What's Hot in Workers' Comp

Significant Workers' Compensation Case Summaries

Marshall, Dennehey, Warner, Coleman & Goggin

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Pennsylvania Workers' Compensation

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A Claimant Who Was Injured After Voluntarily Jumping Down a Flight of Stairs During His Lunch Hour Is Not in the Course and Scope of His Employment and Is Not Entitled to Worker's Compensation Benefits.

Penn State University v. W.C.A.B. (Smith); 630 C.D. 2010; filed February 22, 2011; by Judge Brobson

The claimant, who was employed as a cook with the employer's food service department, also worked in the employer's housing department during the summer. On the day of his injury, he was cleaning dorm rooms. While walking from a dorm to the dining hall, the claimant intentionally jumped down a flight of stairs of approximately 12 steps and sustained serious injuries to both of his legs and ankles.

The claimant filed a claim petition, which the employer challenged by contending that the claimant was not in the course and scope of his employment at the time of the incident. The employer also raised the defense that the claimant was engaged in horseplay, which was in violation of a positive work order. The Workers' Compensation Judge concluded that the claimant was within the course of his employment at the time of his injury, reasoning that the activity was not one that was outside the realm of a claimant's work activities. The Workers' Compensation Judge also found that there was no intentional violation of a positive work order against horseplay. The Workers' Compensation Appeal Board affirmed the Judge's decision.

The Commonwealth Court, however, reversed the decisions below. The court held that the claimant was not in the scope of his employment at the time he leaped from the steps since he was not in furtherance of the employer's business or affairs. The court also did not consider the claimant's action to be a small, temporary departure or break from his employment to administer to his personal comfort. Rather, the court considered the claimant's jump from the stairs while on his lunch break to be wholly foreign to his employment. **II**

Claimant's Failure to Provide Notice of a Work Injury within 120 Days as Required by Section 311 of the Act Warrants Denial of Claim Petition.

Hershgordon v. W.C.A.B. (Pep Boys), No. 2031 C.D. 2010 (Pa. Cmwlth. February 8, 2011), opinion by Judge Butler

A claim and penalty petition were denied by the Workers' Compensation Judge and affirmed by the Appeal Board and Commonwealth Court. The Workers' Compensation Judge had found that the claimant failed to establish through substantial, credible evidence that he provided timely notice of his alleged

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work-related injury to the employer within the 120-day provision of Section 311 of the Act.

The claimant alleged that he slipped and fell, injuring his right foot, and that the employer's store manager helped him up. The claimant did not seek medical treatment with any employer panel physician following the alleged incident, and no injury report was ever prepared. The claimant continued to perform his job without restrictions or loss of earnings for more than two years, until his employment was terminated. The first written report of the alleged incident was given immediately prior to his termination, which was due to a confrontation with a co-worker.

In finding against the claimant, the Workers' Compensation Judge found the claimant's testimony that he reported the work incident not credible since he failed to follow up with his supervisors to ensure that the incident was reported and waited until he faced termination until he formally reported the work accident. The employer's witnesses were deemed credible in their testimony that the claimant did not report a work injury and that they did not know the claimant had any work-related limitations until he was terminated. The claimant's treating physician's notes also did not support the claim as there was no mention of the alleged work injury until more than three years after it occurred.

This case supports the defense that failure to provide proper notice of a work-related injury, with documentation thereof, within 120 days will support the denial of a claim petition. ‖

New Jersey Workers' Compensation

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Dario J. Badalamenti

What Are the Statutory Criteria for Imposing Second Injury Fund Liability in a Workers' Compensation Matter?

James Allen v. The Great Atlantic & Pacific Tea Company, Docket No. A-1333-09T1, 2010 N.J. Super. Unpub. LEXIS 3047 (App. Div., Decided December 21, 2010)

On February 4, 1999, the petitioner, the director of construction for the respondent, was seriously injured when he was involved in a motor vehicle accident which occurred during the course of his employment. As a result of this accident, he sustained a disc herniation at L4-5 requiring three surgical procedures, including a hemi-laminectomy with bilateral nerve root decompression and fusion, re-exploration and posterolateral fusion with implementation of a bone growth stimulator and subsequent removal of the bone growth stimulator. The petitioner underwent lengthy courses of physical therapy, pain management and psychological counseling for severe depression and anxiety. Despite his extensive treatment, the petitioner was left with chronic L5-S1 radiculopathy and bilateral foot drop, as well as constant pain in his back, legs, right foot and left thigh. He was unable to ambulate without a cane and required daily pain medications that adversely impacted his cognitive functioning and general mental state.

On April 15, 2005, the petitioner filed a claim with the Division of Workers' Compensation. Thereafter, the petitioner filed a verified petition with the Second Injury Fund (the "Fund"), alleging that he was permanently and totally disabled as a result of his work-related motor vehicle accident in combination with certain pre-existing disabilities, namely, a herniated disc at L5-S1 for which he underwent surgery in 1994, as well as post-traumatic stress disorder ("PTSD") relating to his service during the Vietnam War.

Robin Romano, Esq.

Robin Romano, shareholder in our Philadelphia office, has been invited by the New Jersey Self Insurers' Association to speak at their annual spring meeting in Atlantic City on May 5-6, 2011. Robin will participate in an attorney panel discussion entitled "So You Think You've Got It Bad?" For more information about this meeting, contact NJSIA at 732-219-0319 or visit their web site at http://www.njselfinsurers.com.

