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What's Hot in Workers' Comp

BEYOND THE PESTLE AND MORTAR—BREAKING DOWN THE TREND TOWARD COMPOUNDED MEDICATIONS*

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J. Jeffrey Watson

Compounding of medication is trending nationwide as a reasonable alternative to commercially and readily available prescription care. This a la carte drug preparation is being billed as the therapy treatment du jour for injured workers nationwide, even when commercially manufactured medications are available at greatly reduced costs. Why? In many instances it is simply because the workers' compensation system is available to foot the bill. Employers, payors and claims professionals handling such matters should be happy to know that there are available solutions and, in most jurisdictions, a framework in place for employers and the claims community to curtail the trend.

Addressing compounded medication may be novel, but employers, workers' compensation claims professionals and litigators have been faced with demands for payment of non-traditional therapeutic medical care for years. We have all had to address a script from a physician prescribing an injured worker a hot tub, gym membership or newfangled device for therapeutic treatment. Where the efficacy of the care cannot be supported, denials have held in multiple jurisdictions for decades.

The same review strategy to address an obligation for payment of a compounded medication should prove just as successful. At the outset, an immediate focus should be the documentation from the medical provider. If proper and sufficient, the inquiry would next turn to the reasonableness and necessity of the prescribed care and an examination of more proven, cheaper options. Finally, the matter can be placed in an administrative or peer review forum, where jurisdictionally appropriate.

Understanding Compounded Medications

The practice of compounding medication is as old as the pestle and mortar itself. A compound, at its definition, is combining, mixing or altering several ingredients to make a new and unique medication. Once a routine activity of the pharmaceutical profession, as medications became commercially prepared and regulated, compounding remained primarily to address unique needs of the individual patient.

When not considered manufacturing, the practice of compounding is predominantly a state-regulated industry that, with exception, remains out of the cross-hairs of the Food and Drug Administration (FDA). Most notably, compounders cannot be required to obtain FDA approval for "patient-specific" drug products. There is a fine-line distinction between the individual FDA oversight of the ingredients being compounded versus the non-regulation of the finished, compounded product. Manufacturers and "outsourcing facilities" remain subject to federal regulation, a landscape that remains in flux subsequent to the Compounding Quality Act of 2013.

Due to its "patient-specific" nature, a utilization analysis of compounded medication within a workers' compensation setting requires an understanding and application of each state's respective workers' compensation, drug regulation and cost containment laws. The starting point for reaching a solution requires an understanding of where these provisions intersect.

In April 2014, Express Scripts, the largest pharmacy benefit management organization in the U.S., posted a Workers' Compensation Drug Trend Report providing analysis of workers' compensation prescription drug costs and utilization. Key findings of the report included:

- 84% of "narcotic spend" can be attributed to only 20% of injured workers.
- The percentage of injured workers obtaining a compounded

medication doubled from 2012 to 2013, costing an average of $1,299.13 per prescription.

- An increase in utilization of compounded medication as a major contributor to the overall "narcotic spend," in light of the fact that commercially available alternatives are available for hundreds, if not thousands of dollars less.

While focusing on pain management drugs and multiple therapy classes, the Trend Report also addressed utilization concerns with the "batch-to-batch" nature of compounded medications. The landscape is absent of reliable clinical studies supporting the efficacy of compounded medication when compared to commercially available alternatives. As such, physicians and pharmacists will have a difficult time providing justification for the utility of compounded medications. The vigilant claims management professional can work within this framework to question the reasonableness and necessity of a compounded script.

Efficacy Concerns

Proponents of compounding of medication often cite studies revealing less long-term damage to the body in chronic pain patients than through traditional pain pill usage. There are also situations where compounded medication may be the less expensive option for patients whose tolerance to traditional pain medications is at issue. Even in light of these potential benefits, however, efficacy concerns remain legitimate. Protocols for preparing each compound are not necessarily standardized, which raises concerns for strength, quality and purity. While a licensed pharmacist has to oversee the process, the actual compounding is often done by a technician or non-pharmacist who has received limited classroom training.

