SURGERY

Robot-Assisted Minimally Invasive Surgery

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This issue was created to help physicians treating Georgia’s injured workers improve their practices and to encourage new physicians to become involved in the Georgia workers’ compensation system.

We are fortunate in Georgia to have a workers’ compensation system that seeks involvement from all of its stakeholders and is responsive to physician perspectives. Our contributors to this issue reflect the diversity of those stakeholders. Their topics cover a broad spectrum of the items of current concern in the system – clinical, regulatory and economic.

Most medical care today is delivered in the context of a three-way relationship involving patient, provider and payer. Treating injuries covered under the Georgia Workers’ Compensation Law involves a fourth party, the employer. In addition to providing relief and effecting a cure, restoring the injured worker to employment is an important part of the medical decision-making process.

Navigating this system presents unique challenges to a medical practice — as well as rewards. In addition to diagnosing a condition and prescribing treatment or performing surgery, physicians also must form opinions about causation, work ability and permanent impairment resulting from the condition. In return, the Georgia Workers’ Compensation Fee Schedule provides for payments for services that are, on average, higher than those of government or commercial health insurance plans. Also, since rehabilitation is key to recovery from work injuries, those services are likely to be approved and reimbursed at a higher rate.

The treatments Georgia physicians render and the determinations they provide affect in some way almost every citizen of our state. The cost and effectiveness of medical care for work injuries are key factors considered by employers who are looking to relocate or remain here, impacting our local economy. Treatment outcomes are tracked by several organizations, including The Workers’ Compensation Research Institute (WCRI), which furnish these data to state agencies and employers.

A recent WRCI publication comparing cost of medical care and outcomes among 15 states showed that Georgia medical costs per claim were typical of the other study states. The study also found that Georgia workers reported outcomes that were typical to those of other states on some of the key measures, but somewhat lower on other measures. In particular, Georgia workers reported somewhat lower rates of return to work and somewhat lower rates of satisfaction with care.

These results are likely to form the basis for future initiatives as all parties continue to work to make our system in Georgia the best that it can be. As you will read, our Medical Association of Georgia (MAG) also remains committed to helping physicians in Atlanta and Georgia provide the best possible care to Injured workers and to seeing that they continue to receive competitive reimbursement for their services.

References
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A man fell 18 feet off a roof, crushing both ankles and suffering a fractured lumbar vertebrae and a dislocated left shoulder. While tragic, the silver lining for this individual was that his employer had workers’ compensation insurance, and the prompt medical treatment provided to this worker facilitated a nearly full recovery. The roofer returned to a non-roofing job after several surgeries and a period of physical therapy and rehabilitation.

When work injuries happen, the State Board of Worker’s Compensation (“the Board”) wants to get workers feeling better and back to work as soon as they are able. Georgia’s medical professionals play the central, and often pivotal, role in determining workers’ health outcomes and, accordingly, also have a huge impact on the disposition of contested claims.

The Board is considering several pressing policy issues that may have a bearing on your practice, and we appreciate the opportunity to share a few of them with you and enlist your help.

Opioid Overutilization and Response

The Problem and National Response. While recognizing that opioids have a place in medicine, we see far too many instances in Georgia’s workers’ compensation system where prolonged use has ended in tragedy for injured workers and their families. More commonly, it has unnecessarily delayed getting injured workers better and back on the job to the detriment of both the workers and their employers.

We participated in the recent National Prescription Drug Abuse and Heroin Summit, which explored the breadth and depth of the opioid problem. According to CDC data from 2007, unintentional drug overdose deaths in the United States occurred once every 19 minutes. Fueled by the growing use of prescription opioid analgesics, the problem has tripled in the 15 years leading up to 2014, culminating in 28,000 opioid-related overdose deaths in that year.

The Summit unveiled several initiatives aimed to curb the opioid problem, including the CDC’s guideline for prescribing opioids for chronic pain released in March. (See www.cdc.gov/drugoverdose/prescribing/guideline.html) Both the American Academy of Orthopaedic Surgeons and the American Academy of Neurology have also issued position statements on the risks of prescribing opioids.

Among other recommendations, the CDC guideline states that opioids should not be used as first-line or routine therapy for chronic pain. The guideline advises clinicians to consider opioid therapy only if clinically meaningful benefits for both pain and function are expected to outweigh risks to the patient.

Further, the guideline emphasizes the importance of counseling patients on the risks of opioid therapy to help facilitate an informed risk/benefit assessment. When opioid therapy is considered, the guideline specifies opioid selection, duration, followup and discontinuation.

What is the Board doing? Georgia participated in a recent study by the Workers’ Compensation Research Institute (WCRI) examining longer-term opioid use over a two-year time period ending March 2012. According to that study, Georgia showed a slight decrease in longer-term use of opioids (0.2 percentage point change over the study period). That decrease, however, was not statistically significant, and we remain concerned about the level of opioid use in Georgia, especially in non-surgical and longer-term situations.

On the judicial side, the Board is mindful of cases...
in which opioids appear to be used inappropriately, particularly for long-term use. The Board has the authority to order a change in treatment or change in physician when situations warrant.

While the Board prefers those decisions be made between the parties, often these issues are litigated. When these matters come before us, one of many factors we consider is the impact and propriety of the drug regimen in place under the current treating physician. While the Board lacks treatment guidelines, we do consider prescribing practices (and their effectiveness toward better worker health outcomes) when exercising Board discretion over medical authorization and change in physician decisions.

On the policy side, we are working with stakeholders (including several doctors) on the Chairman’s medical advisory committee to vet potential solutions to target inappropriate and overuse of opioids. Options discussed have ranged from physician education to a drug formulary. We rely upon the advisory committee to help us assess the advantages and disadvantages of various approaches and welcome your input into that process.

