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What's Hot in Workers' Comp

PENNSYLVANIA WORKERS' COMPENSATION

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Francis X. Wickersham

A claimant's credible testimony, that he was not fully recovered from a work injury, does not alter a judge's decision terminating benefits based on testimony from the employer's medical expert that the claimant was fully recovered.

Carmelo Olivares Hernandez v. WCAB (F&P Holding Co.); 1820 C.D. 2017; filed July 19, 2018; Judge Covey

The employer issued a medical-only Notice of Compensation Payable after the claimant sustained an injury to his upper back while working modified duty from a prior work injury to the low back. Later, the employer laid the claimant off, and the claimant filed a reinstatement petition. The employer then had the claimant seen for an IME and, thereafter, filed a termination petition based on the IME physician's opinion that the claimant was fully recovered.

The Workers' Compensation Judge granted both the reinstatement and termination petitions, finding the claimant totally disabled, but only through the date of the IME, at which time the claimant was fully recovered.

On appeal, the Workers' Compensation Appeal Board reversed the Workers' Compensation Judge's decision, remanding the case for the judge to consider the deposition testimony given by the claimant's medical expert. On remand, the judge again granted both petitions. The Board again reversed the decision that granted the reinstatement petition but affirmed the decision granting the termination petition.

On appeal to the Commonwealth Court, the claimant argued that the granting of the termination petition was inconsistent with the judge's finding credible the claimant's testimony that he was not fully recovered. The Commonwealth Court rejected this argument and concluded that, although the claimant credibly testified that he continued to experience pain from the work injury after the IME, the Workers' Compensation Judge also credited the testimony of the employer's medical expert that the claimant had fully recovered from the work injury. The expert's testimony showed that the claimant's examination was objectively normal and any pain the claimant was having resulted from degenerative changes not related to the work injury. The Workers' Compensation Judge, as a fact finder, had the sole authority to weigh the evidence and properly terminated the claimant's benefits. II

An employer's issuance of Supplemental Agreements to a claimant during a period that the claimant is receiving benefits pursuant to a Notice of Temporary Compensation Payable is not an admission of liability for the alleged work injury.

LifeQuest Nursing Center v. WCAB (Tisdale); 1250 C.D. 2017; filed July 19, 2018; Judge Covey

The employer issued a Notice of Temporary Compensation Payable for an alleged work injury. During the time the claimant was receiving temporary compensation benefits, the employer filed two Supplemental Agreements with the Bureau based on the claimant's release to work and hours made available to her by the employer. The claimant later stopped working, and the employer then filed a Notice Stopping Temporary Compensation and a Notice of Denial. The claimant filed claim and penalty petitions, alleging the employer violated the Act by using Bureau documents in an inappropriate manner and unilaterally stopping partial benefits.

The Workers' Compensation Judge granted the claim petition, but also terminated benefits as of October 9, 2014. In addition, the judge dismissed the penalty petition, finding that the employer was not bound by the Supplemental Agreements since the Notice of Temporary Compensation Payments was properly stopped in accordance with the Act.

On appeal, the Appeal Board modified the Workers' Compensation Judge's decision as to the description of injury, reversed the denial of the penalty petition as well as the termination of the claimant's benefits, and remanded the case to the judge to decide the amount of the penalty. The Workers' Compensation Judge then issued a decision awarding no penalties to the claimant. The Board affirmed, and the employer appealed to the Commonwealth Court.

The Commonwealth Court agreed with the employer that issuing Supplemental Agreements during the time the employer was paying temporary benefits to the claimant was not an admission of liability. According to the court, the agreements were filed merely to document a change in benefits, based on a return to work. Additionally, the court held that the employer was not bound by the injury descriptions contained in the agreements. The court further held that the Board was wrong to conclude that, because the two agreements were filed after the Notice of Temporary Compensation Payable, the Notice of Temporary Compensation Payable converted to a Notice of Compensation Payable. The court concluded that the employer had retained all of its rights and defenses with respect to the underlying claim by timely filing the Notice of Temporary Compensation Payable and Notice of Compensation. Finally, the court found that there was substantial evidence to support the Workers' Compensation Judge's termination of benefits. II

A C&R Agreement cannot be used to set aside a fee review determination. Rather, a determination in favor of a provider may be set aside only by following the proper procedure set forth in the Act.

