What's Hot in Workers' Comp
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Pennsylvania Workers' Compensation

Fee Review Litigation: an Overview

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Medical fee schedule and fee review issues are perhaps the most over-looked areas of the Pennsylvania Workers' Compensation Act, yet they can result in the most damning of decisions against insurance carriers and employers. In the advent of the Bureau of Workers' Compensation's decision to refer out Medical Fee Schedule and Fee Review Petitions to Workers' Compensation Judges for handling, it is incumbent upon employers, carriers and the defense bar to take an active role in the litigation of these cases.

The Act, along with the Regulations and Act 44 Operational Guidelines, are complicated in scope and contain traps for the unwary as they relate to fee schedule and fee review issues. Providers of medical services are given an unsettling "benefit of the doubt" in the litigation process, which has metamorphasized the protocol used by those providers to have medical bills paid under the Act. The time has come for the elimination of the inequities inherent in the fee review system in an effort to restore fairness for carriers and employers. This can only be achieved through the monitoring of all fee review filings and forcing providers to actually prove their cases under the Act.

In an effort to clarify the medical fee schedule and fee review sections of the Act, the following overview is helpful:

(1) **Application for Medical Fee Review:** Section 306(f.1)(5) of the Act details the procedure for filing fee review petitions. In short, a health care provider who disputes the timeliness or the amount of payment from the employer/insurer can file an application for fee review with the Department. The application must be filed no more than 30 days following notification of a disputed treatment or 90 days following the original billing date of treatment. Our Commonwealth Court in *Fidelity & Guaranty Insurance v. W.C.A.B. (Bureau of Workers' Compensation/Community Medical Center)*, recently expanded this filing time limit to 30 days following notification of a disputed treatment or 90 days following the original billing date of treatment whichever is longer.

(2) **Application for Medical Fee Review—Document Required:** Section 109 of the Act defines a medical bill as a statement or invoice for payment of services identifying the claimant, the date of injury, the payment codes and a description of services provided on a standard form prescribed by the Department

of Labor and Industry. Further, Section 306(f.1)(2) of the Act directs the department to prescribe a standard form medical report to be filed periodically by the provider with the carrier or employer. In order to prosecute an application for fee review, a provider usually must submit the applicable Medicare billing form, the required medical report form and the explanation of benefits form, if available. Without proof of the forms, the application will fail if contested.

(3) **Employer/Carrier Defenses—Most Often Overlooked:** In the absence of any contact by the carrier with the Bureau, the fee review application will likely be granted on behalf of the provider. This often is the case even when there exist multiple, obvious defenses to the fee review application. The lack of response to a fee review application is multifactorial in cause. In some instances, the carrier representative did not receive the fee review filing or notice of said filing from the Bureau/provider and/or had missed the Bureau representative's "telephone call" to discuss the case. In other cases, the unfamiliarity with the fee review system sounds the death knell for carriers who do not understand the protocol for fee review hearings. As a result, we have found that many providers, as a matter of course, will now file fee review applications without ever first submitting the bill to the carrier simply because of the success rate they have had in getting fee review petitions granted. This can be avoided by keeping these points in mind:

(a) **Amount and Timeliness:** If a provider is challenging the amount or timeliness of payment with the filing of a penalty petition through the claimant, that petition must be dismissed through appropriate litigation. The provider must file such a request through the fee review system, not as a penalty petition. Yet, voluminous penalty petitions involving timeliness or the amount of bills still clog the system.

(b) **Time Deadlines:** Should the provider fail to challenge disputed treatment within the deadlines discussed above, the fee review application will be dismissed upon motion. The way the carrier handles "disputes" to the bills could enlarge the time deadline to file the application. Without proper representation during the fee review process, some providers fly through the system unscathed by this very simple defense.

(c) **Premature Filings:** Should a provider make application for fee review while a claim is in denial status, the application should be dismissed. We have had this issue crop up more so than any other in the fee review context. When a claim is denied, medical bills associated with the claim are not yet payable. However, providers will still file fee review applications without hesitation. Many times, a lack of response to the filing will result in a decision against the employer/carrier before a claim is even accepted as compensable. Likewise, if a Utilization Review has been requested by the carrier on the billing/treatment at issue, an application for fee review on that same treatment should be dismissed. However, if the fee review petition remains uncontested, this defense will never see a court room. Finally, an application for fee review filed by a provider during the carrier's initial 30-day receipt and review period prescribed by the Act for a medical bill should be dismissed. Again, some providers never even file the bill with the carrier initially and inappropriately state that they have followed the correct protocol in a fee review application. If the carrier does not contest, the fee review could be granted.