Aging Workforce Issues

The Challenges. Like the rest of the country, Georgia’s workers’ compensation system is challenged by aspects of an aging workforce. According to the U.S. Bureau of Labor Statistics, between 1977 and 2007, there was a 101 percent increase in employment of workers 65 and over — a trend that is expected to continue. This trend is associated with an increase in medical and indemnity costs due to the increased risk for injury and larger incidence of comorbidities that can deter recovery.

In addition, an aged worker who is injured often presents practical challenges in claim management. For instance, given the greater incidence of comorbidities in the aging population, it is more difficult to distinguish where the work injury starts and ends as compared to the underlying comorbid condition.

Unlike other states, there is no apportionment of liability. The condition is either compensable or it is not. Georgia’s definition of a workers’ compensation injury includes the aggravation of a preexisting condition by accident arising out of and in the course of employment, but only for so long as the aggravation of the preexisting condition continues to be the cause of the disability; the preexisting condition shall no longer meet this criteria when the aggravation ceases to be the cause of the disability. O.C.G.A. Sec. 34-9-1(4).

Accordingly, this issue is hotly debated and turns on the opinion of the medical professionals involved. If you are attuned at the outset to the significance of the work-related contribution, you can provide more precise medical causation opinions. In turn, having more precise opinions can help facilitate quicker authorization and payment of diagnostics and treatment as well as better assist us in compensability assessments.

What’s New in Physician Panel Requirements?

The Board recently updated its rules in response to marketplace realities that were making it difficult for employers to field a panel of physicians. For background, there are specific rules concerning what constitutes a valid physician panel in Georgia and the consequences for failing to maintain a valid panel. (See O.C.G.A. §34-9-201 and Board Rule 201 for specifics).

Historically, one of those requirements was that no two physicians on the panel be associated with one another. This requirement posed problems both in rural areas where there are fewer physicians and statewide with the growth of medical practice consolidation.

Effective July 1, 2015, there is no longer a requirement that physician panels consist only of non-associated physicians. As a result, you and your associates are eligible to appear on the same employer physician panel.

Coming Soon: Physician Registry

The Board is working on creating a physician registry linked to the Board’s website that will allow any physician interested in workers’ compensation to register by name and specialty and provide contact information.
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Opioid drugs are miraculous products of medical science. They are the cornerstone of anesthesia and post-operative pain control. They alleviate the agony of acute medical conditions such as appendicitis, kidney stones and sickle cell crisis. They relieve pain of severe traumatic injuries. They give comfort and peace to patients with terminal illnesses. But they have also become a major cause of preventable illness and death in America today.

Over-prescription of opioids by physicians is a key factor in today’s opioid crisis. While there are certainly a few practitioners with unethical intentions, most physicians prescribe opioids because they believe the drugs have a therapeutic benefit that outweighs their risk. In fact, the decision to prescribe opioids appears to be more related to physician and patient beliefs, social factors and local control systems than it is to the type or severity of the injury or illness.

First, do no harm…

That was the promise we made when we graduated from medical school. Now consider the following:

- Between 1999 and 2010, sales of prescription opioids increased four-fold
- The number prescription opioid related deaths has increased 200 percent since 2000
- In 2014, almost 19,000 people died from prescription drug overdose

Seventy percent of Georgia workers with pain from non-surgical injuries receive a prescription for an opioid – with the average amount equivalent to 1200 mg of morphine per claim. Here’s what every physician should consider before writing an opioid prescription.
The risk of death increases with the amount prescribed

Opioid overdose risk increases in a dose-dependent manner. Dosages of 50-<100 milligrams morphine equivalent (MME)/day are associated with risk of opioid overdose 1.9 to 4.6 times greater than dosages of 1-<20 MME/day. Dosages ≥100 MME/day are associated with a 2.0-8.9 times greater risk. In a national sample of Veterans Health Administration patients with chronic pain who were prescribed opioids, mean prescribed opioid dosage among patients who died from opioid overdose was 98 MME (median 60 MME) compared with mean prescribed opioid dosage of 48 MME (median 25 MME) among patients not experiencing fatal overdose. See Table 1 for approximate morphine equivalent dosage for common opioids.

Medical evidence for opioid effectiveness in treating chronic pain is non-existent

All medical evidence supporting the use of opioids for treating chronic pain is anecdotal or based on the results of short-term clinical trials. No randomized trials or observational studies have ever been performed to evaluate the long term (>1 year) effectiveness of opioid versus non-opioid therapy with respect to pain, function and quality of life.

Opioids may worsen outcomes in patients with work-related back injuries

A study of injured workers in California with back injuries showed that after controlling for severity of injury, the average duration of disability, medical cost and indemnity payments per claim were directly proportional to the number of prescriptions a patient received. Claims with greater than seven opioid prescriptions had a 370 percent greater duration of disability and a 70 percent greater total cost per claim than those where opioids were not prescribed.

Early prescription of opioids does not help injured workers feel better faster

In fact the opposite is true! A retrospective analysis of 8,443 workers’ compensation claims involving acute back injury in 2008 showed that when controlling for severity of back injury, gender, age and time on the job, outcomes worsened in direct proportion to the amount of opioids prescribed within the first 14 days after injury. Patients who received greater than 450 mg morphine equivalent amount in the first two weeks (the equivalent of hydrocodone 7.5 mg QID) had the following average outcomes in comparison to patients who received no opioids:

- 69 more days of disability
- $15,500 greater medical cost per claim
- Three times greater likelihood of having back surgery
- Six times more likely to receive opioids long term

Continued exposure to opioids causes profound changes to the central nervous system

Within days after initiating opioid treatment, receptors in nociceptive pathways, neurons and glial cells within the spinal cord begin to undergo changes that increase sensitivity to pain; a phenomenon known as

Evidence suggests that avoidance of early prescription of opioids actually improves outcomes as well as reducing the risk of long-term opioid use.
opioid-induced hyperalgesia. This condition increases with the amount and duration of opioid exposure. It may persist for three months or longer following cessation of opioids.9

To conclude, the rate of opioid prescribing in the Georgia’s workers’ compensation system is the same as it is in the United States as a whole. As physicians, it is imperative to be cautious with the use of these medications in both the acute and chronic phase of care when treating the injured worker. Evidence provided by the CDC reports a significant increase in adverse events once the morphine equivalent dose exceeds 100 mg/day.

