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Workers' Compensation and Disability News • Summer 2009



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Protecting Your Job While Coping With a Chronic Illness

By Lesley Alderman

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It started with an odd sensation in her right hand and a feeling of exhaustion so profound she could hardly get through an hour of work, let alone a full day.

After numerous tests and countless doctors' visits, Natasha Frechette, then 27, learned she had multiple sclerosis, a disease that attacks the central nervous system and can cause numbness, blindness and eventual paralysis.

In addition to grappling with the diagnosis, Ms. Frechette was concerned about keeping her job as a data manager for a small research organization in

Brooklyn Park, Minn. "I didn't want to have to depend on someone to take care of me," she said. "But I know that I could wake up tomorrow and not be able to walk."

Workers with chronic illnesses face chronic uncertainty, forced to worry not only about their health but about their jobs as well. The protections afforded chronically ill workers in the United States are thin and somewhat vague. To protect their health and their jobs, workers must navigate employers' policies, which may include short- and long-term disability plans, as well as a patchwork of federal laws and regulations.

A recent study by the Center for Economics and Policy Research, a Washington research organization, found that among 22 rich nations, the United States was the only one that did not guarantee workers paid time off for illness.

Most other countries provide their workers not only with paid sick days, but also time off for cancer treatments, the study found. German citizens, for example, are allowed five sick days and 44 days for cancer treatment, if needed, in addition to vacation days.

Most employers in the United States allow employees to take days off for minor ailments, like the flu or outpatient operations, without docking their pay. And 41 percent offer employees days off - nine, on average - for illness or other reasons, in addition to vacation days, according to a 2007 survey by Mercer, a benefits consulting business based in New York.

But when an employee has a serious or chronic illness, like diabetes, major depression or lupus, the rules about time off become murky.

Two laws offer workers some relief. The Family and Medical Leave Act allows employees to take up to 12 weeks off each year for medical or family emergencies - but without pay. And the Americans With Disabilities Act requires employers to make reasonable adjustments for disabled workers, often in the form of additional time off.

Ms. Frechette explained her condition to her supervisor and said she would need time off for physical and occupational therapy. Her boss



readily agreed, and Ms. Frechette, who plans to marry this fall, continues to work full time. "I'm careful," she said. "I don't want my disease to be seen as a cop-out."

If you are dealing with a chronic illness, here are some strategies to help you maintain your job.

INFORM YOUR EMPLOYER

If you have a condition that could interfere with your performance, tell your boss. "People are often afraid of being discriminated against," said Rosalind Joffe, a career coach who counsels people with chronic illnesses. "I had one client who didn't disclose his illness to anyone. His odd behavior led his boss to conclude he was a drug abuser."

Be honest. Explain what your condition is and how it might affect your work. "Don't be ashamed," Ms. Frechette said.

A supervisor who understands what is wrong is less likely to make false assumptions about what you can and cannot do. "Be clear about your value and what you can deliver," Ms. Joffe said. "If you're a valued employee, your boss will work with you."

If you feel you are being unfairly treated, speak with your supervisor. If that doesn't work, go to the human resources department.

ASK FOR ADJUSTMENTS

If your illness meets the definition of a disability, your employer is required to make reasonable accommodations to your job or work environment, according to the Americans With Disabilities Act.

What is a disability? "It's a physical or mental impairment that substantially limits one or more major life activities," said Chris Kuczynski, director of the division that deals with the disability act at the federal Equal Employment Opportunity Commission.

Although your illness may be episodic or controlled by medications, it is still a disability,

according to a recent amendment to the law.

Your employer does not have to provide an accommodation if it would impose significant difficulty or expense. Asking for a car and driver to take you to and from work would probably not be reasonable, Mr. Kuczynski said. But taking time off for chemotherapy treatments certainly would.

According to the Society for Human Resource Managers, the top five accommodations for the disability act provided by employers in 2005 (the last year for which data are available) were parking or transportation modifications, making existing facilities accessible, offering new equipment to workers, restructuring jobs and modifying the work environment.

