

# NECOEM Reporter

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## NECOEM EVENTS

September 26

Joint Meeting with the Northeast Chapter of the AIHA

October

Watch for DIA/MA Bar Assoc and NECOEM event regarding impartial medical exam

November 29 and 30  
NECOEM/MaAOHN  
ANNUAL  
CONFERENCE

Program to include:

ID, Mental Health, Upper Extremity Injuries, Lumbar Degenerative Disk Disease, Fit for Duty, ADA, Problematic Pre-Placement, Lung Disease, Spirometry, Nanotechnology, Global Warming Problems and Solutions, Divisions in OH, Pain Management Program Pitfalls, Physical Treatments for Low Back Pain, Heart Disease among Firefighters, Fish, Mercury, Child Development, Phthalates and Male Health

For details, raffle and more  
VISIT [WWW.NECOEM.ORG](http://WWW.NECOEM.ORG)

## THE §11A SYSTEM NEEDS A TUNE UP

By Channing Mignor, EsQ.

The impartial examination report is the cornerstone of the medical dispute resolution process at the Department of Industrial Accidents. The §11A statute requires the impartial physician examiner to provide an opinion on diagnosis, causal relationship, and extent of disability and express other medical opinions sought by the parties or as requested by the hearing judge. The §11A exam process has been in place since 1991. As we enter our 16<sup>th</sup> year using

the one medical opinion system, we need to engage in making this form of special medical evidence as complete, fair and responsibly delivered as possible. A tune up is needed.

Since convening in 2006, the Massachusetts Bar Association (MBA) Workers Compensation subcommittee on Impartial Examiners has recognized that, in some instances, the quality and content of the §11A reports fall short of the mark.



Some §11A reports may be incomplete due to time or financial pressures. The

*(Continued on page 2)*

## A Lawyer's Perspective on Pre-employment Physical Examinations

by Anne-Marie L. Storey, Esq.

As an attorney who defends employers in workers' compensation and disability related claims, I would like to share my perspective on the pre-employment physical examination process.

It is important for medical providers to understand that most employers in New England, may be subject to laws which protect otherwise qualified applicants

and employees from discrimination on the basis of physical or mental disability. At the pre-hire stage, employers are essentially limited to telling applicants what the physical requirements of the job are and asking if they are able to satisfy these requirements. The employer may not ask questions likely to solicit information about a disability, may not conduct

medical examinations that seek information about physical or mental impairments or health, and may generally not ask applicants whether they will need a reasonable accommodation to perform the job. Once a bona fide conditional job offer is made, the employer may then ask disability-related questions as long as this is done for all employees hired into that job cate-

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## In Memoriam

Alain J. Couturier, MD, MS, FACOEM, passed away unexpectedly on May 25, 2007. Dr. Couturier received his B.S. at the University of Rhode Island in Kingston in 1980. He received his medical degree from Brown University School of Medicine in 1985 and a Master of Science degree in Health Sciences from Purdue University in 1990. He completed his residency in Occupational Medicine at Boston University Medical Center, and was well-published in the field of Occupational and Environmental Medicine. He was formerly a member of the Editorial Board of *The Occupational and Environmental Medicine Report* for OEM Press. In 2000, Dr. Couturier edited the textbook *Occupational and Environmental Infectious Diseases*. He served as Clinical and Executive Director in various health networks and received many honors including Phi Beta Kappa (University of Rhode Island) and Phi Kappa Phi (Purdue University). Most recently he worked as a Medical Consultant for Unum in Portland, Maine. Dr. Couturier was a die-hard Red Sox fan. He was a loving husband and father, and he will be sorely missed by his friends and colleagues.



(Continued from page 1) §11A

MBA believes the paramount concern is that the injured worker, with whom no doctor-patient relationship is established by §11A, is nonetheless treated with the full dignity and respect she deserves. The completeness of the report produced by the §11A examination process is critical to achieving this goal and to the process of evaluation by the presiding judge.

Both parties to the medical dispute are represented by counsel, who have submitted organized medical records to be reviewed, along with a series of facts presumed to accurately reflect the circumstances of the accident or injurious occupational exposure. Following these are the optional hypothetical questions sought to be addressed by the medical examiner often concerning prior medical conditions and post accident activities. By statute, the impartial examiner's report is the only medical evidence generally admitted into the hearing record and will be given full weight. Under limited circumstances, the hearing judge can consider other medical evidence in making her decision, but this is an excep-

tion to the rule. The §11A doctor's role is crucial.

