What's Hot in Workers' Comp

Significant Workers' Compensation Case Summaries

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Pennsylvania Workers' Compensation

By Francis X. Wickersham, Esquire (610.354.8263 or fxwickersham@mdwcg.com)
and
G. Jay Habas, Esquire (814.480.7802 or gjhabas@mdwcg.com)

Francis X. Wickersham

G. Jay Habas

The Supreme Court holds that an insurer is entitled to supersedeas fund reimbursement for payment of a medical bill made after a request for supersedeas was denied, even though the bill was for medical treatment received before the supersedeas request was made.

Department of Labor and Industry, Bureau of Workers' Compensation v. WCAB (Crawford & Company); 102 MAP 2009; decided July 19, 2011; by Mr. Justice Eakin

In this case, the claimant, who was receiving benefits for a July 1995 work injury, was seen for an IME on March 16, 2004. On June 1st of that year, surgery was performed on the claimant, which the claimant maintained was related to his work injury. On July 19, 2004, the employer filed a Petition to Terminate the claimant's benefits, based on the results of the March 2004 IME. The employer also requested supersedeas in connection with the Termination Petition. The Request for Supersedeas was denied.

In October 2004, the bill for the June 2004 surgery was submitted to the insurer, who made payment in January 2005. In June 2005, the employer's Termination Petition was granted by the Workers' Compensation Judge. The Workers' Compensation Appeal Board (WCAB) affirmed.

The insurer then requested reimbursement from the Supersedeas Fund for the surgery bill, which was over $35,000. However, the Bureau challenged the request. The Bureau took the position that because the claimant's surgery occurred before the Supersedeas Request was made, the insurer was not entitled to a Supersedeas Fund Reimbursement. The Workers' Compensation Judge, however, awarded reimbursement, and the WCAB affirmed, as did the Commonwealth Court.

The Supreme Court affirmed the decisions below, holding that the insurer was entitled to reimbursement from the Supersedeas Fund for the bill for surgery performed prior to the Supersedeas Request being made, but submitted after the request was denied. According to the Court, the insurer had the obligation to cover the bill pending the final determination and that obligation was the direct and singular result of the denial of supersedeas. In the Court's view, to make reimbursement dependent on the date of the event giving rise to the bill would serve to insert an additional element into the Act. The Court also noted that the insurer was not asking for payments made before the supersedeas filing date, much less the date of granting supersedeas. The insurer was seeking reimbursement for payment made after a supersedeas denial, "an obligation incurred when the insurer was denied permission to suspend compensation payments." ||

A claimant's burden of proof on a Reinstatement Petition was not met where the claimant's evidence failed to show that the reason for a suspension of benefits no longer existed.

Upper Darby Township v. WCAB (Nicastro); 1285 C.D. 2010; filed March 17, 2011; by Judge Leavitt

The claimant sustained a work-related injury to his low back in April of 2002. Approximately two years later, he returned to his regular job with no restrictions, and his benefits were suspended pursuant to a Notification of Suspension. In June of 2004, the claimant again hurt his low back and filed a Claim Petition. During litigation, the parties resolved the Claim Petition by stipulation. The parties agreed to the work injury and that there was a limited period of disability from June 8, 2004, through October 7, 2004. It was also agreed that the claimant returned to his regular job without restrictions on October 8, 2004, and that the claimant stopped working for the employer in December of 2004 because of injuries unrelated to his back. The Workers' Compensation Judge issued a decision adopting the stipulation in May of 2006.

Later, in January 2008, the claimant filed a Reinstatement Petition, alleging that his condition worsened and his work injury caused him to suffer a loss of earning power as of January 24, 2008. In actuality, the claimant was requesting a reinstatement as of December 5, 2004, when he stopped working for the employer. During litigation of the Reinstatement Petition, the claimant testified that he was terminated by the employer in December of 2004 for taking too many sick days. He also acknowledged that no specific incident prompted him to seek a reinstatement and said that since December of 2004, he has been capable of performing his pre-injury job without restrictions. The claimant's medical expert testified that the claimant would not have been able to perform his regular job at any time between December of 2004 and November of 2006, when he began treating the claimant.