If you are not sure what type of accommodations you are entitled to or how to ask for them, contact the Job Accommodation Network (800-526-7234), a service provided by the federal Department of Labor. In general, the network recommends that you put your request to your employer in writing. If you work in a small, informal setting, that may not be necessary.

KNOW THE TIME-OFF POLICIES

You can learn about the on-the-books rules by going to your company's intranet or speaking with its human resources department.

If you need to take a few weeks or months off for an operation, for example, or chemotherapy, research your company's short- and long-term disability plans. Disability policies typically allow you to take a specific time off at reduced pay.

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"I'm careful, I don't want my disease to be seen as a cop-out."

Natasha Frechette,
Data Manager,
Brooklyn Park, MN

Protecting Your Job...

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According to Mercer, the consulting firm, 78 percent of employers offer short-term plans and 80 percent offer long-term disability plans.

You can also tap into your 12 weeks of family and medical leave at any time. You may take the time intermittently or all at once. You will not be paid, but your job will be secure.

EXPLORE ALTERNATIVES

If the hours are too long or the work is too taxing to handle while you are ill, find out whether you could work part time or could even take a different job in your company.

If neither is feasible, explore new career possibilities. One of Ms. Joffe's clients was a high-powered lawyer who had a serious heart condition. To reduce stress, he decided to give up litigation and become a teacher.

If you are worried about your finances or health insurance, be sure to check with the advocacy organization focused on your disease. The American Cancer Society, for instance, has a call center (800-227-2345) that helps people who don't have health insurance or are on the verge of losing it.

If your illness finally prohibits you from working altogether, you may apply for Social Security disability insurance. The process is lengthy, and you must be able to prove that you cannot work at any job. The amount you are paid is based on your lifetime earnings - you can find the number on the annual statement you receive from the Social Security Administration.

Generally, payments are modest: the average in 2008 was \$1,063 a month. But once you have received disability payments for two years, you automatically qualify for Medicare coverage. ■

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Hispanic Worker Deaths Up 76% Since 1992

By Rick Jervis

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The number of Hispanic workers who die on the job has risen, even as the overall number of workplace deaths has declined, according to federal statistics.

Hispanic worker deaths increased from 533 in 1992 to 937 in 2007 - a 76% jump. In the same period, total fatalities in all jobs nationwide fell from 6,217 to 5,657, according to the data. The 2007 tally, the latest available from the U.S. Bureau of Labor Statistics, followed a record 990 Hispanic deaths in 2006.

Last year, officials at the Occupational Safety and Health Administration office in Dallas investigated

Industries with highest Hispanic fatalities in 2007

	Construction	317
	Transportation & Warehousing	115
	Natural Resources & Mining	108
	Agriculture, Forestry, Fishing & Hunting	73
	Manufacturing	62

Source: U.S. Bureau of Labor Statistics

50 Hispanic workplace deaths in Texas alone, according to OSHA figures. So far this year, they've investigated 21 fatalities, including three workers who fell 11 stories from a collapsed scaffolding last month in Austin.

"I am particularly concerned about our Hispanic workforce, as Latinos often work low-wage jobs and are more susceptible to injuries in the workplace than other workers," Hilda Solis told USA TODAY. "There can be no excuses for negligence in protecting workers, not even a language barrier."

More Hispanics in the workforce can account for some of the increase in deaths, said Peg Seminario, safety and health director of the AFL-CIO. In 1998, Hispanics represented 10.4% of the U.S. labor force, according to the U.S. Bureau of Labor Statistics. In 2007 they accounted for 14%. Lack of training, poor communication skills and exploitation of workers also lead to accidents and deaths, Seminario said.

Hispanic workers have fallen off roofs, been crushed under heavy machinery and run over by trucks, according to workers' rights advocates, such as the Austin-based Workers Defense Project. Austin alone has reported four Hispanic deaths this year. Last month, OSHA pledged to bolster the number of inspectors in Texas in response to the growing number of construction-related deaths, more than half of them Hispanic.