The impartial physician's report and subsequent testimony by deposition, if sought, are vital to a fair and prompt adjudication of an injured worker's claim and the interests of those other stakeholders in the workers compensation system: the responsible insurers, self-insurers, or affected employers. The MBA Workers Compensation subcommittee believes that certain issues in report writing are not consistently given proper attention. For instance, questions concerning disability and causation are frequently not adequately addressed. Hypothetical questions are sometime overlooked. As a result, challenges to the admissibility of the §11A medical reports are raised at the hearing. The hearings often occur some six to nine months after the medical exam has taken place. Frequently, depositions are then taken of the authoring §11A physicians a very long time after the exam has occurred, or of the examining (IME) physicians, arranged by the insurer or of the treating physicians engaged by the employees. Thus the opinions of these various and additional medical experts are called upon

to contribute their medical opinions to resolve the dispute. The one-medical opinion system contemplated by our statute can instead be transformed into a hydra headed monster of litigation.

Of course, this results in the already lengthy dispute resolution process being magnified disproportionately. Injured workers are often left without adequate funds to support themselves or insurers are required to pay longer than they may be obligated to. Other cases, which could reach the dispute resolution process more promptly, are significantly delayed and left waiting in the wings to be heard for weeks or months, while current cases in the system continue on.

To spotlight this issue and engage in a constructive dialogue with physicians, The MBA Workers Compensation subcommittee is preparing, with the assistance of the Department of Industrial Accidents and the support of the Health Care Services Board, a series of in service training opportunities. We plan to reach out to the community of impartial physician examiners on the roster estab-

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lished by the DIA. We will begin presentations this fall and winter with NE-COEM, as occupational medicine is well suited to understand and address the reporting requirements of the §11A system. The MBA will then continue a dialogue with physicians in different practice areas and throughout the state, especially geographic areas that are underserved.

**Three members of NECOEM are presently consulting with the MBA Workers Compensation subcommittee to develop its program: Dr. Robert Narpstek, Dr. Terence Doorly and Dr. William Patterson.** The subcommittee is also assisted by DIA Impartial Unit director, Sandra Jutras and Senior Judge Martine Carroll.

In many circumstances, the medical treatment sought in the disputed case is delayed to the point where it is no longer useful to the injured worker. A recent case involving a truck driver involved a wait of over three years to be allowed access to a surgeon for a second opinion. Families may be affected by the stress of severe financial hardship. A significant issue and recurring challenge for impartial physicians is to determine the role a preexisting medical condition plays in the workers disability. If the preexisting medical condition is significant, in many circumstances, the worker loses her case and faces the full financial burden of the disability. The challenge for the impartial physician examiner is to determine:

1. whether a preexisting condition exists
2. whether it has a work related origin
3. if it combined with the work injury
4. if it is a major cause or minor cause of the disability

If the ultimate conclusion of the impartial physician is that the work injury no longer plays a major role in the current disability or the need for medical

treatment, then the hearing judge will often conclude the insurer has no further financial responsibility. The financial cost of the disability will be borne by the injured worker. This may be either the correct result or a harsh and unintended consequence, depending on whether the §11A examiner has understood the correct legal standard to be applied.

In our presentations, we will offer examples of cases from a judicial standpoint to illustrate common problems presented by certain types of medical disputes and how various impartial physician examiners have responded with excellence. We will engage in a dialogue concerning those areas in reports where improvement is warranted.

The impartial physician examiner now receives a letter of instruction that has been revised this year by the impartial unit as a result of input of MBA members and administrative judges. Please see sample letter attached. We will be asking the doctors we address for input on this and whether a template should be developed to aid doctors in preparing their reports.

An important case decided by the Reviewing Board of the Department of Industrial Accidents was Viera (March 2005). As a result, administrative judges must now follow a defined analytical model in determining whether a preexisting condition has had a sufficient impact upon a disability claim or need for treatment sought by an employee. Since the medical evidence presented by the impartial physicians report is presumed correct until rebutted, administrative judges look to the §11A physician for medical guidance. Without a clear explanation of the role a preexisting condition may play in a case, a judge may not be able to fulfill her obligation and other sources of medical evidence have to be requested. In those circumstances, it takes considerably

longer for a dispute to be resolved.