In a case focusing on the standards and practices within the compounding industry, a California baby died in June 2014 after he came in contact with his mother's compound transdermal cream. The mother, treating for a work injury, was prescribed a topical compound which included the synthetic pain reliever Tramadol and cough suppressant dextromethorphan. The coroner found lethal doses of these compounded medications in the baby's system. Workers' compensation and court documents reveal that the filling pharmacy billed $1,700 for a 25-day supply of the compounded cream. Facts are in dispute, and lawsuits remain pending.

This tragedy also led investigators to evidence of a "kickback scheme," with millions of dollars changing hands to broker doctors and pharmacists to continue to prescribe the compounded creams to workers' compensation patients. Kickback scheme or not, the profit margins in compounding medications remain the driving force. Often, brokers work with and for pharmacies and physicians to market and drive the "business."

To combat the questions of purity, efficacy and strength, the industry has a compass. The Professional Compounding Centers of America (PCCA) offers membership to compounding pharmacies to gain access to an extensive staff of highly-experienced pharmacists. PCCA maintains an FDA-approved facility and is often the main source for chemicals and formulas for its members.

Access to PCCA also affords members a means to have its compounds tested by a third-party to verify strength of the end product. While the compounding industry has established standards, in most non-sterile facilities the membership is often maintained for marketing purposes without regulation or guarantee that a standard is being followed.

Employer Protocols

For employers or payors, an effective documentation triage needs to be established at the outset. Vigilance is required to establish a practice to review requests for payment of compounded medication. Forms and proper medical documentation must comply with state regulations to ensure that charges are usual, customary and reasonable. Direct communication with the medical provider to document the care and confirm the availability and utilization of commercially available alternatives is an effective initial plan of action.

Some states, such as Delaware and Mississippi, have enacted legislation to limit the costs of compounded drugs. Acts in other states are pending. In all instances, cost containment and fee schedule laws must be consulted for the individual ingredients.

Formularies can be established, although a formulary is not necessarily grounds for denial once a compound has been prescribed.

After initial triage of documentation, queries should be posed to the prescribing physician. "We are simply denying the medication in other jurisdictions and telling the medical providers they need to prescribe something that is of usual and customary costs. No one has really pressed us on it as I doubt they would be able to substantiate the cost in court compared to what a 'regular' pharmacy would charge to make the same concoction," advised Nicole Topper, team lead at Sedgwick Claims Management Services.

Coupled with this approach, it is best practice to use a peer review or utilization review forum in states where available. This will shift the initial burden to the medical provider to demonstrate that the compounded script is reasonable and necessary, a central requirement in most states' workers' compensation statutes. A traditional independent medical evaluation, although sometimes cost-prohibitive, can also be employed in more complex situations.

Challenging Prescriptions

If the "reasonable and necessary" threshold is crossed, payors in states with cost containment and fee review regulations are encouraged to break down the compounded medication to its ingredients before considering payment. The purpose of most regulations is to curtail the escalating costs of medical expenses associated with treating a work injury. The logical progression to determine payment obligations is to break down a compounded script to its individual ingredients. Failing to interpret cost-containment regulations in this manner would be a reopening of Pandora's Box.

"We are used to carriers questioning scripts and denying payment. It is no different with compounded medication," acknowledged William Gallagher, Operations Manager for CKC, Inc., a parent company for multiple retail pharmacy locations. Since 2012, Mr. Gallagher has been responsible for overseeing the compounding operations for CKC. Mr. Gallagher advises that his company remains vigilant and flexible to ensure coverage is available for compounded medication prescriptions his pharmacies receive.

"Most insurance carriers require us to take a look at API's, Active Pharmaceutical Ingredients, when filling a script. Many larger organizations, such as Express Scripts, have lists of ingredients that they have stopped covering. In such instances, we will often use a commercially available alternative. Or, if a compounded medication requires something such as pure Gabapentin Powder and the powder is denied, we will often grind a Gabapentin tablet at much cheaper cost to complete the compounded medication."