Workers without legal documentation to be in the U.S. are less inclined to join a union, which helps protect workers, or protest when conditions seem dangerous, said Raj Nayak of the California-based National Employment Law Project. "They're doing the most dangerous work for longer hours," Nayak said. Jose Omar Puerto, 19, from Honduras, was repairing a roof on an Austin apartment building in 2007 when his aluminum ladder became entangled in electrical wires. He was electrocuted and killed, his sister, Marta Puerto, said.

His company paid for the funeral and the body's return to Honduras, she said. The family received

no further compensation.

"It's an injustice how my brother died," Marta Puerto said. "There are a lot of cases like this, not just my brother's. We need better laws to protect Hispanics."

Some of the fatalities among Hispanics could have been avoided with proper training, said Michael Cunningham of the Texas State Building and Construction Trades Council, a labor consortium. "No matter what country they're from, whether they're here legally or illegally, someone should make sure they have the proper training," he said. ■

“There can be no excuses for negligence in protecting workers, not even a language barrier.”

*Hilda Solis
U.S. Secretary of Labor*

Veterans Affairs Faces Surge of Disability Claims

By James Dao

From The New York Times, July 12, 2009 © 2009 The New York Times All rights reserved.

He jumped at loud noises, had unpredictable flashes of anger and was constantly replaying battle scenes in his head. When Damian J. Todd, who served two tours in Iraq with the Marine Corps, described those symptoms to a psychiatrist in January 2008, the diagnosis was quick: he was suffering from post-traumatic stress disorder.

Less swift was the government's response when Mr. Todd submitted, a month later, a disability claim that would entitle him to a monthly benefit check. Nearly 18 months went by before the Department of Veterans Affairs granted his claim late last month,

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"We've got veterans sleeping under bridges or struggling to fit back in with their families or looking for jobs."

*Representative John Hall,
Democrat of New York*

Veterans Affairs Faces Surge...
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Mr. Todd said.

Mr. Todd, 33, is part of a flood of veterans, young and old, seeking disability compensation from the department for psychological and physical injuries connected to their military service. The backlog of unprocessed claims for those disabilities is now over 400,000, up from 253,000 six years ago, the agency said.

The department says its average time for processing those claims, 162 days, is better than it has been in at least eight years. But it does not deny that it has a major problem, with some claims languishing for many months in the department's overtaxed bureaucracy.

"There are some positive signs in terms of what we're doing," said Michael Walcoff, deputy under secretary for benefits in the Veterans Benefits Administration. "But we know that veterans deserve better."

Mr. Walcoff said the department recently finished hiring 4,200 claims processors, but many will not be fully trained for months. The Government Accountability Office reported last year that the Veterans Affairs Department had about 13,000 people processing disability claims.

The larger significance of the backlog, veterans groups and officials said, is that resources for veterans are being stretched perilously thin by a confluence of factors beyond the influx of veterans from Iraq and Afghanistan.

Aging Vietnam veterans with new or worsening ailments are requesting care. Layoffs are driving unemployed veterans into the department's sprawling health system for the first time. Congress has expanded certain benefits. And improved outreach efforts by the department have encouraged more veterans to seek compensation or care.

Mr. Walcoff said the vast majority of the 82,000 claims the department received each month were not from veterans returning from the current wars. "We're still getting a lot of Vietnam vets," he said.



Veterans advocates say the actual backlog is nearing one million, if minor claims, educational programs and appeals of denied claims are factored in. They point to the discovery last year of benefits applications in disposal bins at several department offices as evidence of shoddy handling of claims. And they assert that they routinely see frustratingly long delays on what seem like straightforward claims.

One group, Veterans for Common Sense, has obtained records showing that some veterans are calling suicide hotlines to talk about their delayed disability claims. The group has called on the department to replace Veterans Benefits Administration leaders.

"We're not saying vets are threatening to commit suicide over the claims issues," said Paul Sullivan, executive director of the group. "We're saying V.A.'s claim situation is so bad that it is exacerbating veterans' already difficult situations."

The sprawling veterans compensation and pension system is expected to pay \$44 billion in benefits to about three million people this year, the largest group of whom served during the Vietnam War.

Under the system, veterans who can demonstrate that a psychological or physical problem resulted from their military service are eligible for compensation and, if the injury is severe enough, free health care. (All new veterans are eligible for health care for five years after they leave service, regardless of whether they are injured.)

