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What's Hot in Workers' Comp

PENNSYLVANIA WORKERS' COMPENSATION

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A presumption of prejudice does not exist in every case where an employer seeks to recover an overpayment of compensation made to a claimant also receiving pension.

City of Pittsburgh & UPMC Benefit Management Services, Inc. v. WCAB (Wright); 329 C.D. 2013; filed 5/1/14; Judge Leavitt

The claimant, a firefighter, sustained a work injury. The employer accepted liability and paid the claimant Heart and Lung benefits equal to his full salary for over a year after the injury. The claimant then elected to take a disability pension, and the Heart and Lung benefits were replaced with workers' compensation benefits. For a period of approximately two months, the employer paid the claimant total disability workers' compensation without an offset for the disability pension the employer was also paying. The employer later issued a Notice of Workers' Compensation Benefit Offset form (LIBC-761), which indicated that benefits were being reduced for an offset the employer was taking for the disability pension. The form also stated that the employer was further reducing the claimant's weekly wage loss benefit by $100 a week for an overpayment of compensation made during the period of time the claimant received both temporary total disability benefits and pension benefits.

The claimant then filed a petition to review the offset, alleging that the calculation was wrong. Additionally, the claimant challenged the employer's attempt to recoup the overpayment on the basis of financial hardship and argued that the employer was not entitled to any offset since he was never provided with an LIBC-756 form (Employee's Report of Benefits for Offsets) before notifying him of its intention to take an offset. However, this argument was made after the record was closed, and the Workers' Compensation Judge found that the claimant waived it. Nevertheless, the Judge determined that the employer was not required to issue form LIBC-756 before taking the offset since they were already aware of the pension. The Judge agreed, however, that the employer was barred from recouping the overpayment due to the financial hardship it would cause. The Judge allowed the employer an ongoing pension offset, but disallowed the recovery of the overpayment. The Judge also ordered the employer to reimburse the claimant the full amount recouped. Both the claimant and the employer appealed to the Workers' Compensation Appeal Board.

The Board affirmed the Judge. Although they agreed that the claimant had waived the issue of the LIBC-756 form being sent before taking an offset, they nevertheless held that tender of the form was a condition precedent to recovering an overpayment of benefits in every case. The Board also concluded that the employer was not entitled to a recoupment of the overpayment. The employer appealed.

The Commonwealth Court held that the issue of the employer's failure to provide the claimant with LIBC-756 form before recouping its overpayment was waived by the claimant and, therefore, did not address the Judge's holding that the employer did not have to issue the form before taking its offset. The court then addressed whether the employer's recovery of the amount it overpaid to the claimant was barred by equitable principles and whether there was a "presumption of prejudice" whenever an employer seeks to recoup an overpayment of offset benefits. The court held there was no such presumption in every case. The court noted that the overpayment in question covered a period of weeks and not a period in excess of six months, and it found that the employer's recoupment of the $100 per week from the claimant was permissible. II

SIDE BAR

The court never answered the question of whether an employer is required to send an LIBC-756 form to a claimant prior to taking an offset, since they considered this argument waived by the claimant. However, it is recommended that the form be sent before the claimant is notified of an offset being taken to prevent the claimant from arguing surprise about the offset.

Dismissal of claim petition was proper where the claimant failed to prove extraterritorial jurisdiction for a work injury that occurred in New York State while the claimant was working at a New York job site.

Charles Greenwalt v. WCAB (Bristol Environmental, Inc.); 1894 C.D. 2013; filed 5/12/14; Judge Simpson

The claimant filed a claim petition alleging that he sustained a work-related low back injury while working for the employer. The employer took the position that Pennsylvania lacked jurisdiction since the claimant's injury occurred in New York and because the claimant's injury did not occur in the course and scope of employment. The Workers' Compensation Judge dismissed the claim petition, determining that the claimant did not prove that jurisdiction in Pennsylvania was proper under §305.2 of the Act. Specifically, the Judge found that at the time of injury, the claimant worked under a contract of hire made in Pennsylvania for employment that was principally localized in New York. The claimant, a union laborer, accepted a job with the employer at a job site in New York State that was located by a business agent. While in New York, the employer obtained lodging for the claimant. The claimant would work throughout the week and return home to Pennsylvania on weekends. The claimant alleged that he hurt his back from a slip and fall on ice as he was walking to his car to warm it up before leaving for the job site.