In Pennsylvania, for example, the Medical Cost Containment Regulations cap the cost of individual prescription medications at 110% of the Average Wholesale Price (AWP). When repricing a compounded script, the API's should be priced individually. An actual Health Insurance Claim Form 1500 for a compounded cream of Ketamine HCL Powder + Clonidine HCL Powder + Gabapentin Powder + Ketoprofen

Powder + PCCA Lidoderm Base was billed at a sticker price of nearly $2,800. Taking the average generic price for each of these five ingredients and applying the applicable regulations results in a much more economical $400 cream.

This approach can be broken down. While pharmacies are mandated to bill at AWP, Mr. Gallagher advises that not every compounded recipe is able to be reduced. "Often the mechanics of a compounded formula do not provide a commercially available alternative at the strength being prescribed. What happens is that there may be too much active ingredient and too little base to make an effective similar compound for the patient to apply."

In such circumstances, it is best to approach the prescribing physician. While some may stand their ground with what has been prescribed, others will acquiesce where commercially available alternatives exist. If the medical provider does appeal the individual repricing strategy in the workers' compensation setting, this should go to a fee review setting where a number of defenses would apply. In Pennsylvania, there have been recent Fee Review Determinations that have curtailed repackaging of medication and have found that drug vendors do not have standing as a traditional provider would. These determinations could serve as precedent when reviewing payments for compounded scripts.

Compounded medication is far from being the snake oil of its time. Approved active ingredients are effective and regulated. However, the profit margins associated with uncontested scripts will continue to fuel the upward trend of injured workers and their physicians utilizing compounded medication as a treatment option. Requiring proper documentation, questioning reasonable alternatives and utilizing administrative remedies will keep compounded medication from becoming the designer drug of the future. II

Pennsylvania Workers' Compensation

By Francis X. Wickersham, Esquire (610.354.8263 or fxwickersham@mdwcg.com)


Francis X. Wickersham

A denial of a petition for a mental injury, on the basis that an armed robbery at gunpoint was not an abnormal work condition for the general manager of a check cashing store, is vacated and returned to the judge for analysis in accordance with *Payes v. WCAB* (*Pa State Police*),79 A.3d 543 (PA 213) (*Payes II*).

Pamela Murphy v. WCAB (Ace Check Cashing, Inc.); 1604 C.D. 2013; filed February 20, 2015; Judge Cohn Jubelirer

The claimant was a general manager of a check cashing store. On June 19, 2010, the claimant and her husband arrived at her employer's main office and store in the morning and parked next to a dumpster. When the husband opened the passenger side door, a gunman jumped out of the dumpster and pointed a gun in the husband's face. The gunman then held the claimant at gunpoint and forced her to go room-to-room and safe-to-safe, unlocking doors and turning off alarms. The claimant was unable to activate her panic button and could not reach the silent alarm. The gunman then forced the claimant upstairs and hog tied her. After the gunman left, the claimant managed to reach her cell phone and called 911. The police then arrived. Later, the claimant filed a claim petition, alleging physical injuries as well as Post-Traumatic Stress Disorder, anxiety and depression.

At the Workers' Compensation Judge level, the employer did not present any evidence disputing that the claimant suffered a psychological injury. Instead, the employer offered testimony from various witnesses relating to the employer's security measures and procedures, the claimant's training in that regard, as well as the employer's suspicion that the claimant committed the robbery that caused her injuries. Although the Judge found the claimant's testimony credible to establish that the incident at work caused her anxiety and fearfulness, which led to PTSD, he found that the robbery was not an abnormal working condition for the claimant as a general manager for a check cashing business. The claimant appealed to the Workers' Compensation Appeal Board, and the Board affirmed.