Armour Pharmacy v. Bureau of Workers' Compensation Fee Review Hearing Office (National Fire Insurance Company of Hartford); 1613 C.D. 2017; filed August 7, 2018; President Judge Leavitt

Following a 1999 work injury, the claimant and the employer entered into a C&R Agreement in 2000, settling the claimant's wage loss benefits, but leaving medical treatment open. In 2015, the employer requested Utilization Review of a topical compound pain cream. A Utilization Review Organization determined that the cream was reasonable and necessary, and the employer did not file a Utilization Review Petition. Later, an identical cream was prescribed for the claimant, and the employer denied payment "based on a Utilization Review." The billing pharmacy filed a timely Fee Review. It was determined that the employer owed the pharmacy $6,644.30 plus 10% interest.

The employer timely requested a hearing to contest the Fee Review Determination. At the hearing, the employer presented the Hearing Officer with a copy of a C&R Agreement approved by a Workers' Compensation Judge just three weeks before. The C&R Agreement included language stating: "No past, present or future benefits shall be paid for any compounded prescription cream, including but not limited to compound prescription creams prescribed by physician Dr. Jason Bundy. (See Addendum)."

The C&R Agreement also said there was "a belief" that the physician had a financial interest in the pharmacy and that neither the physician nor the pharmacy would hold the claimant responsible for charges related to the compounding prescription cream.

In light of the C&R Agreement, the Hearing Officer concluded that the Medical Fee Review Determination could not stand. The pharmacy then appealed to the Commonwealth Court, which held the C&R Agreement could not be used to set aside a Fee Review Determination which concludes that an employer owes reimbursement to a provider for a particular course of treatment. According to the court, paragraph 10 of the C&R Agreement—stating that the employer would pay reasonable, necessary and related medical expenses incurred before the hearing date—obligated the employer to pay for the compound creams dispensed by the pharmacy in 2016 since the expense had already been incurred. The court further noted that a valid C&R Agreement is binding upon the parties, but the pharmacy was not a party to the agreement. Consequently, the court held that a C&R Agreement to which a provider is not a party cannot be used to deprive that provider of the fee review procedures or to excuse the employer from paying the provider. To do so would violate the Act and due process. II

Delaware Workers' Compensation

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

Paul V. Tatlow

The Board finds in favor of the employer and concludes that the correct calculation of the claimant's average weekly wage does not include adding in personal time, holiday time, vacation time, sick time and vacation sell back time since those benefits are not payments for times when the claimant actually performed work.

Salvatore Musemici v. City of Dover, (IAB No. 1468435 – Decided May 25, 2018)

My colleague, Jessica Julian, Esquire, successfully represented the employer in this matter. The claimant sustained a compensable work injury on December 1, 2017, to his right ankle. He filed a motion with the Board to determine the average weekly wage, contending the employer had incorrectly done so.

At the hearing on April 25, 2018, the claimant testified that he was employed with the City of Dover Police Department and that personal

time is allotted at 40 hours each year and that, pursuant to his contract, he is paid for that as well as for vacation time. The claimant also testified that holiday pay includes days during which non-essential personnel are paid for the day, even if they do not work. He indicated that his sick time is a benefit in his contract, but he is still paid if he calls out sick. On cross-examination, the claimant acknowledged that both sick time and holidays involve him being paid, even if he does not work. The employer presented testimony from the Human Resources Coordinator for the City of Dover who testified that the categories that reflect wages when the claimant was actually present at work include extra duty pay, regular pay, overtime pay, shift differential pay, police court straight pay and training pay.

The Board framed the issue as, should the claimant's average weekly wage be calculated using the 26 weeks prior to his work injury, how that should be done and what should be included in that calculation. Under Section 2302 (a) of the Act, the term "average weekly wage" is defined, in part, as the weekly wage earned by the employee at the time of the injury at the job in which the employee was injured, including overtime pay, gratuities and regularly paid bonuses (other than an employer's gratuity or holiday bonuses), but excluding all fringe or other in-kind employment benefits. The Board relied on that statute, as well as case law, for the proposition that payments for any entitlement or benefit other than wages for time actually worked—overtime pay, gratuities, regularly paid bonuses, and room and board—should not be included in the average weekly wage calculation. The Board rejected the claimant's contention that his personal time, holiday time, vacation time, sick time, and vacation sell-back time should be included in the average weekly wage calculation since he admitted that those categories of time/pay were not times during which he "actually worked" or performed work. Rather, the claimant was paid for sick time, vacation time and holiday time, when he takes those days even though he does not work. Accordingly, the Board agreed with the employer's contention that those amounts should not be included in the average weekly wage calculation.

