

TCOM OCCUPATIONAL MEDICINE NEWSLETTER

A health and safety publication of Total Care Occupational Medicine

Spring 2004

Volume 11

On-Site Physical Therapy – Are you getting your money’s worth?

Several years ago, the trend was for larger companies to contract with on-site physical therapy providers. The premise (promise) seemed great – a therapist at the employer’s own site, able to observe employees in action, recommend steps to prevent injury, design ergonomic changes, and treat acutely injured employees without losing time traveling to an off-site therapy office. Beside the theoretical advantages of observing and treating workers in their own environment, the sheer *convenience* of this service was a big sell. Some providers were able to provide most of what they promised, but in order to be economical, the providers had to balance demand and profits.

In talking to TCOM clients who have used on-site providers, a consistent pattern of complaints was evident:

- ❑ Getting a therapist on site was difficult, especially if there were only a few employees being treated, and/or the provider did not have another client in the neighboring region.
- ❑ This often lead to 1-3 week delay in getting a new patient *started* in therapy.
- ❑ Instead of providing the physician’s requested 3 times a week therapy, it might only have been provided on an “as available” basis (once or twice a week).
- ❑ Having a therapist come to the site didn’t ensure that therapy was conveniently scheduled so as to avoid disruption of the work schedule – it all depended on the therapist’s availability.
- ❑ In order to compensate for these problems, the providers sometimes sent different therapists each session, leading to poor continuity of treatment and outcomes.
- ❑ The therapists may be fresh graduates, not trained or certified in the more advanced treatments.
- ❑ Communication with the prescribing physician tended to be poor. Without good communication, treatment plans could not be adjusted, and recovery and return to work were delayed.
- ❑ Equipment and facilities might not have been adequate for treating the full range of musculoskeletal problems. The therapist was required to bring specific equipment for each session, and if not anticipated, the equipment was not available.
- ❑ Ergonomic and preventive programs were provided on a fee for service basis, no differently than with a free-standing therapy provider.

TCOM has seen several clients return to off-site therapy due to dissatisfaction with their on-site providers. Remember, there’s no cost savings if your employee doesn’t get back to regular work. We work for you, to get your employees healed and working. If you would like to discuss TCOM’s therapy program, please call Eric Beck, at 732-748-1900.

TCOM Helps Manage WC Liability

Worker compensation losses take several forms, but for employers, the most troublesome is the fraudulent claim. Worker compensation fraud has 3 major subtypes including fictitious injury, real injury occurring out of work but claimed to be due to work, and real injury occurring at work but with magnification of severity, duration or extent in order to obtain additional benefits. A number of factors are associated with fraudulent claims, but common denominators include the employee believing that they were “done wrong,” feelings of discrimination in the workplace, either by management or co-workers, and general job dissatisfaction. According to Richard Easton, MD, founder of FraudWatch, a company specializing in the documentation and defense against fraudulent medical claims, 47% of fraudulent worker compensation claims involve real injuries with exaggerated claims.

Why isn’t fraud normally detected? In some cases it may be very difficult to do so, but in most, it actually is detected, either by the employer, co-workers, physician, or insurance carrier. The problem is that fraud is rarely documented, defined, declared, or defensible. In order to define and declare a claim to be fraudulent, “red flags” should be consistently declared and documented in an objective fashion. “Red flags” are warning signs, long recognized by the insurance industry as having an association with fraudulent claims.

Flag	Comment
Incident not witnessed	Not witnessed by supervisor or manager; may only be witnessed by friend
Details of injury vague or change	Various interviewers get vague and contradictory story vs. clear, concise detail
Disgruntled employee	Employee angry at management for real or perceived wrong
Injured in unusual locale	Worker was in an area he/she should not be doing work
Not doing normal duties	
Recent discipline	Employee disciplined once or more in past
Job insecurity	Impending strike, layoff, or plant closure
Poor job performance	Fair or poor performance; not motivated
Symptoms > examination	Physical exam does not support claim of injury (e.g. no bruising, inconsistent findings)

Continued on back page

What to Expect from an OSHA Inspection

Most employers do not look forward to OSHA inspections, but understanding why, when, and how such inspections take place can give an employer at least a sense of familiarity with the process. True preparation for an OSHA inspection is the work that goes into daily safety program compliance and documentation. This article will help to explain why and how OSHA conducts inspections.