Consider the following illustrations:

First, a stonemason with degenerative disk disease filed a claim for permanent and total disability from the effects of a 2000 lifting injury to his back. In 2002, the §11A physician offered an opinion which confirmed that the stonemason's back condition was permanent and he was disabled from gainful employment. But since there was no analysis of the role of the preexisting condition, the decision was not upheld on appeal. There was a failure to analyze the role of degenerative joint disease upon the 2000 workplace injury.

Second, a corrections officer with a long history of both pre-existing, non work related and pre-existing occupational knee conditions, reinjured his knee while separating prisoners during an altercation. The §11A doctor neglected to properly analyze the effect of the pre-existing arthritic knee condition, thus causing over a year of extended litigation.

Third, a 60-year-old nurse, with degenerative joint disease, sustained a low back disk injury and was seeking surgery, the need for which was disputed by the insurer. The §11A physician only commented on disability, not at issue in the dispute whatsoever, neglecting to advise the parties whether an L5-S1 discectomy was warranted. As a result, an addendum report was required, causing a delay of 6 months and a further inconvenience to the impartial physician examiner.

#### CONCLUSION

It is incumbent for the impartial physician to address all issues presented in an orderly and

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# WORLD MEDICAL ASSOCIATION WMA STATEMENT ON THE ROLE OF PHYSICIANS IN ENVIRONMENTAL ISSUES

Adopted by the 40th World Medical Assembly Vienna, Austria, September 1988, and  
Revised by the WMA General Assembly, Pilanesberg, South Africa, October 2006

## Introduction

1. The effective practice of medicine increasingly requires that physicians and their professional associations turn their attention to environmental issues that have a bearing on the health of individuals and populations.

2. More than ever, due to diminishing natural resources, these problems relate to the quality and protection of resources necessary to maintain health and indeed sustain life itself. In concrete terms, the key environmental issues are as follow:

a) The degradation of the environment, which must be halted as a matter of urgency so that resources essential to life and health water and pure air remain accessible to all.

b) The ongoing contamination of our reserves of fresh water with hydrocarbons and heavy metals, along with the contamination of ambient and indoor health by toxic agents, which have serious medical consequences, especially in the poorest segments of the globe. Moreover, the greenhouse effect with its concomitant proven rise in temperature should drive our discussions forward and prepare us for increasingly serious environmental and public health consequences.

c) The need to control the use of non-renewable resources such as topsoil, which should constantly be at the forefront of our minds, as should the importance of safeguarding this vital heritage so that it can be passed on to future generations.

d) The need to mobilize resources beyond national frontiers and

to co-ordinate global solutions for the planet as a whole, so as to formulate a unified strategy to confront these worldwide medical and economic problems.

e) The foremost objective is to increase awareness of the vital balance between environmental resources on the one hand, and on the other, biological essentials for the health of everyone everywhere.

3. Our growing awareness of these issues today has, however, failed to prevent an increase in our societies' negative impact on the environment, e.g., melting of glaciers and increasing desertification, nor has it halted the over-exploitation of natural resources, e.g. pollution of rivers and seas, air pollution, deforestation and diminishing arable land. In this context, the migration of people from disadvantaged or developing countries, together with the emergence of new diseases, exacerbates the lack of socioeconomic policies in many parts of the world. From a medical point of view, growth of the population and irresponsible destruction of the environment are unacceptable, and medical organizations throughout the world should redouble their efforts, not only to speak out about these problems, but also to suggest solutions.

## Principles

4. In their role as representatives of physicians, medical associations are duty bound to grapple with these environmental issues. They have a duty to produce analytical studies that include the identification of problems and current international regulations on environmental issues, as well as their impact on the field of health.

5. As physicians operate within the framework of ethics and medical deontology, the environmental regulations advocated should not seek to limit individual autonomy, but rather to enrich the quality of life for all and to perpetuate life-forms on the planet.

6. The WMA should therefore act as an international platform for research, education, and advocacy to help further sustain the environment and its potential to promote health.

7. Thus, when new environmental diseases or syndromes are identified, the WMA should help coordinate the scientific/medical discussions on the available data and their implications for human health. It should foster the development of consensus thinking within medicine, and help to stimulate preventive measures, accurate diagnosis and treatment of these emerging disorders.

