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Comp1One®

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Comp1One®

Comp1One is a comprehensive case management company located in Huntsville, Alabama with clients across the Southeast. Comp1One and sister company, North Alabama Managed Care, Inc. (NAMCI), are divisions of Premier Health Networks of Alabama, LLC featuring PPO network access for direct medical cost savings in group health and workers' compensation.

Comp1One features 24 hour case management services with Certified Nurse Case Managers and the backing of our Board Certified Occupational Health Medical Director. Our nurses and physician are available for pre-certification, utilization management, file reviews, case referrals, peer reviews, and catastrophic injury management.

Comp1One is certified by the state of Alabama Department of Industrial Relations, is licensed and insured, and has been recognized for Best Practices in Injury Management in the state of Alabama.

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Teamwork

A Periodical for Providers and Clients of Comp1One®

The Stiff Elbow

One does not know the ease of beginning until one experiences the struggle to completion. This fictitious ancient proverb could easily apply to work-related elbow injuries. Usually, the initial elbow injury can be accurately diagnosed with treatment plans assuredly assigned. Unfortunately, when an injured worker subsequently develops a stiff elbow and looks back after several months of difficult progress, the well-laid plans seem trivial to present conditions.

The stiff elbow can be the end product of many work-related incidents. A direct blow, penetrating injury, or fall may cause an acute injury, as well as twisting, jerking, jamming, or bending an elbow abnormally. Pain may be sudden and severe. Less impressive conditions such as contusions, epicondylitis, arthritis, bursitis, infection, and lesser fractures can also produce this condition. Exactly why the stiff and contracted elbow occurs is not totally clear, but pain, joint swelling, muscle contraction, limitation of motion with later scar formation all play a role. Our understanding of these factors is primarily descriptive, not cause and effect, and therefore primitive.

Diagnosis of the injured worker with the stiff elbow is not difficult. The ideal patient is eighteen to fifty years old, capable of self-care, has no other elbow problems such as reflex sympathetic dystrophy (RSD), heterotopic ossification, nonunion, or intraarticular injury. He or she must be able to understand and actively participate in his or her care including physical therapy, bracing, and analgesic management. Systemic illnesses such as closed head injury, degenerative arthritis, or diabetes can make treatment difficult if not

impossible. Also, the injured worker must be motivated. He or she may not necessarily be able to leap tall buildings in a single bound, but they will be expected to clear the short ones.

How should these patients be treated? One should repair the correctable items. Nonunion, malunions, RSD, infections, and painful hardware should be addressed and minimized. One should be realistic about what cannot be changed, such as underlying arthritis or closed head injury. Additionally, one cannot change someone else's motivation. The injured worker's genetics and life experiences have been at work long before they had an elbow problem.

Further treatment centers on the degree of contracture. Forty to one hundred and five degrees of extension and flexion, respectively, can be quite compatible with good function even if the

patient does not like the appearance. This range can allow adequate extension to function in the space about the body, and this flexion can allow the patient's hand to reach their face and head. Less motion should be treated with physical therapy until no further progress is made, usually over four to six months. Delay of further treatment greater than one year has been associated with inferior long-term results.

If physical therapy has not produced the desired results and significant contraindications do not exist, then operative treatment should be considered. Again one should ponder all factors, but in my opinion, significant pain or lack of motivation



PHILIP MADDOX, MD

"He or she may not necessarily be able to leap tall buildings in a single bound, but they will be expected to clear the short ones."

(continued on page 2)

Legal Brief

A worker who refuses to comply with authorized medical care can lose all accumulated benefits for the period of noncompliance. Section 25-5-57(a)(4) further provides that an employee who refuses to undergo physical or vocational rehabilitation shall not be deemed to be permanently and totally disabled. In other words, the typical suspension of benefits is temporary with respect to noncompliance. However, the failure to undergo physical or vocational rehabilitation also carries with it permanent loss of benefits in that the plaintiff cannot be found permanently and totally disabled.

Ben Pugh, Attorney
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Company News



TRISHA SADLER

Please join us in welcoming Trisha Sadler to the Comp1One Case Management Team! Trisha has over twelve years of healthcare experience. She will be coordinating the care of injured workers for Comp1One's clients.