(d) **Coding Disputes:** Should a provider challenge the amount of payment due to a coding dispute, the carrier can present evidence at a fee review hearing documenting its compliance under the Act with down coding protocol and have the application for fee review ultimately dismissed. Knowledge of the CPT codes and protocol for down coding is essential in defending these actions. While CPT codes themselves are beyond the scope of this overview, suffice it to say that hearings have been held for hours before hearing officers with argument over correct billing codes. Proper authentication of down coding within the acceptable meaning defined by the Act can and will result in the dismissal of fee review petitions.

Unfortunately, none of these very simple defenses are available to the employer/carrier if the fee review application is left uncontested. Thousands of medical bills are being approved through the fee review system yearly. Many of the petitions could have been dismissed if properly contested. Such a flaw in the way these petitions fly under the radar cannot be imprinted in our protocol. In the interest of fairness and equity, a serious attempt must be made to control these unnecessary costs by appropriately challenging fee review petitions through counsel. **II**

Pennsylvania Workers' Compensation

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Acceptance of Disability Pension Alone Does Not Establish a Presumption that the Claimant Voluntarily Left the Workforce so as To Suspend Benefits. A Suspension Is Appropriate for the Period of Time During Which the Claimant Had Received a Disability Pension and the Physician Identified He Was Capable of Performing Work But the Claimant Did Not Make a Good Faith Effort to Seek Employment.

City of Pittsburgh v. W.C.A.B. (Leonard); 650 C.D. 2010; filed April 20, 2011; by Judge Brobson

This claimant was not working and was receiving workers' compensation benefits when he obtained a service-connected disability pension from the employer. An independent medical evaluation then determined that the claimant was capable of performing light to medium-duty work, which generated a Notice of Ability to Return to Work. The employer filed a Suspension Petition on the basis that the claimant voluntarily removed himself from the workforce because he was capable of modified work and had not sought employment. The Workers' Compensation Judge granted the petition, suspending benefits for the period of time between the date of the Notice of Ability to Return to Work, as at that point the claimant had restored work capabilities, and the date the claimant began a good faith effort to seek work within his restrictions. The Judge's determination was upheld by the Appeal Board and the Commonwealth Court.

The court first restated that proof of job availability is not required where a claimant has voluntarily removed himself from the workforce through retirement but that the mere acceptance of a pension does not establish a presumption that a claimant has voluntarily left the workforce. The court agreed with the Workers' Compensation Judge that it was not until the claimant had received the Notice of Ability to Return to work and then subsequently failed to adequately seek employment that there was sufficient indicia that he had voluntarily left the workforce so as to support a suspension of benefits. When the claimant subsequently made a good faith search for employment within his work capabilities, the period of suspension ended and benefits have to be reinstated. ||

A Request for Utilization Review by the Employer Does Not Constitute an Admission of Causation or Prohibit the Employer From Denying Causation.

Securitas Security Services USA, Inc. v. W.C.A.B. (Schuh); 349 C.D. 2010; filed April 4, 2011; by Judge McCullough

The claimant began receiving workers' compensation benefits for a work-related low back strain and sprain pursuant to a Notice of Temporary Compensation Payable that later converted to a Notice of Compensation Payable. Later, the claimant began to treat with a psychiatrist, and the employer filed a Utilization Review Request (UR) seeking prospective review of the psychiatric treatment the claimant was receiving. Ultimately, the UR Determination found that all of the care was reasonable and necessary. The employer did not appeal. The claimant then filed a Review Petition, seeking to amend the description of his work injury to include depression and anxiety.

In support of that petition, the claimant simply argued that the employer was estopped from disputing causation by virtue of the unappealed UR Determination. The Workers' Compensation Judge agreed, and the petition was granted. The Workers' Compensation Appeal Board affirmed.

The Commonwealth Court, however, reversed. The court held that the employer was not collaterally estopped from contesting causation of the claimant's psychiatric condition by not challenging the UR Determination, finding that treatment to be reasonable and necessary. Moreover, the Commonwealth Court agreed with the employer that the filing of a UR Request on the psychiatric treatment did not constitute an admission that the claimant's anxiety and depression were causally related to the acknowledged work injury. ||

What's Hot in Workers' Comp

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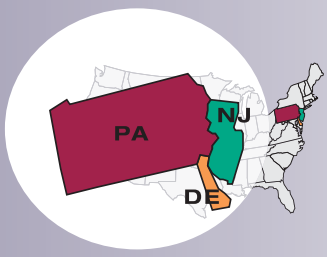

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New Jersey Workers' Compensation

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Is "Merited Criticism" of an Employee's Job Performance Sufficient to Give Rise to a Finding of Compensability in a Psychiatric Disability Claim?