OSHA inspectors, called compliance and safety professionals, conduct inspections to assure compliance with OSHA requirements. Normally, OSHA conducts inspections without notice. Employers have the right to require compliance officers to obtain an inspection warrant before entering the worksite.

Inspection Priorities

OSHA cannot inspect all 7 million workplaces it covers each year. The agency seeks to focus its inspection resources on *the most hazardous workplaces* in the following order of priority.

1. Imminent Danger Situations
Hazards that could cause death or serious physical harm receive top priority. Compliance officers will ask employers to correct these hazards immediately – or removed endangered employees.
2. Fatalities and catastrophes
Incidents that involve death or the hospitalization of three or more employees come next in priority. Employers must report such catastrophes to OSHA within 8 hours.
3. Complaints
Allegations of hazards or violations also receive a high priority. Employees may request

anonymity when they file complaints.

4. Referrals -
of hazard information from other federal, state, or local agencies, individuals, organizations or the media receive consideration for inspection.

5. Follow-ups-
Checks for abatement of violations cited during previous inspections – are also conducted by the agency in certain circumstances.

6. Planned or programmed inspections

Inspections aimed at specific high-hazard industries or individual workplaces that have experienced high rates of injuries and illnesses also receive priority.

Phone and Fax Investigations

OSHA prioritizes all complaints it receives based on their severity. For lower priority hazards, with permission of the complainant, OSHA may telephone the employer to describe the safety concerns, following up with a fax that provides details on alleged safety and health hazards. The employer must respond within five working days, identifying any problems found and noting corrective actions taken or planned. If the response is adequate and the complainant satisfied with the response, OSHA generally will not conduct an on-site inspection.

On-site Inspections

Preparation – Before conducting an inspection, OSHA compliance officers research the inspection history of a workplace, review the operations and processes in use and the standards that most likely apply. They gather appropriate equipment and testing instruments to measure potential hazards.

Presentation of Credentials- The inspection begins with presentation of the compliance officer's credentials, which include both a photograph and serial number.

Opening Conference – The compliance officer will explain why OSHA selected the workplace for inspection and describe the scope of the inspection, walkaround procedures, employee representation and employee interviews. The employer then selects a representative to accompany the compliance officer during the inspection. An authorized representative of the employees, also has the right to go along. In any case, the compliance officer will consult privately with a reasonable number of employees during the inspection.

Walkaround – Following the opening conference, the compliance officer and the representatives will walk through the portions of the workplace covered by the inspection, inspecting for hazards that could lead to employee injury or illness. The compliance officer will also review worksite injury records (OSHA 300 log), and posting of the official OSHA poster. During the walkaround, compliance officers may point out some apparent violations that can be corrected immediately. While the law requires that these hazards must still be cited, prompt correction is a sign of good faith on the part of the employer. Officers try to minimize work interruptions during the inspection and will keep confidential any trade secrets they observe.

Closing Conference – After the walkaround, the officer holds a closing conference with the employer and the employee representatives to discuss the findings. The compliance officer discusses possible courses of action an employer may take following an inspection, which could include an informal conference with OSHA, or contesting citations and proposed penalties. The officer also discusses consultation and employee rights.

Continued on page 5

I.C.S.

INCIDENT COMMAND SYSTEM

A Two-Day Training Seminar presented by the U.S. Department of Labor
Occupational Health and Safety Administration (OSHA)

Corporate Sponsor



JUNE 8 (8:00 AM-4:30 PM) & JUNE 9 (8:00 AM-1:30 PM)

Department of Human Resources, 92 East Main Street, Somerville

The Incident Command System (ICS) is the only nationally recognized emergency response procedure followed by all police, fire and emergency medical services. ICS is mandated by presidential directive under the Homeland Security Act and is an intricate part of the new National Incident Management System. All federal, state and local agencies, public and private, intending to work with government responders or to receive FEMA reimbursements must follow the ICS. The ICS is a resource management method designed to improve the effectiveness, efficiency and safety of responses to emergencies and incidents. ICS also establishes stringent procedures for personnel accountability and equipment status critical to the success of any operation.



