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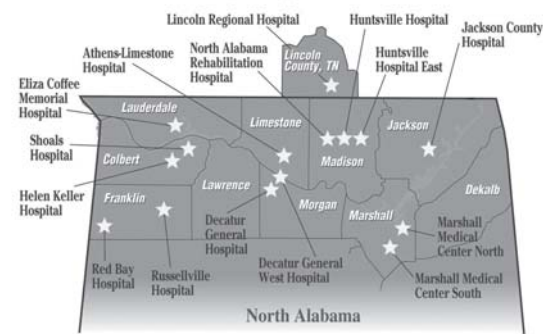
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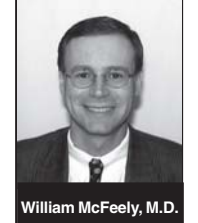
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Evaluation & Management of Ear Injuries at Work



William McFeely, M.D.

Exposure to workplace noise has long been known to cause hearing loss. Other injuries to the ear are also common, but frequently are overlooked. The ear's delicate structures may be damaged in a variety of ways. This article will briefly outline some of the most common disorders resulting from work-related injuries.

Hearing loss is a significant and unfortunately common occupational malady. Over the past several decades both the Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) have initiated efforts to better understand and limit the occurrence of occupational hearing loss, particularly as it relates to excessive noise exposure. OSHA-mandated hearing conservation efforts have made a large difference with respect to reduction of hearing damage.

Excessive noise exposure from unplanned sources, no matter how brief in duration, can have a negative effect on the ear's tiny membranes. A victim may complain only of ear fullness or ringing briefly after the event. A temporary hearing shift downwards is common after a blast or explosion in-

jury; hearing loss persisting more than 24 hours is more concerning. A person complaining of such symptoms should undergo an ear examination to rule out traumatic tympanic membrane (eardrum) perforation and other etiologies such as a foreign body.

Ringling in the ears (tinnitus) is a common chronic complaint in the United States population. Acute high-intensity noise exposure can cause or exacerbate this problem. Head trauma may also lead to tinnitus. Fortunately, there are numerous treatment options for those with intolerable ringing. Pharmaceutical management can be effective. Other options include: custom-fit masking devices, tinnitus retraining therapy, and injection of various medications into the inner ear (perfusion therapy). Therapy for tinnitus must be individualized, and not all physicians offer all of the available options. Only physicians specially trained in ear disorders are able to provide the full range of therapy.

Damage to the eardrum and/or the hearing bones is common after significant head trauma. The chances of ultimate hearing improvement may be higher if

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Is Your Supervisor Involved?

Supervisors play a central role in an effective workers compensation program. More than anyone else in the organization, they are in a position to recognize an employee's behavior and impact the outcome of a workers comp claim. Imagine this conversation between two employees:

Joe: Do you know the most frequent injury in our plant?
Bill: I don't know. I'd imagine backs or shoulders.
Joe: No, it's deeper than that.
Bill: What do you mean, deeper?

Joe: Hurt feelings and failure to communicate. Hurt feelings often cause as much damage in a workplace as debilitating injuries. Poor feedback can make employees unproductive, resentful, disabled and litigious. Supervisors must understand basic information about their organization's program so that proper procedures are followed, hurt feelings are minimized and communication is effective.

Below are some basic guidelines for supervisors involved in management of workers compensation cases:

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Legal Brief

AL 'Most Improved State' Says OSHA. When it comes to workers' compensation, Alabama is the "Most Improved" state in overall ranking, according to the new study, 2004 State Report Cards for Workers' Compensation. Alabama also was among nine states that received an "A" on 2002 report cards, based on data from the U.S. Department of Labor Occupational Safety & Health Administration (OSHA) covering recordable injuries and illnesses for 2000, 2001, and 2002.

Company News

We are pleased to welcome Keith Kunze as our newest Case Manager. A graduate of The University of Alabama, Keith brings over 13 years of orthopaedic experience to our growing team of health-care professionals.