The claimant appealed, and the Appeal Board affirmed. The claimant then appealed to the Commonwealth Court. It was the claimant's contention that his employment was principally localized in Pennsylvania and argued that he was hired in Pennsylvania, trained in Pennsylvania and completed over 30 jobs in the past for the employer in Pennsylvania. Further, the claimant maintained that the job in New York was expected to last only three months for the claimant. Alternatively, the claimant argued that, if it was found that employment was not localized in Pennsylvania, it must be found that employment was not localized in any state, thereby making jurisdiction proper under §305.2 (a) (2) of the Act.

The Commonwealth Court, however, rejected the claimant's arguments and affirmed the Judge's decision. According to the court, the Judge's findings revealed that the claimant's employment was principally localized in New York and not in Pennsylvania. It pointed out that in finding whether employment is principally localized in a given state under the Act, one must consider whether a claimant worked at the location as a rule and not as an exception. The court concluded that the Judge's findings showed that the claimant worked exclusively at a New York job site after undergoing a week of training in Pennsylvania needed to start that work. Further, the court held that the Judge correctly determined that various jobs the claimant performed previously for the employer did not establish a continuous employment relationship for the purposes of determining where employment was principally localized. II

An order from the Judge denying a claim made against the Uninsured Employers Guaranty Fund on the basis of untimely notice was properly reversed where evidence showed that the claimant did not know of the employer's uninsured status until being notified of that possibility by the Bureau.

Pennsylvania Uninsured Employers Guaranty Fund v. WCAB (Lyle and Walt and Al's Auto and Towing Service); 1421 C.D. 2013; filed 5/12/14; Judge Covey

The claimant worked for the employer as a mechanic and sustained a compression fracture injury in the course and scope of his employment. The claimant filed a claim petition, and the employer did not respond. The claimant attempted to have medical bills paid through the employer's automobile liability insurance provider and then through the claimant's first party benefits automobile liability insurer, but both companies denied his claims. Thereafter, the Bureau informed the claimant by letter that the employer may not have had workers' compensation insurance. Four days after receiving this letter, the claimant mailed a Notice of Claim Against Uninsured Employer (notice) to the Bureau. Twenty-five days after the letter, the claimant filed a claim petition with the Bureau, seeking benefits from the employer and the Uninsured Employers Guaranty Fund (Fund). The Fund challenged the petition and took the position that the claim was barred due to the claimant's failure to comply with the notice requirements for making a claim against the Fund.

The Workers' Compensation Judge granted the claim petition filed against the employer, but denied the claim petition filed against the Fund on the basis that the claimant did not give timely notice to the Fund. On appeal, the Appeal Board reversed the dismissal of the claim against the Fund, holding that notice was timely. The Fund appealed to the Commonwealth Court.

The court noted that the claimant filed his notice with the Fund within 45 days of receiving the Bureau's letter stating that the employer may not be insured. The court found that this was compliant with §1603 (b) of the Act, which provides that an injured worker shall notify the Fund within 45 days after the worker knew that the employer was uninsured. The question for the court was whether the letter was the first point at which the claimant knew the employer was uninsured. The Judge found that the claimant knew of the employer's uninsured status before receiving the letter from the Bureau. The Commonwealth Court held otherwise. In the Commonwealth Court's view, the Board properly reasoned that §1603 (b) of the Act is triggered when a claimant "knew" rather than "should have known." The court pointed out that when the claimant learned medical bills were not being paid, he notified the employer, who repeatedly assured him that the problem was being investigated. In addition, when the payment of the claimant's medical bills was denied by the employer's automobile liability insurance carrier, there was no indication in the letter denying the claim that the medical bills would be covered under the employer's workers compensation insurance, nor did it state that the workers' compensation coverage had lapsed. The court, thus, held that the Judge's finding that the claimant had knowledge of the employer's uninsured status months before receiving the letter from the Bureau was not supported by the evidentiary record and, therefore, concluded that the claimant gave timely notification to the Fund. II

The court vacates Judge's decision dismissing employer's modification petition on the basis that the claimant was not at maximum medical improvement at the time of an IRE where the only evidence of record on the issue of MMI was the opinion of the IRE physician.