On appeal to the Commonwealth Court, the claimant argued that the Judge should have considered her case under the "physical/mental standard" and not the "mental/mental" standard. She additionally argued that, even under the "mental/mental" standard, she showed that the armed robbery was not a normal working condition of her employment. The Commonwealth Court rejected the claimant's argument that the case should have been decided under the "physical/mental" standard. The court held that the claimant's PTSD was not the result of her physical injury, which consisted of slight bruising of her wrists and ankles, but the entire experience of the armed robbery. According to the court, physical contact alone is insufficient and does not equate with the physical stimulus. The court did, however, vacate the Judge's decision on the basis that the Judge's conclusion that the armed robbery was not an abnormal work condition for the claimant and that it was not consistent with the standard set forth in the Supreme Court's decision in *Payes v. WCAB (PA State Police)*, 79 A 3rd 543 (Pa. 213) (*Payes II*). In *Payes II*, the Supreme Court clarified the abnormal working conditions standard and held that it must be evaluated on a case-by-case basis, explaining that, because mental injury cases are highly fact sensitive, for actual working conditions to be considered abnormal, they must be considered in the context of specific employment. An abnormal working conditions analysis does not end when it is established that the claimant generically belongs to a profession that involves certain levels or types of stress. The court returned the case to the Judge to apply the appropriate analysis and determine whether the armed robbery was an abnormal working condition. II

A late answer to a claim petition does not bar the employer from challenging the facts pleaded in the petition, and the Judge did not err in denying the petition because it was mailed to the employer at the wrong address.

Patrick Washington v. WCAB (National Freight Industries, Inc.); 1070 C.D. 2014; filed March 4, 2015; Senior Judge Colins

The claimant worked for the employer as a tractor trailer driver. He was in a motor vehicle accident unrelated to work, when his car was rear-ended by another car. After returning to work full duty, the claimant began experiencing pain in both of his arms and hands, which he claimed worsened over time. The claimant later filed a claim petition, alleging total disability from an aggravation of the injuries sustained in the motor vehicle accident in the form of repetitive motion, lifting and driving at work. The claim petition contained an incorrect address for the employer. The employer filed an answer 43 days after the Bureau mailed the claim petition.

At a hearing conducted by the Workers' Compensation Judge, the issue arose as to whether the employer was barred from disputing the factual allegations of the claim petition because of the late answer. However, no motion was ever made by the claimant to bar the employer, and there was no indication in the record that any further evidence on the issue was presented by either party. Later, the Judge issued a decision denying the claim petition. The decision did not address the late answer issue. The claimant appealed to the Appeal Board and argued that, because the employer's answer was late, the Judge erred in failing to rule on and grant his request to bar the employer from contesting that his injury was work related. The Board, however, affirmed.

The Commonwealth Court also affirmed. According to the court, the claimant did not show that the employer's answer was untimely. The court pointed out that, although the Bureau mailed the claim petition to the employer, the address used was not the employer's correct address. The claimant countered that the address to which the claim petition was mailed was actually owned by a corporation that was an affiliate of the employer. However, no such evidence was submitted by the claimant about this at the Judge level. Moreover, service of a document on an address owned by an affiliate of a corporation does not constitute service on the corporation itself. II

Under certain circumstances, an employer may recover attorney's fees when the claimant pursues a frivolous appeal.

Steven Smith v. WCAB (Consolidated Freightways, Inc.); 606 C.D. 2014; filed March 9, 2015; opinion *per curiam*

The claimant filed a May 1996 claim petition, alleging disability from exposure to a chemical on February 28, 1996. A Workers' Compensation Judge dismissed the claim petition, and the dismissal was affirmed on appeal. Subsequently, the claimant filed additional petitions involving the same incident, all of which were an effort to re-litigate the same alleged injury. In fact, as of December 2012, the total number of petitions filed by the claimant for this incident was approximately 17. In addition, the claimant had been before the Commonwealth Court five times for the same claim. The fourth time, the Commonwealth Court said that they agreed with the employer that the appeal was frivolous and that the conduct of the claimant and his counsel had been "obdurate and vexatious." The court further pointed out that the claimant's actions were unfair and unduly burdensome to the employer, who had been forced to defend against each of these unreasonable petitions.