J.T. v. University of Medicine and Dentistry of New Jersey, CP# 2007-12153 (N.J. Division of Workers' Compensation, Decided November 29, 2010)

The petitioner, a former security officer for the employer, filed a claim with the Division of Workers' Compensation alleging occupational exposure to stressful working conditions and harassment from her supervisor. In support of her claim, the petitioner testified as to four incidents of alleged harassment at the hands of her supervisor. The first incident involved the supervisor allowing another employee longer breaks than the petitioner and the other security officers. The petitioner's supervisor testified that there were medical reasons for his decision. The second incident pertained to a reprimand the petitioner received from her supervisor for wrapping herself in a blanket while assigned to a post in the emergency room on a particularly cold evening. The petitioner's supervisor asked that she remove the blanket as it made for an unprofessional appearance. The third incident involved a reprimand the petitioner received for violating the employer's sick leave policy. The last incident pertained to the petitioner's being questioned when she refrained from taking her 30-minute lunch break on a particular afternoon and, instead, clocked out of work a half hour early that same day. As a result of these incidents, the petitioner alleges to have sustained permanent psychiatric disability.

Following trial, the Judge of Compensation held that the petitioner had not sustained her burden of proof as to the compensability of her occupational psychiatric claim. The Judge of Compensation relied on *Goyden v. State Judiciary*, 256 N.J. Super. 438 (App. Div. 1991), which provides the standard for awarding permanent disability for psychological illness arising out of stressful work conditions. In *Goyden*, the Appellate Division held that a petitioner must demonstrate the existence of objective evidence of job stress which, when viewed realistically, establishes working conditions sufficiently stressful to contribute to the development of psychiatric disability. Additionally, the objectively stressful working conditions must be peculiar to the particular workplace. Of significance, *Goyden* held that merited criticism cannot be considered to be a condition characteristic of or peculiar to a particular trade, occupation or place of employment as it is common to all employment.

"Even if [J.T.] did have a . . . psychiatric disability," the Judge of Compensation stated, "it did not arise out of and in the course of her employment." The Judge of Compensation reasoned that "[Merely] correcting the performance of an underling such as ordering her to remove the blanket, warning her of sick leave infractions and ordering her to remain at her station is inherent to [all] employment and, therefore, could not be regarded as 'peculiar' to J.T.'s work place[.] Petitioner failed to produce . . . proofs that her perceived harassment was anything but 'merited criticism' within the meaning of *Goyden*." ||

Delaware Workers' Compensation

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In a Case Dealing With the Statute Requiring Contractors on Construction Sites to Obtain a Certificate of Insurance From Their Subcontractor, the Board Holds that the Contractor Fulfills its Obligation by Obtaining a Certificate of Insurance From the SubSubcontractor and Has No Affirmative Duty to Make Certain that the Insurance Policy Remains in Effect.

Reuben Cordero v. Golf Stream Development Corporation and Subcontractor A Company, (IAB Hearing Numbers: 1357959 and 1357671) Decided February 10, 2011

This case involved the interpretation of §2311(a)(5) of the Delaware Code which requires contractors on construction sites to obtain from their subcontractors and retain for three years a valid certificate of insurance. The statute provides that the failure to do so shall make the contractor liable as the insurer of any workers' compensation claims that occur to employees of the subcontractor.

The claimant was doing roofing work for Subcontractor B when the ladder he was climbing on became detached from the roof and he fell to the ground sustaining injuries. The general contractor on the job site was Contractor A, and below them was Subcontractor A, which was a subcontractor who had, in turn, subcontracted with Subcontractor B as the employer of the claimant. Contractor A had been provided with a certificate of liability insurance by Subcontractor A, and, likewise, Subcontractor A had been provided with a certificate of insurance from Subcontractor B. However, unbeknownst to Contractor A and Subcontractor A, the insurance policy which Subcontractor B had was cancelled on July 10, 2008, and the claimant's injury occurred on July 31, 2008.

The case came before the Board on a legal hearing in which Contractor A and Subcontractor A requested dismissal of the petitions filed against them on the basis that they had complied with the statute. Initially, the Board agreed that Contractor A's Motion to Dismiss should be granted since they had obtained a valid certificate of insurance form Subcontractor A which remained in effect. It was a closer call as to the Motion to Dismiss of Subcontractor A. The Board framed the issue as whether that entity had an affirmative duty to not only obtain the certificate of insurance but to make certain that it remained in effect during the policy period. The Board concluded that Subcontractor A had no such affirmative duty to assure that the certificate of insurance it had obtained from its subcontractor remained effective during the term of the policy. Instead, the Board found that Subcontractor A was entitled to rely in good faith on the certificate of insurance with which it had been provided. Accordingly, Subcontractor A was also dismissed from the litigation. The Board did point out that if Subcontractor A had actual knowledge that the certificate of insurance was no longer valid, the result might be different. ||