Arvilla Oil Field Services, Inc. and State Workers Insurance Fund v. WCAB (Carlson); 1578 C.D. 2013; filed 5/20/14; Judge Leavitt

The claimant sustained a work-related injury to his right hip, low back and right shoulder, which was accepted by the employer by way of Notice of Compensation Payable (NCP). Later, the claimant underwent arthroscopic surgery on the right hip, followed by a total hip replacement. The employer then filed a modification petition, alleging that the claimant had fully recovered from his low back and right shoulder injuries, but stipulated that the claimant had not fully recovered from the hip injury. In connection with that petition, the claimant's medical expert testified and said that the claimant was making progress with treatment, but experienced periodic setbacks. The claimant then filed a petition to review to add lumbar radiculopathy and lumbar spondylosis to the NCP.

Before the pending petitions were decided, the claimant was seen for an IRE. The IRE physician concluded that the claimant had a 10% impairment rating. The employer filed another modification petition based on the IRE results. In support of that petition, the employer relied on the deposition of the IRE physician, who said that, at the time of the exam, the claimant had reached maximum medical improvement (MMI). The claimant presented no evidence in opposition to the opinion given by the IRE physician.

The Workers' Compensation Judge granted the employer's modification petition in part, concluding that the claimant had fully recovered from his right shoulder injury. However, the Judge also concluded that the claimant had not fully recovered from his low back injury. The Judge also dismissed the employer's modification petition based on the results of the IRE, rejecting the opinion of the IRE physician that the claimant had reached MMI. In doing so, the Judge relied on the testimony given by the claimant's expert that he was continuing to make progress but continued to experience setbacks. The employer appealed, and the Appeal Board affirmed.

The Commonwealth Court vacated the decisions below, concluding that the Judge capriciously disregarded the only competent medical evidence of record on whether the claimant reached MMI for purposes of an IRE. The court pointed out that the claimant's medical expert did not testify on the issue of MMI. The court also concluded that it could not be inferred from the deposition of the claimant's expert whether the claimant had not reached MMI at the time of the IRE. The court remanded the case to the Judge and held if the Judge chooses to reject what is uncontroverted evidence, the Judge must adequately explain the reasons for his or her rejection and could not reject it for no reason or an irrational reason. II

Side Bar

The issue of MMI is a vital one for employers who are seeking to adjust a claimant to partial disability status based on an IRE of less than 50%, and the critical factor is the status of the claimant at the time the IRE is performed.

New Jersey Workers' Compensation

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Dario J. Badalamenti

The Appellate Division affirms a perceived inadequate fee award on a motion for medical and/or temporary benefits.

Patel v. Showboat Casino, Docket No. A-3739-12T3, (App. Div., decided 5/22/14)

On July 13, 2007, the petitioner was injured when he slipped and fell on the respondent's premises. Prior to filing a claim with the Division of Workers' Compensation, the petitioner's injury was deemed compensable by the respondent's workers' compensation carrier, and all reasonable and necessary medical treatment was authorized. The petitioner continued to treat until May of 2008, at which time he chose to abandon his claim and discontinue treatment for unspecified reasons. The respondent promptly filed a motion to dismiss for lack of prosecution, which was granted in June of 2008.

In November 2008, petitioner's counsel filed a motion to reinstate petitioner's claim, which the respondent did not contest. Approximately one month later, petitioner's counsel filed a motion for medical and/or temporary benefits. The Judge of Compensation granted the petitioner's motion in January of 2009, with counsel fees to abide final resolution of the claim. In March 2013, the matter was resolved by way of settlement, at which time the Judge awarded a counsel fee of $5,000 on the petitioner's motion for medical and/or temporary benefits. The petitioner appealed the fee award as inadequate in light of his receipt of medical benefits in excess of $250,000 following reinstatement of his claim.

In affirming, the Appellate Division relied on the Judge's comprehensive opinion, detailing her findings and setting forth the reasons for her fee award. As the Judge noted:

> [T]he only matter contested by [Respondent] was the necessity of petitioner's Motion for Medical and/or Temporary Disability Benefits. All of [Respondent's] efforts in arranging for the re-authorization of petitioner's treatment had taken place as a result of Appellant's Motion to Reinstate the Petitioner's claim, and by the time the Motion for Medical and/or Temporary Benefits was filed, the Petitioner's treatment had already been authorized.