8. The WMA should therefore provide a framework for the international co-ordination of medical associations, NGOs, research clinicians, international health organizations, decision-makers and funding providers, in their examination of the human health effects of environmental problems, their prevention, remediation and treatment for individuals and communities.

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## Obese Injured Workers Cost Employers More

Craig W. Curtis, M.D.

If employers don't have enough reasons to encourage fitness, preventive health and embark on employee health programming, a new study in the April 2007 *Archives of Internal Medicine* just added one more.

The 7-year study included more than 11,700 Duke University workers and reviewed a total of 2,539 workers' compensation claims. These claims were estimated at a cost of over \$5 million in medical and \$5 million in indemnity rewards, not a trivial cost for an employer or insurer. Duke University self-insures for worker's compensation.

The study, authored by Truls Ostbye, M.D., Ph.D. from the community and family medicine department of Duke University found that workers' compensation claims were more common and costlier for obese employees. They based their finding on medical records data showing that 2% of these workers were underweight, 42% were of normal BMI, with 30% overweight but not obese, 21% being mild to moderately obese and 5% severely obese.

They established a clear lin-

ear relationship between BMI and rate of claims. Employees in obesity class III (BMI >40) had 11.65 claims per 100 FTEs while normal weight employees reported 50 % less claims, having only 5.8 claims per 100 FTEs.

were related to: lower extremity, wrist or hand, and back as body parts affected. The nature of the illness or injury included pain or inflammation, sprain or strain, and contusion; with falls or slips, lifting and exertion. Ostbye concluded that the combination of obesity and high-risk occupation was a particularly detrimental combination.

As with many health-related studies, many factors play into the maintenance of illness and injury. This study supports the fact that moderately to severely obese employees incur higher rates of work injuries with higher costs. It would argue, along with many other studies, that the investing in our employees' general health and fitness would be a cost effective strategy to make companies

more productive and efficient. Weight loss along, smoke cessation, health screenings, etc. all would add to the bottom line. It is just a matter of getting the employers and employees to take those first steps.

Source: Ostbye, T. et. al *Obesity and Workers' Compensation*, Arch of Internl Med 2007; vol 167: pp766-773

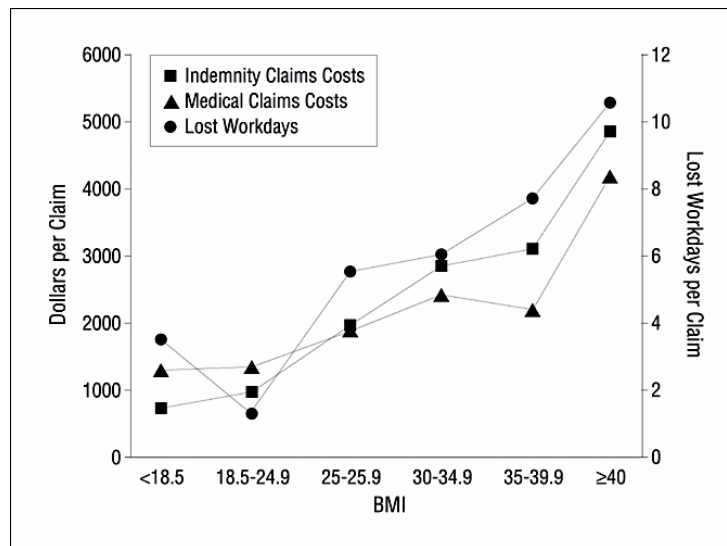


Figure 1. Mean indemnity claims cost, medical claims costs, and number of lost workdays per claim by body mass index (BMI) category.

An even stronger link was found when looking at the effect on lost workdays with 183.63 vs. 14.19 lost workdays per 100 FTEs; medical claims costs (\$51,091 vs. \$7,503 per 100 FTEs. Finally, the effect was even stronger with indemnity claims costs totaling \$59,178 vs. \$5396 per 100 FTEs. They also concluded that the claims most strongly affected by BMI class

(Continued from page 3) §11A clear fashion at the time §11A of the evaluation and to express a complete opinion in the body of the report that is furnished to the judge and the parties. Without this, extensive and unnecessary litigation will surely ensue. The MBA knows that §11A physicians provide a great public service to the workers compensation system.