Where appropriate, earlier steps should be taken by clinicians to provide a greater focus on non-opioid treatment algorithms (physical therapy, NSAIDs) in order to avoid prescribing opioid doses that may represent a danger to patients.

Evidence suggests that avoidance of early prescription of opioids actually improves outcomes as well as reducing the risk of long-term opioid use. We as treating physicians can help mitigate the opioid epidemic by being conservative in the early use of opioids as well as following the CDC Guidelines10 when treating injured workers.
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The marijuana plant contains more than 80 different compounds, collectively referred to as cannabinoids. Among these, the main psychoactive compound is tetrahydrocannabinol (THC). It exerts its euphoric effect through activation of the CB1 receptor found within the central nervous system. Another cannabinoid, Cannabidiol (CBD), binds weakly to the CB1 receptor and does not produce euphoria or intoxication.1

The movement toward legalization of medical marijuana dates back to 1996. Between 1996 and 1999, eight states gave approval for the use of marijuana for medicinal proposes. Now 23 states and the District of Columbia have passed some version of medical marijuana legislation. Colorado and Washington were the first to move all the way to legalization, followed by Oregon and Alaska.

The legalization movement in Georgia has taken a piecemeal approach. The decriminalization on “Low THC oil” for medical use was first proposed to the Georgia legislature in 2014. The bill did not pass the Senate but did pass the House. The following year, Haleigh’s Hope Act (HB 1) passed and was signed by Governor Nathan Deal in 2015.

The law allows a patient with cancer, ALS, seizures (uncontrolled), multiple sclerosis, Crohn’s disease, mitochondrial disease, Parkinson’s disease and sickle cell disease (SCD) to register with the Department of Public Health for a waiver. That allows the patient (or caregiver) to possess up to 20 fluid ounces of “low THC oil” without prosecution. “Low THC oil” is classified as containing a THC concentration of up to 5 percent.

In 2016, additional legislation was proposed in the Georgia House. Muscle spasms, Epidermolysis bullosa, terminal illness, PTSD, intractable pain, autism spectrum disorder, Alzheimer’s disease and “any other medical condition or its treatment approved by the commissioner” were to be added to the list of conditions approved to receive medical marijuana. The legislation did not pass the Senate.

The workers’ compensation system in Georgia has yet to be involved with the issue. The diagnoses that are covered simply are very uncommon in worker’s compensation. However, if other states are an indication, the Board will be involved soon.

In Colorado, there is an Employers Clause within Amendment 64 (which legalizes marijuana) that reads: “Nothing in this section is intended to require an employer to permit or accommodate the use, consumption, possession, transfer, display, transportation, sale or growing of marijuana in the workplace or to affect the ability of employers to have policies restricting the use of THC oil” for medical use was first proposed to the Georgia legislature in 2014. The bill did not pass the Senate but did pass the House. The following year, Haleigh’s Hope Act (HB 1) passed and was signed by Governor Nathan Deal in 2015.

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There has been very little quality research into the treatment of PTSD, chronic pain, autism, or Attention Deficit Disorder and even less research that tries to separate out the effects of the THC verses the CBD.
marijuana by employees.” This language was copied almost word for word into the Georgia law.

The most likely diagnoses to be applied to treatment of injured workers in Georgia are spasms, pain and seizures. The problem with all of these diagnoses is that there is very little quality research into the usefulness of marijuana. The Drug Enforcement Administration (DEA) lists marijuana as a Schedule I drug, which is defined as a drug with no currently accepted medical use and a high potential for abuse. This designation makes research into the potential risks and benefits of medical marijuana difficult.

The courts so far have sent a somewhat mixed message with respect to this issue. In Coats v. Dish Network, the Colorado courts ruled that the employer had the right to fire an employee for marijuana use even though he was registered to use medical marijuana. In a similar case, Garcia v. Tractor Supply, the court ruled that an employee could be fired for legally using marijuana for a medical condition.

However, the New Mexico Workers Compensation Administration has ruled multiple times that the insurer must pay for medical marijuana and include it in the pharmacy fee schedule. A state law to clearly prevent an employer from paying for marijuana did not pass last year in the New Mexico legislature. Evidently this issue remains a moving target.

What do we know about the cost of marijuana to employers? Undeniably, it will present a financial burden: compliance, safety, productivity, flexibility and litigation will all be costly.

What do we know about the health benefits of medical marijuana? High-quality research is sparse. It has clearly been shown that CBD, which does not have hallucinogenic properties, decreases the number of seizures in patients with uncontrolled seizures. Pure Cannabidiol (Epidiolex) is available in Europe. Sativex (CBD and THC in equal concentrations) is approved in much of Europe for the treatment of muscle spasms associated with multiple sclerosis.

There has been very little quality research into the treatment of PTSD, chronic pain, autism or Attention Deficit Disorder and even less research that tries to separate out the effects of THC versus CBD.

Locally, look for issues on two fronts. The Georgia state legislature will take up revisions and or additions to the Haleigh’s Hope Act again this year. It’s expected to add autism and PTSD and possibly Alzheimer’s disease to the list. It may try and increase the legal THC concentration from 5 percent despite the fact that 5 percent is already one of the highest limits in the country.

Also, expect the first medical marijuana case to go before the State Board of Workers’ Compensation soon. No matter what the outcome, expect for it then to be appealed to a higher court.

Successfully diagnosing, treating and returning workers’ compensation (WC) patients can be a rewarding part of a physician’s practice. However, not all of us are meant to take care of these types of cases.