Mary Ann McMeans, Comp1One Case Manager and President of the North Alabama Chapter CMSA along with Vice-President, Ina Warboys, were presented a commendation at the UAH President's Council Annual Reception and Dinner for CMSA's donation to the Nursing program scholarship fund. We are so proud of you Mary Ann!



MARY ANN MCMEANS

Did you know?

More than half (55%) of prescription drug costs in workers' compensation cases are attributed to pain relievers, according to research from the National Council on Compensation Insurance (NCCI) trade group. (www.ncci.com/media/pdf/rx.pdf)

The Stiff Elbow (continued)

are the strongest prognosticators of a poor result after surgery.

Operative treatment can be either arthroscopic or open. Arthroscopic treatment is less invasive and less inflammatory, but is also less effective in severe contractures. This outpatient procedure allows resection of the posterior capsule, anterior capsule, and osteophytes. Arthroscopy can be extremely difficult in the highly traumatized elbow and contraindicated when too close to the ulnar and radial nerves. Open treatment from the medial and/or lateral aspect of the elbow allows greater resection, nerve identification and transposition as well as other procedures, such as hardware removal and heterotopic bone resection. The negative aspects of open treatment lie in the postoperative inflammatory response.

Postoperative care must include physical therapy and bracing. Occasionally, an elbow manipulation may be required, but this is rare. Indomethacin and radiation are also appropriate

treatments when heterotopic bone has formed.

Patients with an elbow-related injury who have been off work should try to return to work as soon as possible. Job modification may be necessary when the pain is severe. Taking regular breaks, alternating tasks and carrying out exercises that involve gentle stretching may help.

Ninety percent of surgical patients will show significant improvement, but do not expect a normal range of motion. How close the injured worker achieves the perfect result depends upon their outlook as well as the severity of the initial insult and underlying disease. Remember, this is a struggle to completion, not an easy return to a normal elbow.

For more information regarding elbow-related pain, contact The Orthopaedic Center at (256) 533-2460.

Philip A. Maddox, M.D.
The Orthopaedic Center

Lack of Injury-Relatedness for Chronic Pain Claims

Imagine the typical claim of disability from low back pain in which there is no objective medical evidence of injury, but everyone concludes that there was an injury simply because the claimant says that he or she has pain. Comprehensive reviews of the scientific literature are available which specify that there is no relationship between physical injury and such presentations. In order to facilitate appropriate evaluation and management of such a claim, an emphasis must first be placed on the lack of association between physical injury and such presentations. Then, more credible explanations for the presentation must be investigated. Given the scientific literature which indicates that such presentations are associated with non-occupational psychological issues, the psychological issues of relevance must be specifically investigated for the individual case at hand. Usually, such investigation is avoided within a workers' compensation claim. But when such an investigation is credibly carried out, it is extremely common for non-occupational risk factors to be revealed. Claim managers and treating doctors then have a full set of

information: On the one hand, the science which clarifies a lack of association between physical injury and claims of disabling low back pain; and on the other hand, evidence of non-occupational risk factors for low back pain having been revealed for the individual claimant. Clinicians and administrators are then able to say to all involved parties: "We have a presentation which is not occupationally related in its basic form, and we have non-occupational factors which provide a credible explanation for the presentation." The claimant can then be directed out of the workers compensation system, in the direction of a non-occupational treatment plan which will have a greater probability of success.

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ROBERT BARTH Ph.D.

Clinical Comments

Traumatic Brain Injuries



DR. KEITH ANDERSON

Traumatic Brain Injury (TBI) is the leading cause of death and disability for Americans between the ages of 1 and 40 with a total annual cost of approximately 25 billion dollars. It has been estimated that the rate of occupational related traumatic brain injury is between 9 and 11 per 100,000 population. This occurs most commonly in the farming, roofing, sanitation, and road construction industries. With such a large proportion of injuries clustered in only a few industries, there are significant opportunities for prevention. The goal of TBI rehabilitation is to improve the patients' functional abilities that will decrease their dependence on others and improve their quality of life.