Compensation is scaled by the severity of the disability: a veteran with dependents who is rated 100 percent disabled, and therefore unable to work, is eligible for more than \$3,000 a month. Post-traumatic stress disorder, or PTSD, has emerged as one of the most prevalent disability claims, after ailments like back pain and knee injuries. Not only are many new veterans receiving a diagnosis of the disorder, but an increasing number of Vietnam veterans are also reporting symptoms for the first time, officials and advocates said.

Delays in getting PTSD claims approved have prompted members of Congress to propose legislation that would reduce the documentation required to prove that a veteran's disorder was caused by specific combat events. Finding such documentation can be difficult for Vietnam veterans, whose memories of events 40 years ago may have grown hazy. Records from that era are also often difficult to find, advocates said.

Veterans who did not serve in combat units but who may have been in firefights or witnessed traumatic events like roadside bombings - common events in Iraq and Afghanistan - also report difficulties documenting the sources of their disorder.

Those hurdles have added to the claims backlog, advocates said. Legislation proposed by Representative John Hall, Democrat of New York, would require the government to grant claims by veterans with the disorder once they demonstrated simply that they had served in a combat theater, which would include all of Afghanistan, Iraq and Vietnam.

The projected cost of the legislation, \$4.7 billion over 10 years, according to the Congressional Budget Office, has become a stumbling block. But Mr. Hall said the cost would be offset by the benefits of reducing the backlog, avoiding appeals of rejected claims and speeding compensation to veterans.

"We've got veterans sleeping under bridges or struggling to fit back in with their families or

looking for jobs," Mr. Hall said. "It's no time to be messing around with compensation that we probably owe them and will probably pay them anyway."

The legislation might have eased the process for Mr. Todd, who flew helicopters in Anbar Province for seven months in 2005 and then served 10 months with an infantry unit in Ramadi, an insurgent stronghold, in 2006 and 2007. He left the Marines in 2007 as a captain.

Many months after Mr. Todd received the PTSD diagnosis and first submitted his claim, the department asked him to document two stressful events that might have caused his trauma. For one, he described driving a girl to the hospital after she was torn apart by a bomb. She survived, but the memory still brings him to tears.

Now attempting to start his own business, Mr. Todd, who lives in Orange County, N.Y., said he would receive \$770 a month for his disorder, as well as for shoulder, back, knee and hearing problems linked to his service.

"There are a lot of other kids who need the money more," he said. "I just want the process to change, because it is ridiculous." ■

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“By reducing the administrative costs of health care, we can better spend those resources on patient care and health improvement.”

Sanne Magnan
Commissioner of Health

E-Billing Initiative Reported Off to Generally Smooth Start

By Bill Kidd

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Minnesota health care providers and payers began using electronic for claims — including those involving workers’ compensation patients — on July 15 as part of a state-mandated program aimed at cutting costs and improving efficiency.

Initial signs are that the effort is proving successful.

Jim Golden, director of the Division of Health Policy at the Department of Health, reports the program has run smoothly overall during its first three weeks – with some minor problems.

“We have had no formal complaints,” Golden told WorkCompCentral Friday. “There has been some confusion about what happens if a provider or payer is unable to comply.”

“But we have resolved things through informal conversations...We don’t believe everyone is fully compliant, but we think they are making good-faith efforts to get into compliance,” Golden said.

Golden reported that while group health care plans have been using e-billing “for some time,” workers’ compensation carriers and property and casualty insurers tend to have less experience with the practice.

“We’ve tried to work with the workers’ comp carriers...We’ve been in contract with Texas and California for advice,” Golden said. “We wanted

to be as consistent as we could to minimize the challenges in compliance.”

One challenge has been with clearinghouses, Golden said — because the clearinghouses aren’t always able to “talk to each other.”

Workers’ compensation carriers may be using a clearinghouse that is perfect for handling their claims, while health care providers may have a different clearinghouse that handles their billings without problems — but the clearinghouses “don’t always connect,” Golden said. “We have discussed this with the clearinghouses,” he noted.