With constructive feedback from bench and bar, §11A reports can be made even better. The MBA looks forward to working with NECOEM to launch this project. We are soliciting feedback and would appreciate any comments to improve the §11A system from NECOEM members. Impartial Unit Director Sandra Jutras can be reached at sandraj@dia.state.ma.us.

Attorney Channing Migner is chair of the MBA Workers Compensation subcommittee on Impartial Examiners. He has practiced Workers Compensation law since 1985, representing injured workers. He is a member of the Board of Directors of WILG (Workers Injury Law & Advocacy Group) and a graduate of Suffolk University Law School. He can be reached at cm@MassWorkersCompHelp.com

## From Rhode Island

Steve McCloy, MD, Pawtucket RI



Rhode Island's Slater Mill was the birthplace of the industrial revolution in the Colonies. True to the character of "Rogues' Island," the plans were stolen and carried from the British Isles in Slater's brain.

The past thirty years have witnessed an awesome change in RI's industry and job markets. In 1977, RI was the costume jewelry capital of the world. Browne and Sharpe enjoyed a worldwide reputation for precision measuring instruments. Gorham Silver produced the Americas Cup and the Newport team won it each year. Union Wadding, a producer of textiles for the Continental

Army, closed its doors. So did Gorham. Browne and Sharpe still exists as a shadow of itself. Narragansett beer is brewed somewhere else. Providence has washed off much of its industrial grime to become the Renaissance City. And, the mayor will finish his prison sentence this summer.

This state of one million people has ten NECOEM members. How have they fared in this topsy-turvy state?

**Susan Andrews, MD** brought her skills as the director of a prison medical system to Electric Boat in Quonset. "EB" is the state's largest non-governmental employer. **Jay Burstein, MD, MPH** directs Corporate Care, a provider of occupational health services out of St. Joseph Hospital's Providence Unit. **Susan Green, MD, MPH** directs a busy practice of OEM out of Newport Hospital in southern RI.

At the opposite end of the state in Woonsocket, **Jacqueline Hess, MD, FACOEM** is medical director at CVS, a nationwide pharmacy chain. **Dana Sparhawk, MD, MPH** was Occupational Health + Rehab's first physician. He has brought his veteran

skills with him as OH+R melded into Concentra.

Though not currently an ACOEM member, **T. Nicolas Tsiongas, MD, MPH** left his private practice of OEM to become the medical director of the Southeastern New England region of the United States Postal Service.

I could not reach **Patrick Ford, MD, CIH, FACOEM** or **Horace Martin, MD, PhD, JD, MACOEM** to learn what they are doing and where.

Is there anyone in private OEM practice? Yes. **Randall L. Updegrove, MD, MPH** practices out of University Orthopedics, a large multi-site practice affiliated with Lifespan Hospitals. **Steven G. McCloy, MD** hung his own solo practice shingle September 2005 after a six-year career at OH+R.

It is important also to recognize the contribution to industrial health by other physicians who are not members of NECOEM as well as the daily work of our associate clinician colleagues who are nurse practitioners and physician assistants.

## From Massachusetts

Robert Naparstek, MD, Avon, MA



On May 17, 2007 the Massachusetts Medical Society endorsed a resolution pertaining to eliminating

Mercury from the medical waste stream. The Committee on Occupational and Environmental Medicine (Chair-Dr. Dean Hashimoto) put forth a resolution that the Society should encourage hospitals and all private doctors' offices to endeavor to rid their practices of the use of Mercury (e.g.-sphygmomanometers, thermometers, feeding tubes, batteries, thermostats) and recycle all existing Mercury as soon as possible. Although, efforts to this goal have already been underway such as recycling fluorescent bulbs, health-care, according to the EPA still remains the third largest contributor of Mercury pollution and its resultant morbidity

and mortality. In fact, in 2000, Mercury thermometers accounted for seventeen tons or 10 per cent in the municipal solid waste stream. Presently, the CDC estimates that one in ten American women currently has a high enough Mercury level to cause neurological effects in their offspring. There is still up to fifty times more Mercury in medical waste than municipal waste.

For further information please go to [www.noharm.org](http://www.noharm.org).

(Continued from page 1) **Pre-Employment**

gory. An employer could be at risk collecting this information.