There must be a commitment on the part of the provider to give extra time, fill out paperwork and handle specific issues. One must be comfortable in treating not only clear-cut cases but also those patients with vague symptoms without a specific injury.

We are usually accustomed to dealing with only patients and their families. With workers’ comp cases, correspondence from adjusters, case managers and even attorneys must often be handled. Sometimes communication is required to resolve conflicts in opinions.

As professionals, we must not only treat but also educate employers, insurers and case managers as well as help prevent injury in the workplace.

For patients with a workers’ compensation-related medical issue, having to take time off due to injury is quite distressing. The fear of losing one’s job due to an inability to keep up with what the position demands can cause anxiety. It may also put the patient at risk of further harm in their attempts to continue working while injured.

As an orthopaedist and sports medicine physician, I approach the injured worker as an athlete. I want to return the patient back into the game as soon as possible. Getting a patient back to gainful employment can be equally rewarding as getting an athlete back to their sport.

How is the Injured Worker Different?
As the Authorized Treating Physician (ATP) in Georgia, we must diagnose and present a treatment plan for the injured worker that determines:

- Causation: Is the injury due to direct trauma or overuse from job duties?
- Work status: Is it safe for the patient to return to full or restricted duty and how soon? Treatment Course: What is the anticipated time frame to Maximal Medical Improvement (MMI)?
- Legal issues: What is the anticipated permanent impairment and functional limitations once the patient is deemed to be at MMI?

Maximizing Good Outcomes
As we establish the doctor-patient relationship, it is paramount to be impartial and ensure that you have the best interest of your patient. After all, you are the patient’s best advocate. It is important to emphasize active patient participation and set expectations from the beginning. Once a treatment plan is devised, it is important to educate the patient, case manager, adjuster, attorney and your Workers Compensation Coordinator.

Closer follow-up is a good idea to ensure patient compliance and insurance approval. This also allows changes to job restrictions as the patient’s symptoms improve or regress. If the patient is not improving, reconsider treatment options and/or diagnosis. Keep in mind that the importance
As professionals, we must not only treat but also educate employers, insurers and case managers as well as help prevent injury in the workplace.

should be placed on injury healing for functional restoration over subjective pain relief. This is critical when determining surgical intervention.

Prior to deciding on a procedure, ask why and how you have come to the conclusion to intervene. It is very important that the mechanism of injury, history, symptoms and exam positively correlate.

➡ Return to Work

When determining when an injured worker may return to their job, the provider should emphasize return to work, even with restrictions, within 2-3 weeks from injury or surgery. This will keep the patient in his/her routine. Patients can return to work even if in chronic pain as long as they are functional and the job duties do not increase risk of further injury. It has been shown that patients out of work more than 6 months are unlikely to return.

Understand the demands of the workplace or job of the patient. Show interest, evaluate the job description and familiarize yourself with in-house occupational health staff. The patient will appreciate that you understand their perspective and understand that you aren’t with the employer “just to get them back to work.”

Illness behavior resulting in secondary gain can lead to prolonged perceived disability by patient. To deter avoidance behavior, encourage normal behavior and function. Involve case management or consider secondary gain if patient does not progress as expected in a 6-12 week timeframe.

Be aware of the many factors that may cause the patient to fail to return to pre-injury work status:
• Some legitimate patients cannot return to work safely due to the nature of injury or high demands of job
• Employers are not willing to accommodate restrictions
• Malingering/secondary gain
• Psychological issues
• Worker dissatisfaction with employer
• Symptom magnification

➡ Causation

Recognize that many injuries, particularly those that arise from “overuse” happen insidiously and only are recognized or manifested at work. These are not necessarily related to work.

The concept of contralateral injury due to ‘overcompensation’ is a red flag and should be approached with caution.

➡ Fairness

Give the patient benefit of the doubt. There is a tendency to find fault with the treating physician in the private pay sector and a tendency to find fault with the patient in the workers’ compensation arena. There are times that the physician may have had the wrong diagnosis, resulting in the patient having protracted symptoms. Leave judgement at the door, and keep an open mind when evaluating second opinions or IME.

Evaluate each patient thoroughly, objectively and honestly. Be impartial.

➡ Keep Good Records, and Communicate!

Documentation is more important here than anywhere else. Workers’ compensation cases are highly litigated, and you may be asked to give testimony based on your medical records.

In general, keep clean, concise documentation in your practice. Electronic medical records (EMR) can be cumbersome, but these are very helpful in keeping track of phone calls, visit status reports(VSR), and work status forms and other correspondence.

Be proactive in communication with the case managers and adjusters. Avoid situations where someone must read your mind because they have to rely solely on your clinic notes. Identify problem cases, and bring them to their attention. With early communication, case managers may help expedite the treatment process. Provide timely notes to the adjuster with work restrictions.

Getting the patient to MMI is helpful, as their functional status may improve after settling a case. Get out Permanent Partial Disability (PPD) ratings as soon as possible to facilitate this.

➡ Pearls/Pitfalls

Market yourself to get yourself on panels. Panels can change quickly and often, so stay in touch with the insurance carriers and employers.

Use other peers on the panel for second opinions to help reinforce the treatment plan.

Never belittle or criticize other medical providers. This will only adversely affect your credibility.

Although Georgia law allows the authorized treating physician (ATP) to dictate treatment, it is good practice to seek pre-approval through the WC insurance provider. Also try to use the insurance-preferred providers. Of course always have the best interest of the patient, and deviate if necessary. Early and clear communication is important so you can present your case and the carrier can see why you have made specific recommendations.

Pain management may be helpful, but put a limit on the course of treatment to discourage chronic treatment.

As your WC practice grows, your time will become increasingly limited. Therefore, I recommend employing a Workers’ Compensation Coordinator to help streamline the treatment and communication process with all involved parties.

Many physicians shy away from a workers’ compensation-focused practice because the process is misunderstood or appears too time consuming. Realize that the vast majority of injured workers are eager to return to work and carry good outcomes.