Students attending the Incident Command System 200 Training will be certified by the NJ State Police at the "Basic" level of the ICS curriculum. Certified students will be registered with the NJ State Police and their names will be kept on file in the Division database. Certification and registration are important for verifying compliance with Presidential Directive #5 of the Homeland Security Act.

REGISTER NOW—SEATING LIMITED!

Register me for the June 8 & 9 Training Seminar. \$100 SCBP Members; \$150 Non-Members

Name(s): _____ Phone: _____

Company: _____

Address: _____

Payment: Check enclosed (Make payable to: Somerset County Business Partnership) Charge my credit card

Signature: _____ # _____ exp. _____

REGISTRATION OPTIONS

Fax back this form (908)722-7823 ▪ Register and pay online at www.SomersetBusinessPartnership.com
Mail to: Somerset County Business Partnership, P.O. Box 833 • Somerville, NJ 08876 ▪ (908) 218-4300

MRI for Back?

The Debate Continues

2003 was a busy year for scientists investigating back pain and its radiological diagnosis. Doctors, patients, and employers all agree that accurate diagnosis and treatment lead to faster symptom resolution and return to duty. However, there is a large gap between patients, physicians (depending on orientation) and insurance carriers on what's the best way to get from here to there. We know that to date, prior studies have shown high false positive rates of lumbar MRI findings, calling into question the significance of "prolapsed discs," "bulging disc," facet arthropathy and herniated discs. Up to 60% of people *without* back pain have been found to have abnormalities on the MRI.

Three new studies published in 2003 looked at MRI imaging in back pain. Bideman and Battie designed a study to look at identical twins. They compared MRI findings in the twins with reported current, past year, and lifetime low back pain complaints. One hundred and fifteen pairs of twins aged 35 to 69 were studied. The investigators found that disc height was associated with all back pain complaints. Annular tears, a tear in the outer fibrous ring of the disc, was associated with frequency and intensity of back pain in the preceding 12 months. Other MRI findings did not explain the various symptom histories. This study raised new questions about what causes back pain. The only findings found to correlate to complaints are usually thought to have limited clinical importance, and poor sensitivity.

Jarvik and Hollingsworth published a study in the Journal of the American Medical Association looking at the clinical and economic consequences of replacing back x-rays with rapid MRI. They took 380 patients whose physicians had ordered back x-rays, and randomly assigned them to either x-ray or MRI. The researchers measured back-related disability, pain, satisfaction and cost scores for the two procedures. At one year, patients undergoing rapid MRI were found to be more than twice as likely to have had surgery. Patients and physicians preferred the MRI; but, no significant differences were found in disability or pain. The authors concluded that rapid MRI for patients with low back pain offers little benefit and may increase the cost of care. Backing up this study is another one by Hollingsworth looking at a theoretical model of performing

MRI's in primary care patients with back pain in order to exclude cancer as a cause of pain. This study did not find enough evidence to support routine use of rapid MRI to detect cancer.

Is the Aching Back from Aching Bones?

Arthritis of the spine is common. In addition to degenerative arthritis (wear and tear), inflammatory arthritis attacks the bone through the immune system. Sometimes, the blood tests used to diagnose inflammatory arthritis are normal, even though the arthritis isn't degenerative. This category of arthritis is called seronegative spondylarthropathies. A study performed last year looked at abnormalities in the sacroiliac joint in this type of arthritis, comparing MRI, CT, and plain x-rays. The authors found that both MRI and CT were superior to plain x-ray in staging erosion of the bone, but only MRI allowed visualization of the inflammation going on inside the bone and surrounding ligaments. The study also found that MRI was reliable in differentiating between active and chronic inflammation of the sacroiliac joint.