The claimant's most recent petitions were denied by another Judge, whose dismissal of the petitions was affirmed by the Appeal Board. The claimant again appealed to the Commonwealth Court, which again dismissed the claimant's appeal. This time, though, the court awarded costs and counsel fees incurred by the employer to defend the appeal against the claimant and his attorney. According to the court, the ability of the courts to impose sanctions under Pennsylvania Rule of Appellate Procedure 2744 in cases such as this one remains. II

Side Bar

It has been conventional wisdom that costs for a frivolous appeal could not be imposed against a workers' compensation claimant since the Supreme Court's decision in *Phillips v. WCAB (Century Steel)*, 721 A.2nd 109 (Pa. 1999). The Commonwealth Court cited the *Phillips* case in their opinion. However, it also pointed out that in *Phillips*, the Supreme Court specifically distinguished it from another case, *Patel v. WCAB (Saquoit Fibers Company)*, 520 A.2nd 525 (Pa. Cmwlth. 1987), wherein sanctions were imposed on a claimant for a frivolous appeal that the Supreme Court considered a clear case of abuse. The Commonwealth Court believed that this was the Supreme Court's way of leaving open the ability of the appellate courts to impose sanctions.

In situations where the Act does not address a method of calculating the average weekly wage, the average weekly wage may be calculated using an alternative method that will advance the overall humanitarian purpose of the Act.

Benjamin Anderson v. WCAB (F.O. Transport and Uninsured Employers Guaranty Fund); 181 C.D. 2014; filed March 10, 2015; by Judge Leadbetter

The claimant filed a claim petition against the employer alleging he sustained a work-related injury on December 27, 2007, while working as a truck driver. The claimant had applied for a truck driver position in November of 2007. At that time, he was told by the employer's owner that he would be paid 30% of the employer's charges for a load to be delivered and would earn $1,000 to $1,200 per week. The claimant was also told that he would receive $100 for each run to pay lumpers (a person unloading a truck). In the claimant's first run, he unloaded the truck himself and kept the lumper fees. In his second run, the claimant paid lumpers $100. In his third run, he unloaded the truck himself because he did not have enough money to pay a lumper. While unloading, he suffered an injury, and, according to the claimant, the injury occurred about a week and a half to two weeks after he was hired.

The Workers' Compensation Judge granted the claim petition, finding that the claimant was an employee and not an independent contractor. The Judge also concluded that the claimant's average weekly wage (AWW) could not be calculated under §309 (d.2) of the Act, which provides that if an employee works less than a complete period of 13 calendar weeks and does not have fixed weekly wages, the AWW should be the hourly wage rate multiplied by the number of hours the employee was expected to work per week. The Judge, therefore, used an alternative method and arrived at an AWW of $405. Essentially, the Judge multiplied the three runs made by the claimant by $270 and divided that by two weeks of employment. He awarded the claimant benefits at the rate of $364.50 per week.

The claimant appealed to the Appeal Board and argued that his wages should have been $1,100 to $1,200, based on his testimony, or $900 to $1,000, based on the employer's testimony concerning expected weekly earnings. The Board, however, agreed with the Judge's AWW calculation. Nevertheless, they remanded the case to the Judge to address whether the lumper fees kept by the claimant should be included in the AWW.

On remand, the Judge concluded that the lumper fees should not be included in the AWW. The Judge also granted a petition to suspend the claimant's workers' compensation benefits filed by the Uninsured Employers Guaranty Fund (Fund) on the basis that the claimant had a

residual earning capacity in excess of his average weekly wage. The Board affirmed.

