aging process. Individuals may be asymptomatic despite these changes until inciting events, such as, repetitive awkward lifting, heavy lifting with poor body mechanics, slips and falls.

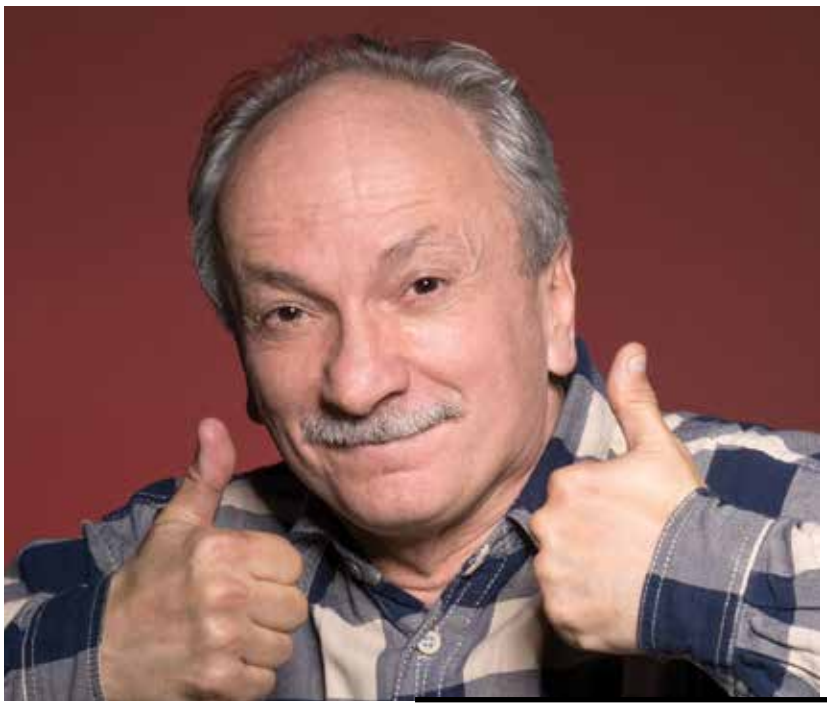
This can often be reduced or prevented with improving body strength and flexibility. Improving lower extremity flexibility, in particular the hamstring flexibility, improves the ability to lift with good body mechanics. Using aides to reduce physical exertion may benefit all workers, particularly the aging workers. This includes mechanical lifting devices, such as, hand trucks and Hoyer lifts.

Flexibility, improved core strength and overall strength and stamina, working close to the body, and using proper body mechanics may prevent back injuries and lengthen the aging worker's work life.

Using good body mechanics when lifting and working closer to the body (working between the thigh and chest range) may prevent or reduce back injuries. Devices such as an adjustable worktable may be beneficial. Working on core strengthening may be instrumental in preventing back injuries in the aging worker. Improving lifestyle and general health is instrumental with improving flexibility, strength, and stamina. Footwear with cushion or orthotics and flooring with some give (changing from concrete floors to wood) may absorb more shock from the spine.

Some companies implemented stretching programs prior to each shift. This is best when performed in a non-rigorous fashion and in the worker's normal work attire. Stretching while standing is preferred over floor exercises while at work. This may improve morale and give workers instant gratification. In addition, stretching improves spine and limb flexibility, which prevents injuries

After a history and physical, spine injuries may be treated with physical therapy to improve flexibility and strength. A home exercise program may assist with recovery and preventing future spine injuries in the aging worker. Modalities (ice or heat) and medications (nonsteroidal anti-inflammatories, etc) decrease inflammation and reduce pain. Imaging studies may reveal degenerative changes in the aging injured worker, as well as, potential more acute changes (fractures, etc). If there is no improvement, spinal injection therapy, such as, epidural steroid injections or facet joint injections may be beneficial. In more resistant and catastrophic cases, spine surgery may be an option.