Finally, a study published in the Journal of Nuclear Medicine investigated the role of "transitional vertebrae" in back pain. A transitional vertebrae is an abnormally formed bone usually found at the base of the low back above the sacrum. In order to determine whether the transitional vertebrae causes problems by altering the biomechanics of weight transfer, these scientists correlated plain x-rays, MRI, CT, and nuclear SPECT scans in 48 patient known to have back pain and transitional vertebrae. SPECT scans use the emission of radioactive particles in inflamed or highly active tissues to create a picture of "hot areas." The authors found that 81% of the patients had high uptake at the joint between the transitional vertebrae and the sacrum on SPECT scan. The study suggests that the transitional vertebrae does alter stress on the joints, and may be responsible for a subset of back pain. MRI, CT and plain films demonstrated abnormalities at the joint in less than 50% of patients.



English Language Fluency Required by DOT

Section 391.11 (b)(2) of DOT rules require that the prospective driver "can read and speak the English language sufficiently to converse with the general public, to understand highway traffic signs, and signals in the English language, to respond to official inquiries, and to make entries on reports and records." A DOT notice of proposed rule making published in 1997 was withdrawn last summer. The proposed DOT rule would have changed the requirement of English language proficiency, and was requested by the ACLU. The ACLU argued that since there is no English language requirement for *obtaining* a CDL, and since the *FHWA authorizes administration of the CDL test in foreign languages*, the DOT shouldn't require English proficiency. The proposed rule was rescinded after a recent truck crash resulting in 5 fatalities. The truck's Bosnian born driver ran a stop sign and killed a family of five. The driver, who does not speak English, was charged with vehicular homicide as well as not being qualified to have an intrastate CDL. The employer is responsible for determining whether the driver meets the English language criteria under section 391.11. This requirement is not part of the medical certification process, and there are no provisions within the medical certificate to comment on English proficiency. Employers should review their internal processes to determine if a screening mechanism exists to assess applicants' English language proficiency.

AMPHETAMINE USE ON THE RISE

Quest Diagnostics reports that workplace amphetamine use has increased significantly in the past 5 years. In the U.S. workforce, amphetamine positive tests have gone up 70% over the last half decade. Illegal amphetamines include ecstasy, crank, speed, and meth. Generally called speed, amphetamines can be snorted, swallowed, injected or smoked. Legal sources include over the counter diet pills and cold remedies, and prescription medicines for weight loss or attention deficit disorder. Amphetamines may cause disorientation, euphoria, & hallucinations, and can be detected in the urine 1-2 days after use. Amphetamine users may appear irritable, anxious, paranoid, and have rapid speech, tremors, and long periods without sleep.

Ever wonder who the worst drivers are? So did the insurance industry, but instead of looking at factors such as age and number of years driving, the industry took a turn and decided to examine driving records by occupation. We know that young drivers are worse drivers, so it was no surprise that students ranked first in the number of accidents, moving violations, and speeding violations. The surprise was that physicians, lawyers, architects, and real estate brokers followed, in that order, in number of accidents. Maybe more education means more accidents.



OSHA INSPECTIONS

(continued from page 2)

Results

OSHA must issue a citation and proposed penalty within six months of the violation's occurrence. Citations describe OSHA requirements allegedly violated, list any proposed penalties and give a deadline for correcting the alleged hazards. Violations are categorized as "other than serious", "serious", "willful", "repeated", and "failure to abate." Penalties may range up to \$7,000 for each serious violation and up to \$70,000 for each willful or repeated violation. Penalties may be reduced based on an employer's good faith, inspection history, and size of business. For serious violations, OSHA may also reduce the proposed penalty based on the gravity of the alleged violation. No good faith adjustments are made for willful violations.

Appeals

When OSHA issues a citation to an employer, it also offers the employer an opportunity for an informal conference with the OSHA Area Director to discuss citations, penalties, abatement dates, or any other information pertinent to the inspection. The agency and the employer may work out a settlement agreement to resolve the matter and to eliminate the hazard. Alternatively, employers have 15 working days after receipt of citations to formally contest the alleged violations and/or penalties by sending a written notice to the Area Director. OSHA forwards the contest to the Occupational Safety and Health Review Commission for independent review. Alternatively, citations, penalties, and abatement dates that are not challenged by the employer or settled become a final order of the review commission.

Driving Safety By Occupation

First Aid for Cuts

Minor cuts and burns are so common, that most people are comfortable taking care of their own wounds. However, when a cut or burn is severe enough to require medical attention, knowing how to handle the injury immediately may make a big difference in outcome.