With a little more understanding of the process and the willingness to put in the appropriate time, hopefully more highly qualified physicians will take on the task of helping our injured workers.
MAG Supports the Care of Georgia’s Injured Workers

Physicians are needed for under-served specialties – can you help?

By Donald J. Palmisano Jr.

Led by Chair Judge Frank McKay, Directors Judge Elizabeth Gobeil and Judge Harrill Dawkins and Executive Director/Chief Operating Officer Delece A. Brooks, the Georgia State Board of Workers’ Compensation (SBWC) deserves a round of applause for the success that it has achieved in recent years.

In managing the state’s complicated worker’s compensation system, SBWC addresses a number of important issues that affect physicians, including legislation, regulations and payment.

Importantly, SBWC solicits the input of advisory councils that consist of affected stakeholders before it establishes new policy or renders key decisions. The Medical Association of Georgia (MAG) consequently has a representative on SBWC’s Medical Advisory Committee (MAC), which includes physicians, hospitals, health insurers, employers, administrators, attorneys, pharmacists and others.

This diverse group serves as a forum for these stakeholders to discuss ways to improve Georgia’s workers’ compensation system. Every stakeholder has a seat at the table, every member has a vested interest in its success, and every member has a chance to provide input – which results in a fairer, more equitable system that includes safeguards that reduce unintentional consequences.

Physicians are the key cog in the Georgia’s workers’ compensation system. So it is no surprise that SBWC makes a genuine effort to ensure that physicians remain satisfied with the system.

SBWC does not typically move forward with a rules change or propose legislation unless there is a consensus within the affected advisory council.

**Keys to Physician Involvement in the System**

Knowing that a delay in a patient’s care results in higher costs for employers, SBWC’s goal is to create a system that enables its beneficiaries to receive the medical care they need so they can return to work as soon as possible.

With input from MAG and other advocacy organizations, SBWC understands that there are several key criteria that physicians will consider before they elect to care for a workers’ compensation patient. The first is pay, which must be sustainable (i.e., cover the full and net cost of providing the care). The second is the administrative burden, which must be reasonable when compared to commercial payers and government programs.

Because of the opportunity to expand their patient base and the fact that the current Georgia workers’ compensation fee schedule reimburses many physician services at a premium over commercial, Medicare and Medicaid rates, some physician practices have embraced treating injured workers as a significant part of their business. Unfortuately, there remains a shortage of physicians in the workers’ compensation system in several key specialties, including pulmonology, rheumatology and neurology.

**Bridging the Gap**

MAG has conducted surveys to better understand this dynamic. We confirmed that there is in fact a perception among physicians within these specialties that workers’ compensation patients mean lower pay and a greater administrative burden (e.g., paperwork, phone calls and “lots of attorneys”).

We also discovered that the physicians who see workers’ compensation patients in these specialties are more prone to
be unwittingly subjected to health insurer “rental networks,” which often unexpectedly reduce their fee schedule by as much as 30 percent. It’s not that hard to imagine why a physician or practice manager who is trying to run a sustainable business might think twice about seeing workers’ compensation patients.

And we determined that physicians in these specialties often struggle with objectivity when it comes to evaluating workers’ compensation patients. If a patient breaks a bone on a job site, there’s a good chance the injury is going to be covered by a workers’ compensation claim. But the physicians in these specialties often don’t have that kind of black and white clarity. They are often required to evaluate subjective complaints or differentiate between work-related problems and pre-existing conditions, which can put them in the middle of an employee/employer conflict.

Finally, the physicians in these specialties told us that they are not always free to conduct their own independent evaluations for workers’ compensation patients (e.g., imaging studies and EMG/NCS). Instead, they say that they are sometimes forced to send their patients to certain facilities and regularly have problems retrieving the test results.

In an effort to address the shortage of physicians in the aforementioned specialties in the workers’ compensation system in Georgia, MAG has discussed several key solutions to SWBC. This includes:

- Reducing the administrative burden these specialties are subjected to and ensuring these specialties only have to be concerned about what is best for the healthcare of that patient.

- Limiting or prohibiting a silent PPO/rental networks or comparable entities’ ability to apply commercial health insurance discounts to workers’ compensation patient claims.

**Become Involved**

Workers’ compensation insurance is an important part of Georgia’s healthcare system. MAG will continue to take steps to ensure that it is economically viable and sustainable for medical practices to care for patients who are covered by workers’ compensation insurance so they receive the care they need and return to work as soon as possible.

Physicians and practice entities that are interested in participating in the treatment of injured workers or who have suggestions for improving Georgia’s workers’ compensation system are encouraged to contact MAG at workerscomp@mag.org.
For the past three decades, I have been privileged to represent individuals who were injured at work. My clients come from all walks of life. They are flight attendants, electricians, nurses, production workers, plumbers, construction workers, teachers, over-the-road drivers and mechanics. They are diverse in age, as well as racially diverse.

However, they all share a common bond; none of them anticipated that they would suffer a work-related injury. Few were prepared to experience the significant financial and family stress that inevitably results from being out of work for an extended period of time. All of my clients are looking for and are entitled to receive prompt, quality medical treatment for their injuries.

Most injured workers are sent to an industrial clinic shortly after their accident takes place. Typically, they are seen by a different physician or physician’s assistant at every visit. Physical therapy is ordered, and medication is dispensed. Everyone is treated in the same cookie-cutter manner. There is little continuity of care. Minimal time is spent with the patient. Frustration levels are high. All too often, weeks, or even months, of conservative treatment fail. It is only then that diagnostic testing such as an MRI or CT scan is ordered.

Many times the testing takes place only at the insistence of the frustrated injured worker. When the diagnostic test results confirm that the injured worker's subjective complaints are supported by objective findings, a referral is finally made to a specialist. The injured worker then has to wait for the insurer to approve the specialist and to schedule the initial appointment. This can take an extraordinarily long amount of time and can negatively impact the outcome of their treatment.