Injured aging workers are often able to return to work while being treated with job modifications or restrictions. Spine bracing may improve spinal posture and improve lifting techniques. As the injured worker improves, the work status is usually upgraded.

L. Anita Cone-Sullivan, M.D.
Physiatrist
Resurgens Orthopaedics

Back Surgery Offers Long-Term Societal Benefits, According to New Study • Workplace Productivity a Significant Issue for Americans Suffering from Herniated Discs

Dr. Brooks, M.D.

Rosemont, Ill – Annually, more than 10 million people experience back pain in the United States. More than 200,000 of these patients undergo surgery to alleviate pain due to a herniated disc. Surgery to remove the disc has been found to be an effective way to improve these patients' quality of life in cases where conservative treatment is ineffective, but until now, little was known about the societal benefits of surgery and workplace productivity in particular. A new study uncovered that the estimated average annual earnings of working patients who undergo surgery are $47,619, compared to $45,694 for those with non-surgical treatments. Therefore, the annual earnings are increased by $1,925 for those patients receiving surgery. Additionally, patients who undergo surgery miss three fewer days of work each year as compared to patients who elect for nonsurgical treatment.

The new study, published in the April issue of The Journal of Clinical Orthopaedics and Related Research (CORR) suggests surgical treatment for herniated discs increases average annual earnings and reduces the number of work days employees miss due to back pain. The authors of "Cost-effectiveness of Lumbar Discectomy," found these surgeries are cost-effective and may result in savings to society when patients' back pain is alleviated over the long term. The study found that over a four-year period, surgery resulted in cost offsets of more than $5,000 due to higher earnings for patients receiving surgery.

For example, terrible back pain following an injury on the field limited lacrosse coach Scott Hillerfrom coaching, and even made it difficult to perform everyday tasks such as walking around the house and holding his children. After trying non-operative treatments, Scott underwent disc herniation repair surgery and now is able to live a life without pain due to a herniated disc.

"Back pain is one of the most common and the most difficult orthopaedic conditions for patients, since both standing and sitting may exacerbate the pain. As a result, whether you work in physical labor or sitting at a desk, back pain can affect your ability to work," said Michael Schafer, MD, professor of orthopaedic surgery, Northwestern University and an author of the study. "Pain from a herniated disc causes the average employee to miss 26 days of work each year and spend 34 days in bed. Surgery, when appropriate, can lessen the pain, increase productivity and reduce number of missed workdays. This study strengthened the body of research that indicates surgery to repair herniated discs can be effective and cost-effective for patients."

To conduct the study, researchers reviewed literature and used patient reported outcomes from prior studies. The collected data were applied to a Markov Decision Model where they estimated direct and indirect costs associated with surgical and continued non-operative treatment for a herniated disc by comparing costs for household income and missed workdays and disability payments.

The full study is available at **ANationInMotion.org/value/disc.**

The American Academy of Orthopaedic Surgeons (AAOS) commissioned KNG Health Consulting, LLC (KNG Health) and its partner, IHS Global Inc., to prepare this study.

Online location of this article: ***http://newsroom.aaos.org/media-resources/Press-releases***

Nearly 10% of employees use drugs in the workplace...Who are your 10%?

No workplace is immune to employee substance abuse and yet many companies struggle to identify solutions to this growing problem. The nonmedical use of prescription opioids, alone, has cost the workplace more than $42 billion in workplace productivity losses.[1] Overall, drug users cost employers over $180 billion per year; not millions, billions.[2]

What do drug abusing employees mean to my business?[3]

- 10 times more likely to miss work
- 3.6 times more likely to be involved in on-the-job accidents
- 5 times more likely to injure themselves or another in the process
- 5 times more likely to file a workers' compensation claim
- 33% less productive
- Average absentee rate of 30-35 days per year
- 300% higher medical costs and benefits which increase health insurance rates

What can you do to fight this problem?

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How Can a Physical Therapist Help My Chronic Headaches?