On appeal to the Commonwealth Court, the claimant again argued that the Judge's average weekly wage calculation was incorrect. The court concurred with the Judge that the AWW could not be calculated using the method in §309 (d.2) of the Act. But, the court held that the method adopted by the Judge was incorrect and agreed with the claimant's argument that his AWW should have been $810, which was the total amount he earned before the work injury. The claimant earned no wages in the first week of his two-week employment with the employer because there was no work available to him. Consequently, the court thought that inclusion of the claimant's first week of employment in calculating his average weekly wage would not accurately reflect the economic reality of his pre-injury ability to generate further earnings. The court reversed the decision suspending the claimant's benefits and remanded the case to the Judge to modify them based on the claimant's average weekly wage of $810 and an earning capacity of $440 per week. II

New Jersey Workers' Compensation

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

Dario J. Badalamenti

The Appellate Division provides clarification of the premises rule in the context of injuries occurring during ingress and egress from work.

Burke v. Investors Bank, Docket No. A-1551-13T1, 2015 N.J. Super. Unpub. LEXIS 552 (App. Div., decided March 16, 2015)

The petitioner parked her car in the parking garage of the office building in which she worked for the respondent, which was one of five tenants in the multi-story building. After parking her car, the petitioner entered one of the building's two entrances and walked through the lobby toward a bank of elevators. As she approached an open elevator, she tripped and fell into the elevator, injuring her knee.

The petitioner filed a claim with the Division of Workers' Compensation seeking medical and indemnity benefits. The parties consented to a bifurcated trial as to the issue of compensability and application of N.J.S.A. 34:15-36—*i.e.*, the so-called "premises rule"—which provides, in relevant part, that:

> [E]mployment shall be deemed to commence when an employee arrives at the employer's place of employment to report for work and shall terminate when the employee leaves the employer's place of employment, excluding areas not under the control of the employer.

At the conclusion of testimony, the Judge of Compensation issued a bench decision finding that the petitioner's injury was not compensable. The Judge stated:

> [T]he respondent employer did not dictate any specific entry into the lobby, nor mandate any specific use of one elevator or preclude the use of the stairways in order for [Burke] to gain access to the tenth-floor office. And it is clear that the entryway, the lobby and the elevators are not in the control of respondent.

The petitioner appealed.

In affirming the Judge's ruling, the Appellate Division relied on *Hersh v. County of Morris*, 217 N.J. 236 (2014). In *Hersh*, the petitioner was injured after she parked her car in an employer-provided parking garage and was struck by a car as she attempted to cross a public street to get to her office. The Supreme Court found that the petitioner's claim was not compensable. It reasoned:

> [T]he case law supports the principle that public places that are not under the control of the employer are not considered part of the employer's premises for purposes of workers' compensation benefits, even if employees use the route for ingress or egress to the place of employment, except in those instances where the employer controls the route.

Applying the principles set forth in *Hersh*, the Appellate Division concluded that the petitioner's injury was not compensable. There was no evidence that the respondent maintained or had exclusive use of the lobby or elevators in the building it occupied; that it exercised any control over the lobby or the elevators where the petitioner's injury occurred; nor that it directed the petitioner to utilize the route she took to get to her tenth floor office. As such, it could not be said that the petitioner was on the respondent's premises at the time of her injury. II

Side Bar

N.J.S.A. 34:15-36 was part of the legislature's amendment to the Act in 1979, which reinstituted the "premises rule" that limits an employer's liability for injuries occurring in areas controlled by the employer only. However, the Act fails to define the term "control" in this context. Absent such a definition, the Supreme Court has stated that control exists when the employer "owns, maintains, or has exclusive use of the property." *Kristiansen v. Morgan*, 153 N.J. 298 (1998). Accordingly, whether an employee's injury during ingress or egress to work is compensable under the Act is a fact-sensitive determination of the employer's control over the site of the accident.

Delaware Workers' Compensation

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

Paul V. Tatlow

The Board denies the employer's motion for a continuance based on a lack of "good cause" and because the employer's lack of preparedness was self-created.

Andres Urdaneta v. Trader Joe's, (IAB No. 1419092 – Decided March 10, 2015)

This case involved the claimant's petition to determine compensation due that was filed on October 15, 2014, and that was scheduled for a hearing before the Board on March 31, 2015. The employer filed a motion for a continuance of the hearing in order to allow sufficient time to defend the claim. This motion was opposed by the claimant.