The mechanism of injury for TBI can be broken down into primary and secondary events. Primary brain injury involves the direct mechanical injury or contusion of the brain cortex. Stretch and shear type injury occurs to the axons of the hemispheres white matter or the deeper structures. Secondary injury can take place resulting in hyperemia ischemia and disruption of the blood brain barrier resulting in edema. Intracranial hemorrhage can occur as well as epidural and subdural hematomas. Such insults can also cause hypoxia, hypotension, and increased intracranial pressure as well as acidosis.

Head injury can be classified as mild, moderate, and severe. Emergency rooms use the Glasgow coma score (GCS) to help classify head injuries based on the level of consciousness during the initial neurological examination. Eye response, best verbal response, and best motor response are assigned numbers. Mild head injuries are classified GCS 13-15, moderate head injuries are classified GCS 9-12, and severe head injuries are classified GCS <8. Patients with severe head injuries are comatose.

Treatment of TBI begins in the field starting with emergency medical system.

Proper extrication and preventing secondary injuries is of the utmost importance. Once in the emergency room, patients are classified. With mild TBI, secondary injuries are treated or ruled out. With a normal GCS score of 15, patients can be observed at home for 12-24 hours for evolution of delayed head injury complications. With a score of 13-14 patients are generally admitted to the hospital for frequent neurological checks.

With moderate TBI (GCS 9-12), once again secondary injuries need to be treated. All patients with moderate TBI undergo CT scans of their head to evaluate for intracranial trauma. Neurosurgery is usually consulted and the patients are admitted to a neuro-intensive care unit for observation. Seizure prophylaxis is considered for patients with cerebral contusion, small intercranial hemorrhages, or subdural hematoma. Oxygenation and perfusion are followed closely as well as neuro checks.

With severe TBI (GCS <8), patients are usually intubated to protect their airways. Intracranial pressure is controlled with hyperventilation and/or Mannitol. Systemic hypotension is usually caused by hemorrhagic shock and is treated aggressively by the trauma team. A CT scan of the head is ordered as soon as the patient is stabilized. The neurosurgeon will decide on evacuation of intracranial hematoma based on the size, location, and midline shift of structures. Often a catheter is placed to monitor intracranial pressure.

Rehabilitation is usually not needed for mild TBI, however, latent symptoms such as headache, attention deficit, decreased concentration, and memory problems can occur and need to be addressed. If these symptoms are noted, intervention and treatment with the neuro psychologist can be very beneficial.

Moderate brain injury patients and severe brain injury patients are good candidates for inpatient traumatic rehabilitation. Low level severe TBI patients are

usually admitted to a coma stimulation unit. Preventative measures are instituted to prevent contractures, bed sores, urinary tract infections, and respiratory infections.

The interdisciplinary rehabilitation team is comprised of the Physiatrist (physician specializing in rehabilitation medicine), rehabilitation nurses, occupational therapy, physical therapy, neuro psychology, speech therapy, and case manager. Obviously the patient's family/support system is an integral part of the team. The Physiatrist starts with a complete history and physical examination and then formulates a treatment plan. All of the team members' duties overlap and intersect so that proper carryover of new skills is accomplished. Occupational therapy helps with activities of daily living, cognitive issues, visual skills, and coordination. Physical therapists work with large muscle groups and gross motor skills such as mobility, transfer training, ambulation, and balance skills. Speech therapists work with swallowing and aphasia issues. Neuropsychologists address cognitive deficits with a goal of remediation and retraining. Rehabilitation nurses help with bowel, bladder, skin and medication training. Case managers help coordinate the family education as well as the continued outpatient rehabilitation program.

Each patient who sustains a TBI is unique and complex. A highly specialized team is needed at both the acute and rehabilitation levels of care for the best possible outcome. Although traumatic brain injury is a major cause of lost work time, it is treatable and every effort should be made to choose highly skilled and experienced rehabilitation specialists to speed the employee's recovery and return to work. For more information contact HealthSouth Rehabilitation Hospital 256-535-2300.

Keith C. Anderson D.O.
Medical Director
Health South Rehabilitation Hospital
and Comprehensive Rehab