Minnesota’s law requiring e-billing covers approximately 60,000 providers, including doctors, hospitals, dentists, chiropractors, pharmacies and others.

The Department of Health reports that more than 55 million health care claims from the providers are processed in Minnesota, “resulting in significant transactions costs — and opportunities for savings.”

The e-billing requirements are part of broader statewide health reforms, Commissioner of Health Sanne Magnan noted. “By reducing the administrative costs of health care, we can better spend those resources on patient care and health improvement,” Magnan said.

The Department of Health estimates that when the law is fully implemented, the electronic exchange of routine health care business transactions will save the state’s health care system more than \$60 million per year.

The requirements that took effect July 15 call for providers to bill for their services electronically, using a single, standard data content and format, and for payers to accept the electronic bills.

The new requirements do not change the nature of transactions between consumers and their providers or health plans, the department noted.

The regulations apply to all health care providers who provide services for a fee in Minnesota and who are also eligible for reimbursement under the state’s Medical Assistance program.

Payers covered by the law include such “group purchasers” as insurance carriers and third-party administrators licensed in or doing business in Minnesota.

The insurance carriers covered by the law include workers' compensation, automobile and property-casualty carriers.

The law also applies to accident and health insurers, HMOs, the Minnesota Department of Human Services, which administers the state's Medical Assistance and MinnesotaCare programs, and other payers.

Golden reported that in January, payers and providers were required to exchange “eligibility verification transactions,” but workers' compensation carriers were exempted from the requirement. The carriers will be included in remittance advice exchange requirements — involving explanation of what has happened with a claim — in December, he said.

Jennifer Lundblad, president and chief executive officer of Stratis Health and cochairwoman of the e-Health Advisory Committee, noted that the last initiative is “part of a bigger effort” to move Minnesota to greater use of electronic options in the health care sector.

“We hope that it will improve cost and efficiency,” Lundblad said.

Thus far, Lundblad reported, “I think it has gone relatively smoothly. Whenever there is change, you will have some bumps along the way.”

Lundblad said professional organizations and trade associations have helped in providing technical expertise and support to the effort. “I think everyone is committed to making it work,” she added.

Golden said the department also is working with stakeholders to comply with the changes required under HIPAA for electronic exchange of information.

The federal government requires that the current version (4010A1) be changed to the new version (5010) by January 2012, Golden said. “We're working on what changes we will need to make to do that,” he reported. ■

Benefit of Popular Spinal Surgery Is Questioned

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By Joseph Pereira and Keith J. Winstein

In the past decade, a low-risk technique for repairing fractured bones in the spine has surged in popularity, to an estimated 100,000 operations last year in the U.S.

But in the first two studies to rigorously examine the effect of the procedure, known as vertebroplasty, researchers found no detectable benefit when compared with a placebo group of patients who received a sham procedure that only mimicked the real thing.

It was the latest of several cases in which a popular medical procedure has been called into question by independent studies. The results are likely to stir further debate about assertions—heard often in the Washington debate over health-care legislation—that unnecessary or relatively ineffective medical procedures are contributing to soaring costs.

Vertebroplasty is usually performed by radiologists, who inject bone cement directly into a fractured

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"Vertebroplasty should not be done any longer, unless it's in the setting of a study."

*Jeffrey Jarvik,
University of
Washington and senior
author on one of the
studies*

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vertebra to shore it up. The procedure, which is covered by Medicare, ranges in cost from \$2,000 to \$5,000.

"Vertebroplasty should not be done any longer, unless it's in the setting of a study," said Jeffrey Jarvik, of the University of Washington, who served as the senior author on one of the studies, which was funded by the National Institutes of Health.

The results, published in this week's *New England Journal of Medicine*, will also focus more attention on "comparative-effectiveness" research-studies, endorsed by the Obama administration and draft health-care bills in Congress, that aim to assess the benefits of different treatments already on the market. A number of Republicans in Congress and others have opposed more federal funding for such research on the ground that it will lead the government to decline payment for new treatments of individuals until they are proven to work on large groups.