At trial, the Judge of Compensation acknowledged the petitioner's pre-existing low back pathology and PTSD but found that neither condition, according to the petitioner's own testimony, limited his ability to work. Further, none of the medical experts who testified on behalf of either the petitioner or the respondent were able to unequivocally establish that the petitioner's prior low-back injury or PTSD resulted in any pre-existing partial permanent disability as is required to implicate the Fund. As the Judge of Compensation noted, the record was devoid of evidence establishing that the petitioner's pre-existing conditions caused a "material lessening of [his] working ability or an impairment in his carrying on the ordinary pursuits of life." Accordingly, the Judge of Compensation found that the petitioner was permanently and totally disabled as a result of his February 4, 1999, motor vehicle accident alone and dismissed the petitioner's claim against the Fund. The respondent appealed.

In affirming the Judge of Compensation's ruling, the Appellate Division relied on the statutory criteria for imposing Fund liability as set forth in N.J.S.A. 34:15-95. In relevant part, N.J.S.A. 34:15-95 provides that:

> [C]ompensation payments . . . shall be made to persons totally disabled, as a result of experiencing a subsequent permanent injury . . . when such persons had previously been permanently and partially disabled from some other cause; provided, however, that no person shall be eligible to receive payments from the Second Injury Fund . . . if the disability resulting from the injury caused by the person's last compensable accident in itself and irrespective of any previous condition or disability constitutes total and permanent disability.

Analyzed in light of these principles, the Appellate Division found that the Judge of Compensation's findings and conclusions were based on sufficient credible evidence in the record and by applicable law.

In examining the record, the Appellate Division found compelling the petitioner's own testimony describing his working ability before the compensable accident. In relevant part, the petitioner testified that following his low back surgery in 1994, he had returned to work without any difficulty and for several years thereafter travelled 100,000 miles per year and worked 55 to 70 hours per week, conducting inspections of construction sites which required climbing and other strenuous activities. The petitioner testified that he remained an avid outdoorsman, both hunting and fishing routinely. The petitioner also testified that despite suffering from PTSD from the Vietnam War, he took no medication, nor did his PTSD cause him either mental or physical impairment at work.

As the Appellate Division emphasized, none of the medical experts who testified at trial could give an opinion that there was either a material lessening of the petitioner's working ability or an impairment in carrying on his ordinary pursuits of life before the compensable automobile accident of February 4, 1999. To the contrary, the petitioner's own testimony suggested that his pre-existing injuries had no impact on his ability to function normally either at home or work. Consequently, the Appellate Division concluded that the Judge of Compensation was correct in finding that the respondent failed to establish that either the petitioner's pre-existing low back injury or PTSD resulted in any partial permanent disability requiring an apportionment of liability to the Fund. ❚❚

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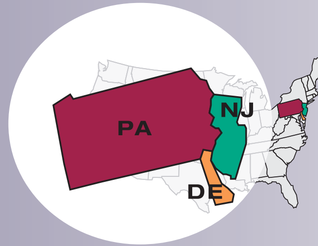

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Delaware Workers' Compensation

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Paul V. Tatlow

The Board Held an Employer Liable to Pay the Claimant's Surgery Bill as Well as a Statutory Fine Where it Failed to Properly Submit the Medical Bill to Utilization Review Within the Required Time.

Debra Williams v. Sanitors Inc., (IAB Hearing Number: 1273026) Decided November 12, 2010

This case involved a legal hearing requested by the claimant on a Utilization Review issue, and the decision provides some instruction on the handling of medicals under the Healthcare Practice Guidelines.

The claimant had surgery for an accepted work injury without any preauthorization having been given for the surgery. Thereafter, the surgical center submitted its bills and the operative report to the employer's insurance carrier by certified mail on September 27, 2010. The bill consisted of two parts: for the treating surgeon in the amount of $32,538; for his assistant in the amount of $6,510. The carrier, on October 19, 2010, filed a timely Utilization Review request but only regarding the bill for the physician's assistant.

The claimant's contention was that the employer had not properly followed the Utilization Review procedure. The Board determined that the employer had neither paid the charges of the surgeon nor submitted them to Utilization Review as required by §2322 F (h). The Board further noted that the requested Utilization Review as to the bill from the physician's assistant was rejected and properly so on the basis that the treatment provided by the surgeon and his assistant were the same and that Utilization Review could not review the treatment in question unless both bills were being challenged. Accordingly, the Board concluded that the carrier had failed to perfect the Utilization Review referral and, therefore, both the bill for the doctor as well as that for his assistant must be paid in accordance with the Practice Guidelines. In addition, since the carrier had failed either to pay or properly contest the surgeon's bill within the 30-day time limit, it was found liable for a statutory fine in the minimum amount of $1,000.

A second issue raised by the claimant was that the carrier had improperly used a third party in an attempt to negotiate a lower payment on the surgeon's bill by offering to pay the amount of $19,522. The Board found that there was nothing improper with this use of a third party and that the Act does not prohibit an employer or carrier from attempting to negotiate a lesser payment to a health care provider. The reason for this is that the fee schedule established under the Practice Guidelines sets forth the maximum allowable payment, but this does not mean the provider cannot accept a lesser amount. On the other hand, the Board did point out that the provider is not required to accept such a lower payment and that, obviously, the doctor in this case refused the lower amount offered.