Keith Kunze

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All submissions, sponsorship inquiries and information regarding publication should be addressed to bethc@compone.org

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Supervisor Training (continued)



Dana Sellers

1. Be attentive. Be ready to recognize what is going on with your employees.
2. Observe. Focus on specific aspects of each employee's behavior in order to meet the employee's needs.
3. Document, Document, and Document!
4. Be thoughtful and nonjudgmental. Acknowledge the employee's point of view.
5. Keep the employee associated with the workplace. Know when to call and what to say. Typical remarks may include: "We miss you at work and want you to know that we're thinking about you" or "Do you have any concerns that I can help you with during your recovery?"
6. Be consistent. You must follow the same procedures for all employees regardless

- of your personal or professional relationship with them.
7. Maintain confidentiality. Respecting employee confidentiality is critical to developing a trusting relationship. Discuss employee problems in private, be straightforward, and only provide information to the necessary parties.
8. Follow up. A key part of the supervisor's role, follow up action will ensure that the employee is compliant, that modified duty assignments are followed closely, and that improvements are made to avoid a repeat injury or incident.

Supervisors should also receive training to develop effective communication skills. Supervisor training is available in several formats including seminars, films, lectures or printed materials. Top management, an outside consultant or a combination of these may conduct the training sessions. Regardless of the size of an

Ear Injuries at Work (continued)

identified and treated early. Surgical repair of these structures is frequently possible. There are many excellent commercially available choices for ossicular (hearing bone) repair. Hearing aids may be considered if the patient is not a surgical candidate. Fracture of the temporal bone around the ear can lead to leakage of inner ear fluid; this can result in hearing loss, tinnitus, and sometimes dizziness. Fracture also can result in leakage of spinal fluid. This is a serious injury which may result in meningitis if not addressed. A severe temporal bone fracture commonly is associated with damage to the facial nerve. This clinically may look like a Bell's palsy (drooping immobile face), but is due to impingement of the nerve by the bone fragments. Early decompression surgery may be necessary in order to regain maximum facial function.

A variety of inner ear vestibular (balance) disorders can result from trauma to the head or ear. Positional vertigo, Meniere's disease, and labyrinthine concussion are common examples which present as dizziness or unsteadiness. Some disorders may appear in a delayed manner, often weeks or months after the injury. If such diagnoses are suspected, it is important to refer these patients to a

specialist so that an appropriate work-up and therapy can be initiated.

Any injured worker with an abnormal ear exam, or with ear symptoms that do not resolve quickly, should be referred for further evaluation. An otolaryngologist (ENT Physician) is generally capable of handling many of these injuries. If the situation is more complicated, referral directly to an otolaryngologist with fellowship training in ear-related disorders may be warranted. An

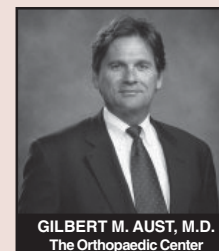
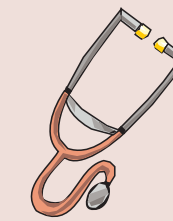
Otologist or Neurotologist can handle every type of complex injury to the ear, especially when middle or inner ear structures are involved. Severe hearing loss, bothersome tinnitus, dizziness, persistent drainage from the ear, and facial nerve weakness are all worrisome symptoms that require urgent referral. Most work-related ear injuries are treatable if recognized early. Early intervention can frequently mitigate subsequent damage. It is important for health care personnel to be aware of these occupational ear injuries.

*William J. McFeely, Jr., M.D.
Fellowship Trained Ear Surgeon
Otolaryngology, Otology, Neurotology &
Skull Base Surgery
North Alabama ENT Associates, P.C.*

"Most work-related ear injuries are treatable if recognized early."