This is where the value of a pre-employment physical comes into play. A properly conducted pre-employment physical examination should provide the employer the information it needs to determine whether an employee is capable of performing the essential functions of the job, and whether reasonable accommodation is needed to allow the employee to do so. A poorly conducted pre-employment physical examination can have the opposite result.

Therefore, to conduct a useful pre-employment physical, the physician must have a current and complete list of the essential job functions of the prospective job. Without this information, the physician has no basis on which to evaluate the employee and determine whether he can perform the job or whether he needs reasonable accommodation to do so.

The value, or lack thereof,

of a pre-employment physical examination does not end at the time of hire. Lawyers are often in a position to use the results of pre-employment examinations in other ways. For instance, suppose an employee injures his back while working for one employer. He leaves that job and is hired by a subsequent employer for similar work. When he experiences back pain again, he brings a claim against both employers for workers' compensation benefits. The lawyer defending the claim for the first employer will certainly want to know if a pre-employment physical examination was conducted prior to the second job. If it was, and it does not show that the individual had any lifting or other restrictions related to his back, those results can be used to show that the employee's injury is related solely to the subsequent employer.

Likewise, if the physical examination shows ongoing complaints or restrictions, the lawyer defending the second employer will use it to show

that the injury from the first job had not resolved.

These are just a few of the issues raised by pre-employment physical examinations. The bottom line is that a decision should first be made about whether a pre-employment physical examination is reasonable and necessary for the job category at issue. If it is, the pre-employment physical examination must be performed thoroughly and with a full understanding of the job at issue in order to be of value to the hiring employer.

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## From Vermont

Verne Backus, MD, , St. Albans , VT



A year ago in the Vermont NE-COEM News we were happy to report that legislative changes to

the Vermont Workers' Compensation fee schedule were planning for an increase in 3 parts on January 1, 2007, October 1, 2007 and lastly January 1, 2008. Each increase is 1/3 of a plan to bring the fee schedule from what had been set to be equivalent to BCBS rates averaged in Vermont and New Hampshire in 1994

when they were last increased to similar BCBS levels that are current. The first 1/3 did go into affect last January. I called our current Director of Vermont's Workers' Compensation and Safety Division, Stephen J Monahan and asked him about the outcome of the study that had been authorized under State Bill # H.109 which I had discussed in the Summer, 2006 NE-COEM newsletter that allow the Department of Labor to examine the cost of the fee increases. If this study had found the fee schedule increases were to put an "undue burden" on the worker's compensation cost then it could have led to aborting the fee increases. The study however predicted that reductions primarily in numbers of new claims and to a lesser degree maybe reduction in lengths of claims would offset the fee increases and ac-

ording to what I learned this has indeed occurred for the first 1/3 increase that took effect on Jan 1, 2007. Furthermore it is predicted the 2nd and third increases will be similarly absorbed by the cost reductions. This is certainly good news given that Vermont has a much higher than average rate of injuries compared to other states. One other detail regarding the fee changes relates to outpatient anesthesia charges which were inadvertently not included in the changes. The was apparently an oversight and work is being done to work out and implement increases for this as well.

A new item to report with this newsletter is a current project to reduce the administrative burdens built into the Vermont Workers' Compensation system. This came about unexpectedly

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## NECOEM

NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the pre-eminent organization of occupational and environmental physicians, associate and affiliate clinicians.

NECOEM has over 200 physician, associate and affiliate members and is dedicated to preventing and treating occupational injuries and illnesses. NECOEM provides continuing medical education for its members and other clinicians in order to enhance the care that they provide to men and women in the workplace. NECOEM is an advocate for workplace safety, occupational health research, raising public awareness of occupational and environmental health issues, providing guidance on public health policy, and recognizing outstanding achievement by individuals in occupational and environmental health.

*The editorial board welcomes letters to the editor. Write or email to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes.*

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*(Continued from page 7)*

from a provision in a the Catamount Health Plan program from 2 years ago that it was realized this year applies to Workers' Compensation too. The result is expected to lead to some streamlining

and include faster payments to providers. Vermont's WC system is a "form" driven system that can be quite cumbersome at present.

As always feel free to continue any other dialog with me at [vbackus@gmail.com](mailto:vbackus@gmail.com) and we can include in future newsletters.