"If we're going to institute health-care reform, this is an example of what can and should be done" to justify paying for popular but unproven procedures, Dr. Jarvik said. "There's rigorous evidence that [vertebroplasty] doesn't work any better than a control intervention, and we should stop paying for it."

Some members of the Society of Interventional Radiology, which recommends the procedure, disagreed. "We take a patient who's been lying in bed in a hospital, bedridden, you do the procedure and they're home the next day. That is not a placebo," said Allan Brook, the director of interventional neuroradiology at Montefiore Medical Center in New York City.

Dr. Brook contended that patients in the studies may not have been the ones who could benefit most from the surgery—those with the most pain. He noted that most patients who were offered the chance to participate declined to enroll, which he says suggests that they didn't want to take the chance of being assigned to the "control" group that received the fake surgery.



"When someone takes out your appendix for an infection, there was never a trial for that. You just need it," Dr. Brook said.

The federally funded study signed up 131 patients in the U.S., Britain and Australia. Half of them received a vertebroplasty, in which the back is numbed, an injection is made into the vertebra, and bone cement is injected by a radiologist or spine surgeon to shore up a fracture. The other group of patients received a sham procedure, including the numbing, but no injection. The doctor opened the container of bone cement so its scent would fill the operating room to disguise whether these patients were receiving a real surgery or not.

After a month, both groups saw a substantial reduction in various measures of disability and pain, assessed by a questionnaire. But the reductions were a statistical tie—the actual procedure yielded no gain beyond the placebo effect of the sham surgery.

A separate study, including 78 patients and conducted similarly, was funded by the Australian government and Cook Medical Inc., a U.S. manufacturer of bone cement. It reached a similar conclusion: Vertebroplasty didn't relieve pain any more than the sham surgery, measured three months later.

"Most doctors in this country thought the trial was unethical, because they were so convinced vertebroplasty works," said Avery Evans, a radiologist at the University of Virginia who participated in the U.S. study. He said several hospitals didn't allow their doctors to participate. "Everybody's experience has been that it works.

This study throws that into doubt," said Dr. Evans, who said he has done thousands of vertebroplasties. "If there's no benefit to it, then we need to stop doing it."

The results follow a 1999 loosening of regulations concerning the marketing of bone cement. In that year, orthopedic makers persuaded the Food and Drug Administration to downgrade the classification of bone cement to a low-risk regulatory category that doesn't necessarily require clinical trials to show a product is effective at what it claims to do. At that time, the cement was sold to attach prosthetic joints to the bone, such as in the knee or hip.

Five years later, the FDA allowed makers of bone cement, including Stryker Corp., Johnson & Johnson and Cook, to market their products for use in a vertebroplasty-without a prosthetic, and without needing a controlled clinical trial that vertebroplasties are effective.

An FDA official said the agency's decision was based on previous use of bone cements to fill in fractured bones. "We determine it's not so extremely different that it's outside the box," said Heather Rosecrans, who directs the agency's review of such devices.

Stryker and J&J declined to comment. Cook pointed to the small number of patients in each of the latest trials. "Bottom line is that more data, more research needs to be done here," said Daniel Sirota, global business unit leader at Cook.

Other findings that have questioned established treatments included a large 2002 study that found no benefit to two popular knee surgeries, compared with a sham treatment. Another study, in 2007, found that heart stents, which prop open clogged arteries and are used on about a million Americans a year, yielded no long-term benefit when added to a drug regimen in patients with chronic chest pain.

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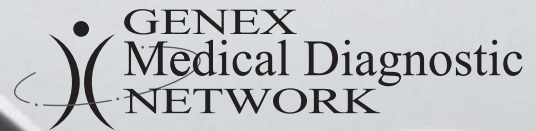
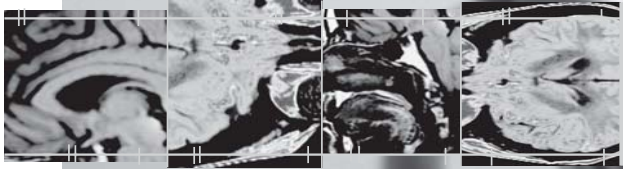


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