When my clients see a specialist, they are looking for someone who will listen carefully to their complaints, understand the mechanism of their injury, examine them thoroughly and discuss the merits of various treatment options. Frequently, my clients tell me that their doctor briefly talks to them and then performs either a cursory physical examination or no physical examination at all.

When diagnostic test results are being reviewed, injured workers greatly appreciate it when the treating physician takes the time to show them the films, explain in layman’s terms the precise nature of their injury and answers all of their questions. If surgery is recommended, the treating doctor should offer the patient a clear understanding of what their surgery will entail and discuss the anticipated recovery period as well as what outcome they can expect.

Injured workers need to be educated about whether there is a reasonable likelihood that they will be able to return to their pre-injury job when they reach maximum medical improvement (MMI) or if the anticipated permanent restrictions will mean that they will need to look for another line of work.

Another concern my clients share with me is that their treating physicians do not tell them what their work status will be before they leave the office. I have also heard of instances where the doctor excuses

Most injured workers are sent to an industrial clinic shortly after their accident takes place.
Employers and insurers both need and want strong physicians and practices to partner with in fulfilling the need for treatment of their injured workers. The expectations of exemplary medical treatment, good communication and quick appointment availability are no less than we all require for ourselves and our families. Employers and insurers should demand no less for their injured workers.

To successfully manage work-related illness and injury, it’s important for the physician to have a general understanding of some key medical aspects of the Georgia Workers’ Compensation system and to stay informed on any changes in the system’s rules that may affect the treatment. As an insurance claims specialist, I like to take an active role in the treatment and recovery of my client’s employees. Here are a few things that I have identified based on my experience that may be helpful to you and your patients.

The Physician Panel

The Physician Panel is a requirement that is unique to Georgia. It is required by Georgia law O.C.G.A. 34-9-201 for employers to have a panel, or a list of physicians posted in prominent places upon their business premises.

Following an injury, the worker’s choice of a treating physician is limited to the physicians on the panel. That physician then becomes the authorized treating physician (ATP) unless replaced by either the patient (one time only), mutual agreement of both parties or by direction of the State Board. The panel has very specific legal criteria that must be met by the employers and insurers for it to be considered a valid panel. The panel allows employers and insurers to have control over the quality of care their workers receive, so they are usually very selective regarding the physicians or practices to include on the list.

If a physician has agreed to be named on the posted panel, he or she has agreed to accept patients from that employer. A very important part of the agreement is being able to schedule an appointment and obtain a physician examination quickly after an accident occurs. Employers and insurers hold in very high regard how quickly their injured workers can be seen when they are determining if a specific physician or practice will be listed on their panel.

Providing an Impairment Rating

Another issue unique to workers’ compensation that is required of the ATP is an assignment of an impairment rating, if applicable. Once an injured worker has come to the end of their treatment and is placed at maximum medical improvement (MMI) by the treating physician, the employer or insurer should then ask the treating physician if there is any impairment rating.

It is important for physicians to understand that this requirement is a legal one, and employers and insurers do not have any choice in the matter when it comes to requesting an impairment rating. Currently in Georgia, permanent partial impairment ratings (PPI) are based on The Guides to the Evaluation of Permanent Impairment, 5th edition, published by the American Medical Association. If the physician states that the injured worker will have some measure of permanent partial impairment, they must provide this with their reasoning based on the applicable section of the AMA Guides, 5th edition in writing to the employer/insurer. This will equate to monetary value for the injured worker. However, if the physician feels the injured worker sustained no disability, it is within their right to opine to a 0 percent rating as well.

Communication is Key

At some point, we’ve all heard the reference to the three rules of real estate, “location, location, location!” In workers’ compensation, the first three rules are also all the same: communication, communication, communication!

This means communication between the employer/insurer and the injured worker, communication between the injured worker and the physician, and communication between the physician and the employer/insurer. Yes, you read that correctly! It is absolutely correct, permissible and legal in Georgia for the physician to maintain direct contact with the employer and/or insurer.

Continued on page 23
himself during the appointment, leaves the examining room, then calls the adjuster or employer. When the doctor returns, he or she then tells the patient that “workers’ comp” will not allow the patient to be kept out of work. This is not an accurate statement of workers’ compensation law. The authorized treating physician has complete autonomy to decide whether a patient can or cannot return to work.

Treating physicians in workers’ compensation cases need to keep in mind that just like in any other setting, their ethical obligation is to deliver the best medical care to the patient without regard to who is paying the bill. Doctors need to push insurers for authorization of physical therapy, additional testing, specialist referrals and surgery approval. Delays should not be tolerated any more in the workers’ compensation system than they would be if the patient were treating under his or her personal health insurance.

Unfortunately, there is an inherent conflict of interest in the workers’ compensation arena because some panel physicians fear that if they exercise independent judgment and disregard pressure from the employer to quickly release the patient to return to full-duty work, they will be removed from the employer’s panel.

Injured workers change physicians for a myriad of reasons. Some of my clients request a change in physician because they feel like their doctor is not listening to their complaints. Others sense that their doctor appears to be more interested in satisfying the employer and insurer than in treating the patient.

Many times conservative treatment has failed, and injured workers are not being offered other treatment options. Sometimes surgery has yielded less-than-optimal results, and a second opinion is necessary to determine whether additional surgery is warranted. Clients with chronic pain will seek a change in physician when their treating orthopedic or neurosurgeon will not prescribe adequate pain medication yet refuses to make a referral to a pain management specialist.

The best physician-patient relationships in workers’ compensation cases are built upon trust and good communication between the parties. Injured workers need to believe that their doctors are concerned about their welfare and will advocate for them. The goal in every workers’ compensation case is for the patient to improve from a physical standpoint so that he or she will be able to return to work. Successful physician-patient relationships are the foundation for achieving this desired result.
In fact, it is very difficult for physicians who are treating injured workers to not have contact with the employer/insurer, as there sometimes is information that can only be provided by the employer/insurer. Proper billing information, written job descriptions, availability of light duty work and authorizations if required by the physician’s office are just a few examples. Communications can also include discussions with the physician regarding causality; the relatedness of the recommended treatment to the specific work injury; as well as confirmation the physician has all prior medical records and diagnostic testing. Both state and federal laws provide an exception to HIPPA for workers’ compensation claims.