The Workers' Compensation Judge granted the Reinstatement Petition, and the WCAB affirmed. The Commonwealth Court, however, reversed. They agreed with the employer that the claimant failed to meet his burden of proof for the Reinstatement Petition since he failed to show that the reasons for the suspension no longer existed. The court pointed out that the claimant had previously stipulated that he stopped working for the employer in December 2004 for reasons unrelated to the work injury. The court also noted that the claimant acknowledged he could perform his regular job as of December 2004 and February 2008. The court viewed this testimony as contrary to the theory that the claimant's work injury once again negatively impacted his earning power. **II**

Pennsylvania Supreme Court redefines what constitutes sufficient notice of a work injury.

Gentex Corporation v. WCAB (Morack); No. 33 MAP 2010; filed July 20, 2011; Madame Justice Todd

The claimant in this case, a 45-year employee who worked as an Air Force helmet inspector, left work complaining about intolerable pain in her hands but did not report her condition as work-related. She submitted an application for short-term disability benefits, indicating that she did not believe that her condition was work-related, and attributed it to pre-existing fibromyalgia and high blood pressure. Two months after leaving work, the claimant was diagnosed with work-related tendonitis, bilateral carpal tunnel syndrome and a cartilage tear. She then left voice messages with the human resource manager, at least one of which was that she had unspecified "work-related problems." No medical documentation was submitted to the employer identifying the conditions as work-related.

The Workers' Compensation Judge found that the claimant gave timely notice of her injury under section 311 of the Act and sufficiently described it pursuant to section 312, and the WCAB agreed. The Commonwealth Court reversed as to the sufficiency of the description of the notice under section 312, finding that the short-term disability application and voice message did not adequately describe a work-related injury.

The Supreme Court, in holding that the claimant provided sufficient notice of a work injury, held that a precise description of the work injury is not necessary and that the notice requirement under section 312 is met when it is conveyed in ordinary language, takes into consideration the context and setting of the injury, and may be provided over a period of time or a series of communications if the exact nature of the injury and its work-relatedness is not immediately known by the claimant. While the Court acknowledged that the claimant's notice in this case was not "letter perfect," it nonetheless stressed that the humanitarian purpose of the Act directs that "a meritorious claim ought not, if possible, be defeated for technical reasons and technicalities." The Court stated that what constitutes sufficient notice is a fact-intensive inquiry taking into consideration the totality of the circumstances.

The *Gentex* decision is disconcerting to employers and insurers as it can be viewed as promoting a low threshold for claimants to satisfy the notice requirement of section 312, as well as seemingly shifting the burden to the employer to identify the occurrence of a work injury where an employee does not specify or offer medical evidence that a medical condition or injury is work-related, and, indeed, provides information to the contrary that the problem is due to a pre-existing condition. Of concern is the Court's suggestion that the mere mention of a "work-related problem" is sufficient to trigger an employer's duty to investigate the circumstances to determine if compensation is due or face sanctions. **II**

New Jersey Workers' Compensation

By Dario J. Badalamenti, Esquire (973.618.4122 or djbadalamenti@mdwcg.com)

Dario J. Badalamenti

The Appellate Division finds husband entitled to workers' compensation dependency benefits after wife dies of pulmonary embolism while performing sedentary work.