In support of the motion, counsel for the employer argued that, despite the petition being filed in October 2014, it was unaware of the claim until January 5, 2015. The employer further argued that they had scheduled the claimant for a DME but could not obtain an available date until after the hearing date. Claimant's counsel asserted that, to the contrary, both the employer and its carrier were aware of the petition in October 2014. In support of that contention, counsel for the claimant demonstrated that she had verbal and written communications with both the employer and its carrier in October 2014 and had provided a copy of the DCD petition. Despite all of this, the evidence showed that the carrier did not assign counsel to the case until January 2015.

The applicable law in this situation, as discussed by the Board, is Section 2348(c) of the Act, which requires a showing of "good cause" in order to grant an extension of the 120-day deadline for holding a hearing on a DCD petition from the date of the notice of the pre-trial conference being issued. The Board reviewed the various bases for establishing "good cause," which include a previously scheduled witness being unavailable, the unavailability of counsel because of a conflicting court appearance or a justifiable substitution of counsel. The Board found that none of these reasons applied and that the employer's difficulty in being prepared for the hearing was self-created. Accordingly, the Board concluded that there was no "good cause" for a continuance of the hearing and that the problems the employer and its carrier had in not being prepared for the hearing were self-created by the delay in responding to the claimant's petition. Accordingly, the motion for continuance was denied. ||

Side Bar

As any practitioner will attest, the 120-day time limit on holding hearings on DCD petitions moves very quickly, even in cases that are handled efficiently. This case illustrates the problems that occur when such a petition is not handled appropriately, which, in this case, appear to involve at a minimum the employer having no medical defense to the petition. The lesson to be taken from this case is that it is imperative for both employers and carriers to work together along with their defense counsel in order to make certain that all petitions—especially DCD petitions—are responded to in a prompt and efficient manner. This requires communication between all three parties in order to review the merits of the petition, formulate a defense strategy and prepare all appropriate evidence to defend against the case.

News from Marshall Dennehey

From Monday, June 1st through Tuesday, June 2nd, the Pennsylvania Bureau of Workers' Compensation will hold its 14th Annual Pennsylvania Workers' Compensation Conference at the Hershey Lodge and Convention Center. **Niki Ingram** (Philadelphia, PA), director of the Workers' Compensation Department, will participate in *Basic WC Law, Part 2*, where she joins four other industry professionals for a panel discussion on the specific claims processes from the moment of injury until the final adjudication from both the injured worker's and the employer's point of view. For more information or to register, click here.

On Monday, April 27, 2015, **Angela DeMary** (Cherry Hill, NJ) will be a presenter at the *Advanced Workers' Compensation* seminar hosted by the National Business Institute. The seminar will provide current, definitive information on all aspects of workers' compensation law and procedure. Angela will be discussing issues in workers' compensation law, such as permanent total and partial disability, managed health care provisions, computation of benefits, fraud, settlement and average weekly wage considerations. She will also address litigation techniques for handling difficult cases, including preparation of the injured employee's case, preparation of the employer's case, presenting evidence, settlement strategies, and ADA and FMLA implications. For more information and to register, click here.

Tony Natale (Philadelphia, PA) successfully defended a Philadelphia-based chemical mixing company in an appeal arising out of a workplace injury in Lancaster, Pennsylvania. The claimant sustained a large disc herniation at the L5-S1 level of his spine while lifting company property. Ultimately, the claimant developed severe right-sided radiculopathy and was given a surgical recommendation. The diagnosis and mechanism of injury were never disputed by the employer/insurer. However, Tony was able to uphold the underlying dismissal of the claim petition based on the claimant's failure to give notice of any injury within the meaning of the Act. The appeal centered on the perceived violation that the Notice provision of the Act has on the "humanitarian perspectives" of the legislation. Tony argued that the letter of the law can be harsh at times, but nonetheless fair. The Appeal Board agreed and dismissed the claimant's appeal. ||