As the petitioner's medical benefits resulted not from his motion for medical and/or temporary disability, but, rather, from the uncontested reinstatement of his claim, the Judge reasoned that petitioner's counsel was not entitled to a fee based on the costs of the petitioner's medical treatment. Rather, only a modest counsel fee was warranted based on petitioner's counsel's efforts in representing the petitioner as to his overall claim, including the services necessary to achieve its reinstatement. II

Side Bar

An award of counsel fees on a motion for medical and/or temporary benefits is at the discretion of the Judge of Compensation. However, as this case illustrates, when a respondent is able to demonstrate prompt compliance with its obligation to furnish reasonable and necessary medical treatment, either before or after the filing of the motion, it can be argued that only a modest counsel fee is appropriate.

Delaware Workers' Compensation

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Paul V. Tatlow

Medical bills incurred by the claimant for surgery are not compensable where the medical provider was not a certified provider in Delaware and did not obtain pre-authorization from the employer.

D&B Transportation v. Howard Vanvliet, (Superior Court-C.A. No. 13A-06-002 JTV) – Decided 4/30/14

This case was before the Superior Court on an appeal taken by the employer from the Board's decision which granted the claimant's petition to determine additional compensation in regard to a 2010 spinal surgery and also for subsequent pain management treatment.

The claimant had sustained a compensable work injury to his neck in February 2001. He had spinal surgery that year and received disability benefits. Many years later, on August 11, 2010, the claimant had a second spinal surgery by a surgeon in Maryland, who was not certified under the Workers' Compensation Act. The claimant filed a petition to determine additional compensation, seeking retroactive pre-authorization for the cervical spine surgery that was performed by the Maryland surgeon a few weeks prior to the filing of the petition. At the hearing, the employer argued that the surgeon was neither certified nor had he obtained pre-authorization to perform the surgery. The claimant argued that a treating physician need not be certified or pre-authorized to perform medical treatment so long as it was necessary, reasonable and related to the accepted work injury. The Board dismissed the claimant's petition for payment of the surgical medical expenses on the basis that the statute required that, if the claimant resides in Delaware and/or uses a Delaware provider, the provider must either be certified or receive pre-authorization to be reimbursed under the Act.

Following an appeal by the claimant and a remand, the Board in a subsequent decision accepted the opinions of several medical experts and concluded that the surgery at issue, as well as the subsequent pain management treatment, was necessary, reasonable and related to the claimant's work injury and, therefore, was compensable. The employer appealed from that decision, contending that the Board had erred. The court relied on the recent Delaware Supreme Court case in *Wyatt v. Rescare Home Care*, 81 A.3d 1253 (Del. 2013), which held that medical treatment given by an uncertified provider who has not obtained pre-authorization is not compensable unless certain narrow exceptions are met. As applied to this case, the court found that the evidence was clear that the Maryland surgeon was not a certified provider under the Act nor did he obtain pre-authorization for the spinal surgery. Therefore, the court held that, relying on *Wyatt*, the claimant could not recover the medical expenses at issue for the 2010 surgery since neither of those requirements was met. II

Side Bar

The *Wyatt* and *Vanvliet* cases have created concern among the claimants' bar such that the Delaware Trial Lawyers Association has proposed an amendment to portions of §2301 and §2322 of the Act which would expand the ability of claimants to treat with out-of-state and non-certified medical providers. The defense bar is opposing the proposed amendment on the basis that it would serve to undermine the Utilization Review and Healthcare Practice Guidelines. At the time of this writing, there are efforts underway to reach some type of compromise where the proposed amendment to the Act would be acceptable to both sides.

News from Marshall Dennehey

In her role as co-chair of the Women's Rights Committee of the Philadelphia Bar Association, **Niki Ingram** (Philadelphia, PA) and Marshall Dennehey hosted a Women's Rights Committee Meeting in our Philadelphia office on Thursday, June 5. Titled, "Your Law Degree: A Passport to Your Future," the program focused on opportunities and the role of the female attorney in academia. Speakers included Monica Taylor, VP of Development and Alumni Relations at the University of Delaware; Vanessa Lawrence, Associate Professor at Temple University; and LeaNora Ruffin, Assistant Dean of Career Development at Widener University School of Law.

Angela DeMary (Cherry Hill, NJ) was a member of the panel for the Fourth Annual Workers' Compensation Seminar presented by the New Jersey Department of Labor-Division of Workers' Compensation. This year's topics included *Expert Advice in Handling Second Injury Fund Cases*; *Temporary Disability Issues Since the Cunningham Case*; and *Ethical Issues in Fair Dealing With the Court and Other Parties*.