After a review of your health history and a thorough examination, if it appears that you do have tension-type headaches, your physical therapist will work with you to design a plan of care to meet your goals. If the evaluation indicates that you may have a different type of headache – such as sinus, migraine, or cluster headache – your physical therapist likely will refer you to another health care professional for additional diagnostic tests and treatment.

Your physical therapist will work with you to correct the problems that are causing your pain and will help you learn to prevent headaches through simple changes in your posture and lifestyle:

Improve neck mobility. Physical therapists use a specialized technique called manual therapy to increase movement and relieve pain and to stretch the muscles of the back of the neck.

Improve your strength. You will learn exercises to increase the strength of the muscles that help stabilize your upper back and neck to improve your posture and endurance and make it easier for you to sit or stand for longer periods of time without discomfort.

Improve your posture. You will learn ways to improve your posture. Whether it is simply pushing your chest out or pulling your shoulder blades backward and together, slight modifications to everyday living can make a vast improvement in posture.

A physical therapist can evaluate how your work style may be the culprit!
They can recommend the proper modifications for your workstation or home office. **Tips may include:**

- Using a headset instead of a regular phone
- Adjusting your computer screen so that it is no lower than the level of your eyes
- Finding an appropriate desk chair
- Adjusting the position of your computer mouse

Some of the Conditions Treated by Physical Therapists:

- Arthritis
- Back Pain
- Balance
- Burns
- Carpal Tunnel Syndrome
- Developmental Delays
- Chronic Obstructive Pulmonary Disease (COPD)
- Dislocations
- Fractures
- Hand Injuries
- Headaches
- Incontinence
- Lymphedema
- Osteoporosis
- Pelvic Pain
- Sports Injuries
- Stroke
- Traumatic Brain Injury (TBI)

APTA
American Physical Therapy Association

Source for this article is American Physical Therapy Association at ***http://www.apta.org***

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Negative-Pressure Wound Therapy

Doris Hopkins RN, MSN

Negative-pressure wound therapy (NPWT) is a therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds. It also enhances healing of first and second degree burns. The therapy involves the controlled application of sub-atmospheric pressure to the local wound environment using a sealed wound dressing connected to a vacuum pump.

NPWT, commonly known as a wound V.A.C. (Vacuum Assisted Closure), promotes wound healing by applying a vacuum through a special sealed dressing. Three types of filler material are used over the wound surface: open-cell foam, gauze, and transparent film or honeycombed textiles with a dimpled wound contact surface. Foam dressings are used to fill open cavity wounds and can be cut to size to fit wounds. The foam dressing is applied, filling the wound and then a film drape is applied over the top to create a seal around the dressing. Open weave cotton gauze can be covered with a transparent film, and a flat drain is sandwiched in gauze and placed onto the wound. The film drape covers the wound and creates a complete seal and then the drain is connected to the pump via the tubing.

Typically, the dressing is changed two to three times per week. The continued vacuum draws out fluid from the wound and increases blood flow to the area. The vacuum may be applied continuously or intermittently depending on the type of wound being treated and the clinical objectives. The levels of pressure used vary between –125 and –75 mmHg depending on the material used and patient tolerance.

NPWT devices can also deliver fluids, such as saline or antibiotics to irrigate the wound, or provide intermittent removal of used fluid to support the cleaning and drainage of the wound bed. The vacuum therapy applies mechanical forces to the wound to create an environment that promotes wound healing. The forces are known as macrostrain and microstain. Macrostain is the visible stretch that occurs when negative pressure contracts the foam. As a result it draws the wound edges together, provides direct and complete wound bed contact, evenly distributes negative pressure, and removes the exudate and infectious materials.

Microstrain is the microdeformation at the cellular level which leads to the cell stretch. This reduces edema, promotes perfusion, and promotes granulation tissue formation by facilitating cell migration and proliferation. In the past patients would have to be in hospitals or rehabilitation facilities for constant wound care. At the least there would be multiple trips in a week to a wound care clinic. With advancing technology patients are now able to receive chronic wound treatment in the comfort of their homes.