O.C.G.A. 34-9-207: (a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician...

(42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1): “The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers’ compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault”

Clear communication is critical, and is a “must have” for employers and insurers when they are selecting the physicians to participate on their panels. While helpful office staff and nurses are greatly appreciated, direct communication with the physician is something that most employers and insurers prize above all else.

**Pre-Authorization of Treatment**

Many physicians and their staff who provide treatment for workers’ compensation patients have likely experienced a delay in receiving responses to requests made for further treatment or diagnostic testing. Contrary to popular belief, pre-authorization for medical treatment rendered by an authorized treating physician is not required under the Workers’ Compensation Act.

Many physicians’ offices may prefer to obtain authorization before setting up further treatment or testing, however it is in no way required. Employers and insurers are required by law to provide reimbursement for any and all related medical services provided to an injured worker by an authorized treating physician. There are also penalties that are applicable if reimbursement is not made timely, which is within 30 days of the receipt of the bill and all required accompanying medical documentation, by the employer and insurer.

For physicians willing to dip a toe into the sometimes murky, but always deep waters of workers’ compensation, it can be a very mutually rewarding relationship for them as well as for the employers and insurers. Common ground between the two is more easily achieved than present perception might lead us to believe. Everyone, from the injured patient to the employer, benefits from good medical care.
A new clinic, the first of its kind in the state of Georgia, now offers advanced and complex care to patients with chronic diseases. Opened as of August 1, WellStar Comprehensive Care at Kennestone serves people who have heart failure or advanced heart failure with a need for a ventricular assist device, COPD, pulmonary hypertension and interstitial lung disease. Additionally, the program houses an anticoagulation clinic.

According to Director Cindy Holcomb, the Comprehensive Care program was modeled, in some ways, on WellStar’s highly successful STAT Clinic, which brings comprehensive, patient-centered care to people with lung cancer.

“When WellStar developed a home health oversight program for people with chronic heart failure, it wasn’t long before we realized we needed a physical location where we could see patients. So we started the Heart Failure Clinic,” she says. “Inspired by the STAT Clinic, we began to see what kind of resources it would take to keep patients with both heart and pulmonary conditions from being admitted and readmitted to the hospital. The goal was to create a more efficient way for them to receive all of the necessary tests and see all the appropriate physicians.”

Developed on this unique model of care delivery, the Comprehensive Care clinic has gathered together, all in one site, a team of physicians, advanced practice providers, nurse navigators, social workers, case managers, nutritionists, clinical pharmacists, behavioral health and palliative medicine practitioners. Additional services include point-of-care lab testing, administration of IV medications for heart failure, nebulizers, retinal exams and more. Plus, patients can be monitored to ensure that they are up to date on vaccines and screenings like mammograms.

Setting up this type of specialty, multidisciplinary clinic requires a great deal of forethought and planning, including ensuring that all facilities are set up correctly and in regulatory compliance.

“As an outpatient department of Kennestone Hospital, we’re aligned in a regulatory manner with the hospital,” Holcomb says. “Our employees report directly to the appropriate departments, which closes the compliance loop for them. Since we’re located slightly off campus, we had to ensure that we’re set up with the appropriate security. Those are examples of the wealth of thought that has gone into establishing the program.”
Benefits for patients, families and physician community

Chirag Patel, M.D., physician sponsor of the Comprehensive Care program, says the clinic is intended to be a resource serving more entities than just the patient.

“A clinic like this is helpful to patients in that they can have all of their medical needs addressed in one place, and their families receive necessary support, too,” he says. “But it’s of great benefit to physicians who have complex patients with complicated medical, social and financial needs, who, therefore, require more sophisticated monitoring and outreach. Physicians can refer these patients to us, where their care will be coordinated among multiple specialists and for the additional services they need.”

Holcomb adds that the program was designed specifically around the fact that complex patients are also very time-intensive patients.

“We’ve created a care model that allows our team to take the necessary time with these patients. An average appointment lasts an hour or longer,” she says. “We ask each patient specific questions that will help determine their individual care plan, such as whether or not they have access to transportation and the ability to pick up their prescriptions. It’s difficult for a traditional physician to find out and manage all of this information when they usually spend only 15-20 minutes with a patient on average.”

Additionally, the Comprehensive Care program will be gathering patient clinical data that can be used in clinical trials and to improve quality of treatment and outcomes. Patel says that the data will have many applications for patient care and educational purposes.

“As our patient volume increases, we’ll have meaningful data that we can use to improve the quality of our processes and thereby improve patient outcomes,” Patel says. “We can also use the data to help us in figuring out ways to reduce hospital readmissions and emergency department utilizations for these patients. Additionally, it could be helpful to us in increasing the patient’s knowledge of their disease and in developing advanced care, palliative care and end-of-life plans.”

Patel cites education of patients and family members as another important goal for the program, one that could result in improved quality of life.

“We want patients to be savvy about their disease. We want them to recognize when they are in a situation where they need medical attention, but we also want them to be able to self-manage a little bit,” Patel says. “When patients and their families are informed and prepared, it can help reduce the number of times they are admitted to the hospital.”

Teaming up with patients for better care

As part of the model, each member of the Comprehensive Care program team is encouraged to develop close relationships with patients and families, but also increase their own knowledge base and become experts in their areas of care.

“We want to teach our medical assistants how to be ‘health coaches,’” Holcomb says. “We want them to learn how to be the patient’s eyes and ears so that they can offer additional support.”