Clinical Comments

RADIAL TEAR SYNDROME



GILBERT M. AUST, M.D.
The Orthopaedic Center

What's wrong when you injure your back and the doctor says there is nothing wrong? This may have happened to you, or at least you know someone to whom it has happened. It is not an uncommon occurrence. Sometimes it is called a sprain or pulled muscles but you rightly ask, "how can pulled muscles sometimes not heal in six weeks? What is going on?" Please read on.

Lower back injuries and pain are second only to the common cold in causing doctor visits. They affect, at one time or another, 85% of the adult population. Most injuries occur as a result of twisting motions, i.e. getting out of a car, falling or lifting heavy objects. Probably 85% of the time the injury you experience is to a disc in your lower back, and 95% of the time to one of the lower three discs.

To understand what is going on, we must briefly discuss the anatomy of the lower back. First of all, the lower back or lumbar spine is located between the ribs and pelvis and usually consists of five bones called vertebrae. The top one is L1 or lumbar one and the lowest is L5 or lumbar five. The back half of each vertebra has a one-inch hole in it through a water/filled sac containing the spinal nerves passages. The front half of the vertebrae is solid bone and is separated by each adjacent vertebra by a one-half inch cushion called a disc. This is what we usually hurt when we injure our lower back. Each disc is like a flattened golf ball. There is a core of fish meat like material surrounded by wraps and wraps of fibrous tissue. If you were to slice

the disc across, the core would make up two-thirds of the diameter and the wraps of fibrous tissue, like rings of a tree, would make up the outer one-third. Only the outer one-eighth of the discs has nerve endings in it. What happens when you twist your lower back is that you tear some or all of the wraps of fibrous tissue. It hurts because the tear goes into the area where there are nerve endings. If the tear is complete, some of the disc core may escape and you have a herniated or ruptured disc. When this occurs and pinches a nerve, you may require a discectomy, a surgical procedure where the ruptured part of the disc is removed. The procedure is done as an outpatient or an overnight stay, through a small incision using a microscope or magnifying glasses.

Many times, however, when you twist your back the tear in the outer disc is incomplete. The tear will go into the sensitive outer layers and be quite painful but no herniation occurs. We can see herniations on an MRI scan or a myelogram, but generally not incomplete tears of the disc. This is a mystery that causes persistent pain in the lower back but is not visible on MRI scan. Fortunately, the body heals the majority of the tears and this is why 90% of lower back injuries heal themselves. Patient's with persistent lower back pain lasting longer than three months and no abnormality on the MRI scan, most frequently are suffering from this undetectable partial tear of the disc called radial tear syndrome. To confirm its presence the patient requires a discogram. This is a procedure where the patient is put partially to sleep and a needle is inserted into the suspicious disc or discs. With the patient awake, dye is injected into the disc and if a radial

tear is present, it can be seen radiographically and the patient will experience his/her familiar lower back pain. The discogram is very similar in experience to a colonoscopy for those of you who have had that opportunity.

For persistent painful radial tears, several treatment options are available. Epidural steroid injections generally do not work since the tear is on the inside of the disc. Simple discectomy generally does not work either. Until just recently, the only treatment was fusion, where the vertebrae above and below the painful disc are grafted and made to grow together. We still frequently do this procedure, both traditionally and through minimally invasive techniques.

Most recently, however, the FDA has approved artificial lumbar discs, similar in concept to total joints and other parts of the body. The artificial disc consists of two plates, each attaching to the end of a vertebra with a plastic spacer in between. This device replaces the damaged disc and still allows motion between the vertebrae, which is a more natural "fix" of the problem.

Artificial discs are inserted through a small abdominal incision and patients generally go home in one to two days following the procedure. The procedure is not significantly painful and recovery is approximately two to three weeks, making this the procedure of choice for this most vexing and often invisible problem called radial tear syndrome.

*Gilbert M. Aust, M.D.
The Orthopaedic Center
(256) 539-2728
www.visittoc.com*