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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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CONDITIONS TREATED

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

NON-SURGICAL TREATMENTS

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

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What Is Meant By a Pre-Existing Condition?

First, what do we mean by a pre-existing condition? A pre-existing condition is any condition in the injured part of your body that existed prior to the accident for which you now claim damages. A pre-existing condition may be congenital in origin, caused by another accident or illness, or simply caused by the aging process itself. Our backs and our knees are prime candidates for pre-existing conditions. Let's use the back as an example. Many of us are born with a condition in our spine in which the spinal canal is narrower that the average person's spine. This is an example of a congenitally caused condition. In and of itself, it may pose no health or physical problem, but it may make you more susceptible to injury when you are involved in an accident. In fact, you are likely to be unaware of this condition until, after an accident, you undergo an MRI. The fact that you were unaware of the condition before the accident means that it was asymptomatic – or did not cause pain or disability. But for the accident, you may have never known of the condition and it may never become symptomatic.

You could have also suffered a prior accidental injury to the spine and sustained a bulging or herniated disc. Either of these conditions may have caused temporary disability. You may have even undergone surgery, reached maximum medical improvement, and returned to work. Your return to work could have been with some continuing complaints of pain; however, you were able to continue earning your living in your craft. If you now sustain additional injury to the same part of your back, a jury will be entitled to determine to what extent your pre-existing condition was aggravated. Aging involves getting up every morning and going about your daily activities, and doing this year after year. Aging, as we all know, takes a toll on our physical condition. If you have an MRI after an injury, the radiologist may note what is commonly called "degenerative disc disease." This is a condition which can be caused by nothing more than mere aging. (It may also be caused by trauma.) This too may make you more susceptible to injury. This condition might also have been asymptomatic prior to your most recent accident. If you now herniate a disc that was previously merely "degenerative," you have now aggravated that condition.

You might also be diagnosed with an illness which pre-existed your accident. A horrible example, but one frequently discussed in the cases, is some form of cancer. An illness such as this, which may affect your work-life / life expectancy, is likely to be considered by the Court to determine the railroad's measure of responsibility for future damages. This will be true even if it does not involve the same part of the body. If a pre-accident, or post-accident, health problem has an impact on your ability to work or your life expectancy, the railroad is entitled to introduce evidence of such a problem to reduce its potential damage award. To illustrate, let's assume your normal work-life expectancy is an additional twenty years. Due to the negligence of the railroad, you can no longer work. However, a condition such as cancer, reduces your life expectancy to ten years. The railroad will only have to pay ten years of future lost wages.

The foregoing simply serves to illustrate generally what Hoey & Farina is referring to when we discuss a pre-existing condition. Our laws are premised upon the concept that we are responsible for the harm that we cause and not conditions that we have not caused. The FELA recognizes this basic concept of fairness in providing that the railroad is responsible for those injuries which it negligently causes "in whole or in part." If the railroad negligently aggravates a pre-existing condition and causes either additional injury or disability, you are entitled to recover for this additional damage.

For example, after returning to work from a prior back injury, you sustain an additional work injury, you are now entitled to receive compensation for the additional period of disability and the worsening of any symptomatology that continues on. If you cannot return to work, you are entitled to recover for the additional injury to your work-life capacity. Proof of these damages will require medical testimony, as well as your own testimony, which will be evaluated by the jury. In order to make this claim in a credible fashion, you must advise your personal injury lawyer at Hoey & Farina of your prior health problems so that they may introduce the appropriate evidence. If the aggravation consists of a subjective increase in your complaints of pain, your failure to be forthright about prior conditions will severely compromise your case. Your credibility, coupled with your physicians' testimony, is crucial to establishing an aggravation of a pre-existing condition.

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