Renner v. AT&T, Docket No. A-2393-10T3, 2011 N.J. Super. Unpub. LEXIS 1668 (App. Div., Decided June 27, 2011)

The decedent was a 25-year employee of the respondent who often worked from home, where she sat at her computer for long hours in order to meet various deadlines imposed by her superiors. On the evening of September 24, 2007, the decedent began working on a project at home. Although the length of time she worked on the project was disputed, there was evidence presented at trial to allow for an inference that she worked throughout the night and well into the following morning. At or about 11:30 a.m. on the morning of September 25, 2007, the decedent began experiencing chest pain and shortness of breath. She phoned 911 and was taken by ambulance to the hospital, where she was pronounced dead on arrival. The medical examiner concluded that the cause of death was a pulmonary embolism. An autopsy also revealed that the decedent, age 47, weighed 304 pounds at the time of her death and had an enlarged heart.

The petitioner, the decedent's husband, filed a dependency claim with the Division of Workers' Compensation. He contended that because the decedent's work required her to sit an inordinately long period of time on the day in question, she developed a blood clot in her leg which embolized in her pulmonary artery, resulting in her death. The Judge of Compensation determined that the petitioner's claim was compensable under N.J.S.A. 34:15-7.2, the section of the workers' compensation statute addressing cardiovascular injury or death, and awarded dependency benefits to the petitioner. The respondent appealed.

In affirming the Judge of Compensation's ruling, the Appellate Division examined Section 7.2 of the workers' compensation statute, which states in relevant part, "In any claim for compensation for injury or death from cardiovascular . . . causes, the claimant shall prove by a preponderance of the credible evidence that the injury or death was produced by the work effort or strain involving a substantial condition, event or happening in excess of the wear and tear of the claimant's daily living and in reasonable medical probability caused in a material degree the cardiovascular . . . injury or death resulting therefrom." The statute goes on to define "material degree" as "an appreciable degree or a degree substantially greater than de minimis."

The Appellate Division found that, although the decedent lived a relatively sedentary life in and out of work, there was sufficient credible evidence to support the Judge of Compensation's finding that her work inactivity on the day in question was greater than her non-work inactivity. Further, and despite the presence of a variety of other risk factors including obesity and cardiac abnormalities, the Appellate Division was satisfied that there was sufficient medical evidence present to allow the Judge of Compensation to conclude that this prolonged work inactivity caused the decedent's pulmonary embolism to a material degree. **II**

Delaware Workers' Compensation

By Paul V. Tatlow, Esquire (302.552.4035 or pvtatlow@mdwcg.com)

Paul V. Tatlow

The Board issues fines against an insurance carrier for failing to comply with the Health Care Practice Guidelines where it made only partial payments to a medical provider on four separate claims.

Motion By First State Orthopaedics, (IAB Hearing # 1362536) Decided June 9, 2011

This case involved a motion by a physician group against the insurance carrier seeking to compel full payment of various bills that had been submitted. The decision does not specify the bills, but from other such cases filed by the physicians, it is believed that they were the physician's reports which, pursuant to the Practice Guidelines, must be paid in the full amount of $30 per report. The bills at issue here had only been partially paid by the carrier.

At the legal hearing, the carrier argued that the doctors should be required to file a formal petition with the Board before it can seek payment of the bills. The Board disagreed and ruled that by making the partial payments, the necessity, reasonableness and causal relatedness of the treatment to the work injury was deemed admitted by the carrier. Therefore, the Board reasoned that the practice could seek full payment of the acknowledged compensable charges by way of a legal motion rather than a petition.

On the merits of the case, the Board, in what is believed to be the first decision on this issue, found that the carrier had violated its duty under the Act to either pay the submitted bills within 30 days or contest them through utilization review. There were four separate claims at issue, and the Board, as to each of them, ordered the carrier to pay the balance of the bill with interest and also assessed a fine of 1,000 per claim, for a total of $4,000, to be paid by the carrier to the Fund. Finally, claimant's counsel was awarded a counsel fee of $2,000 for his efforts in getting the bills paid.

The lesson of this case is that, while the amounts at issue were not great, failing to comply with the Health Care Practice Guidelines in Delaware can subject employers and carriers to substantial sanctions and fines. ||