Cuts that penetrate most, or all the way through the skin need to be seen by a doctor. The primary reason for closing wounds with stitches is to prevent ongoing blood loss and infection. Even if the wound stops bleeding with pressure and a bandage, it may open up if there is any stress or stretch across the cut.

The doctor should clean and close the wound ideally within 6 hours. After 6 hours, the risk of infection becomes much greater. Sometimes cuts aren't deep, but they are contaminated by embedded dirt and debris. These wounds must be thoroughly cleaned out to prevent infection, and necessitate medical attention even if sutures aren't needed.

If blood is spurting from the cut, it means that an artery has been cut.

- Position the victim so that if he/she passes out, the victim will be protected. Lay the victim on the ground.
- Apply pressure directly over the wound, and elevate the limb above the level of the heart. Of course, if possible latex or vinyl gloves should be worn. Use gauze or a clean cloth to apply pressure directly over the wound.
- If there is a penetrating object, leave it in place.
- If bleeding continues, put more padding over the wound and continue firm compression. Don't remove the padding.

For wounds that are not spurting blood, the wound can be washed with soap and water, making sure that contaminated runoff does not go into the wound. Cover the wound with a gauze pad or clean cloth and tape or tie in place. Care should be exercised to observe the victim's facial color. Even with minor injuries, some people get faint and pass out from the site of blood. If either the victim or a bystander looks pale, feels nauseated, hot and sweaty, or dizzy, he/she should lay down. Elevate the feet. A cool compress can be applied to the back of the neck. Do not attempt to sit or stand the person up until color has returned, and feelings of nausea, dizziness, etc. have passed.

Worker Comp Liability *Continued from page 1*

Additional red flags include the employee having a second job or home business where he/she still works, past experience with worker compensation litigation, or multiple claims resulting in significant lost time. Red flags can be documented and declared by anyone in the process of the claim - management, physician, or claims agent. Once documented, the insurance carrier should be notified of the suspicion. All major carriers have fraud investigation units that employ various tactics to determine if fraud actually exists.

TCOM physicians routinely take note of inconsistencies in history, examination, and past injury claims when caring for employees. Although our physicians treat all patients with respect based on the assumption of patient honesty, once red flags are observed, they are noted in the record. Depending on the nature of the red flag, a call may be placed to the insurance carrier or employer to voice concern or request assistance in deciphering if additional flags are present. At times, specific examination to detect non-physiological or anatomical responses will be carried out. When red flags are detected, determinations of injury severity and work ability shift from incorporating subjective reports of the employee to focusing highly on the objective findings. At times, strategies to close a case quickly will be employed. These might include rapid imaging or nerve testing, referral for a second opinion, or a short course of physical therapy. In many instances, a well-trained therapist will document inconsistencies in history, physical abilities, and non-mechanical pain responses. With this documentation in hand, the physician is solidly grounded to tell the employee that further treatment is not indicated, regardless of his complaint of pain.

A REAL CASE: Recently, TCOM successfully terminated treatment for a construction worker who allegedly **slipped after working for one day** on the site. **The injury, un-witnessed**, resulted in severe back and leg pain. TCOM physicians, taking a thorough history, determined that this employee had serious back injuries in the past, but that **his history was vague, poorly recalled, and inconsistent**. He recalled last seeking treatment 1 year prior. Because of these red flags, **the physician called the employer**, who revealed that because **the employee had not been working to expectations**, the supervisor consulted with the shop steward and indicated that the **employee might be dismissed from the site**. Shortly thereafter, the employee reported the slip and fall. The site safety director could not find any ice in the area of the alleged fall. With this information in hand, TCOM physicians pressed hard for past medical records, calling the insurance company in addition to the employee's personal physician. Documents from his physician indicate that the patient was treated for severe back and leg pain two weeks prior to the alleged injury, and had been referred for additional pain management and epidural injections. Upon receipt of the records, the employee was discharged back to the care of his personal physician. The case was closed and the condition deemed pre-existing.

370 Campus Drive
Somerset, NJ 08873

TOTAL CARE OCCUPATIONAL MEDICINE