Staff members are encouraged to develop autonomy and to come up with innovations in care. The result is a team of specialized individuals providing unique, individualized care to each patient who comes through the Comprehensive Care clinic.

Future of program

Patel says there are many long-term goals for the Comprehensive Care program, some of which have not yet been fully explored in detail.

“Behavioral health is an area that we’d like to address more fully. Many people with complex health issues also have mental health issues. So we’d like to implement an increased behavioral health component in our program,” he says. “Another area we want to broaden is telemonitoring; we want to extend this service beyond patients with cardiac and pulmonary diseases to those with other chronic disease states.”

Expansion is also on the radar for the Comprehensive Care program. While the flagship clinic will operate on the campus of WellStar Kennestone Hospital, Patel says that he can envision the program expanding to other locations throughout the WellStar system.

He encourages physicians throughout the Atlanta community to consider referring their patients with complex medical issues to the Comprehensive Care program.

“Call us, tell us the challenge,” he says. “Tell us what we can do to help.”

WellStar's Comprehensive Care Model

The Comprehensive Care program provides a multidisciplinary approach to address all aspects of care in one location and coordinates care among providers and caregivers. The team includes:

Providers & Clinical Staff:
- Physicians
- Advanced practice professionals
- Nurses
- Medical assistants
- Respiratory therapy
- Behavioral health providers
- Palliative medicine
- Nurse navigator
- Support staff
- Patient access specialists
- Data analyst
- Case managers
- Social workers
- Clinical pharmacists
- Nutritionist

Patients receive:
- Individualized care plans
- Individual and group education
- End-of-life support

Contact WellStar Comprehensive Care at Kennestone at 470.793.0200
Interventional radiologists continue to expand the number of diseases and conditions that can be treated with minimally invasive techniques. Atlanta Medicine recently spoke with two Atlanta-area physicians who are performing some innovative procedures for patients with certain types of cancer, spine fractures, neuropathies and more.

**Image guidance improves efficacy of cancer treatments**

Praveen Reddy, M.D., a vascular and interventional radiologist with Northside Radiology Associates, says that advances in interventional radiology (IR) are making a big difference in the oncology field.

“Today, we have a wide spectrum of interventional treatments that can help cancer patients, from basic procedures like installing chest ports that are used to deliver chemotherapy to chemoembolization, in which anti-cancer drugs are injected directly into the blood vessel feeding a cancerous tumor. For example, to treat liver cancer, we can insert a catheter into the hepatic artery for direct delivery of chemotherapy,” he says. “In addition to chemotherapy, we have techniques for the direct delivery of radiation and local treatments with ablative therapy with radiofrequency ablation, cryoablation and microwave ablation.”

Reddy adds that people with osteoporosis often experience fractures of the spine that can be treated successfully through an interventional radiological technique.

“For this condition, we insert needles into the spine to inject a compound that stabilizes the fractures. Most patients experience relief from their pain within hours,” he says. “This procedure is especially beneficial for older adults who are at higher risk for developing pneumonia and other illnesses if they cannot be active.”

Additionally, IR is a mainstay in women’s interventions, including uterine artery and emergent embolization, according to Reddy.

“One of the most common procedures we perform is uterine artery embolization for symptomatic fibroid tumors. It’s a nonsurgical treatment that stops the blood flow to the fibroids and gives relief from symptoms such as bleeding and pain,” he says. “We can also perform emergent embolization with Caesarian sections and baby deliveries that have gone awry to stop significant bleeding.”

Reddy states that data being gathered from clinical trials has proven efficacy of these and other IR procedures.
“We’re currently looking at the data for the interventional delivery of chemotherapy and checking survival rates for cancer patients who receive it,” he says. “The results are promising.”

**Cyroablation therapy improves lives of people with chronic pain**

David Prologo, M.D., associated with Emory University School of Medicine’s Division of Interventional Radiology, has focused his research on helping patients who are experiencing chronic pain. He has found notable success in treating patients who have painful cancers, phantom limb pain and more by using image guidance to deliver cryoablation therapy.

“In our ‘day job’ as interventional radiologists, we traditionally perform treatments with percutaneous probes to deliver therapies to targeted areas,” he says. “But in cryoablation therapy, we use probes and image guidance to target nerves and deliver a freezing ablation to deaden the pain.”

Prologo says that the true innovation of the treatment is due to the marriage of existing technologies.

“Interventional radiologists were already using the probes for other procedures, and image guidance was being used for other conditions like biopsies and trauma injuries,” he says. “By using these same tools to address painful conditions, we have been able to offer unique options for patients whose pain has been essentially deemed untreatable in the past.”

Usually guided by a CT scanner, cryoablation therapy is delivered via a 17-gauge needle, through which Argon gas flows to create an ablation zone of cold. Wherever the needle is placed, that ablation zone is formed.

Prologo says the number of applications that can be successfully treated with cryoablation therapy continues to expand.

“We’ve found it helps people who suffer from neuralgia, phantom limb pain, neuropathies, back pain and pain related to spinal cord injury,” he says. “But the granddaddy of them all is cancer pain. People with metastatic cancer can get relief with this treatment.”

Prologo adds that he would like to get the word out to amputees and veterans that cryoablation therapy can help them with the phantom limb pain they experience.

“We know that in the U.S. today, there are at least 2,000 amputees from war in the past 10 years. In our practice, we’ve seen a few veterans, but not nearly the number in our area that suffer from phantom limb pain,” he says. “We haven’t been able to reach these veterans the way we’d like. So we’re applying to the Department of Defense for grant funding in order to perform this procedure for our veterans in need.”

To date, Prologo and his colleagues have treated more than 200 patients using percutaneous palliative cryoablation, but he says that it is not known yet whether the effects are permanent.

“The therapy is so new that we don’t know the long-range effects yet,” he says. “But it appears to be long-lasting.”

Interventional radiologists continue to expand the number of diseases and conditions that can be treated with minimally invasive techniques.
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