In conclusion, the Board stated that the claimant's proper gross amount of wages for the 26 weeks prior to his injury was $42,191.50, which included extra duty pay, regular pay, overtime, shift differential pay, court straight pay, training pay and compensatory time used. That figure, when divided by the 26 weeks actually worked, resulted in an average weekly wage of $1,622.75. That was held to be the correct average weekly wage as contended by the employer. II

Florida Workers' Compensation

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Linda W. Farrell

A Judge of Compensation Claims may consider a claimant's financial need relative to her request for an advance.

Anderson v. Broward County Sheriff's Office and Gallagher Bassett Services, Inc., (Fla. 1st DCA, No. 1D17-5151, July 25, 2018)

The claimant, a deputy sheriff, suffered a compensable injury in 2014. She was ultimately released to full duty and returned to work. In 2017, she requested a $2,000 advance in order to pay for an IME. The claimant had a base salary of $75,000 and also earned overtime doing off-duty security. She had not worked overtime in the two years preceding the motion, however, due to two pregnancies.

The employer argued that the claimant failed to show a financial need for the advance. The claimant contended that she established eligibility based on her 1% permanent impairment rating and the fact that the purpose of the advance was to pay the expense of an IME to support her pending petition for benefits. The Judge of Compensation Claims denied the motion for an advance, holding that the claimant failed to present evidence that her income was insufficient to pay for an IME, nor did she otherwise demonstrate a financial need for the advance.

Section 440.20(12)(c)(2) provides:

> In the event the claimant has not returned to the same or equivalent employment with no substantial reduction in wages or has suffered a substantial loss of earning capacity or a physical impairment, actual or apparent…2. An advance payment of compensation not in excess of $2,000 may be ordered by an [JCC]…after giving due consideration to the interests of the person entitled thereto.

The court pointed out that it has previously required a claimant seeking an advance to establish a "legitimate interest" or an "adequate justification," along with evidence that the claimed need for the advance has "some plausible nexus to the principal purpose" of Chapter 440, namely, "to address medical and related financial needs arising from workplace injuries." To hold otherwise would "result in automatic $2,000 advances from employers/carriers to claimants despite no connection to a pending claim for medical or related care or even a demonstrated need for the funds." *ESIS/Ace Am. Ins. Co. v. Kuhn*, 104 So.3d 1114 (Fla. 1st DCA 2014).

The First District Court of Appeals affirmed, holding that a Judge of Compensation Claims may consider a claimant's financial need for an advance even when the purpose of the advance is to pay for expenses related to establishing compensability or entitlement to benefits. II

New Jersey Workers' Compensation

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Dario J. Badalamenti

A Judge of Compensation relies on the opinion of respondent's treating physician in finding that petitioner failed to sustain her burden of proof and denying petitioner's motion for medical and temporary benefits.

Lebednikas v. Zallie Supermarkets, Inc., Docket No. A-2859-16T1 (App. Div., decided July 24, 2018)

In 2002, the petitioner underwent a partial right knee replacement. On January 21, 2014, while working for the respondent, the petitioner caught her foot on a floor tile and twisted her right knee. She received authorized medical treatment with a number of physicians, including Dr. Kahn, the orthopedic surgeon who had performed the partial right knee replacement in 2002. As her symptoms continued—despite physical therapy, anti-inflammatories and the use of a hinged knee brace—Dr. Kahn recommended a total knee replacement, which he causally related to the 2014 incident.

The petitioner filed a motion with the Division of Workers' Compensation seeking a total knee replacement as recommended by Dr. Kahn. In support of her motion, she presented the testimony of Dr. Cataldo, D.O., an expert in osteopathic medicine with no experience in orthopedic surgery. Dr. Cataldo testified that, based on his examination of the petitioner and his review of the treatment records and imaging studies, he believed the petitioner's need for a total knee replacement was due to her January 21, 2014, incident.

The respondent presented the testimony of Dr. DiVerniero—board certified orthopedic surgeon who has performed hundreds of knee replacements, including fifty revisions of partial knee replacements—who had treated the petitioner following her January 21, 2014, incident. Dr. DiVerniero testified that the petitioner required the total knee replacement even before her 2014 incident. Specifically, Dr. DiVerniero opined that the wear in the components of her partial knee replacement occurred over twelve years of normal functioning, which generated wear-debris particles, causing inflammation and effusion. He explained that the petitioner's twisting injury, although it may have aggravated her soft tissue, did not change the integrity of her components.

The Judge of Compensation denied the petitioner's motion based upon Dr. DiVerniero's testimony, which he found to be more specialized, more credible and more persuasive than the proofs offered by the petitioner. The judge found that the petitioner failed to sustain her burden of proof in establishing that her total knee replacement was necessitated by her January 21, 2014, incident.

In her appeal, the petitioner argued, in relevant part, that Dr. DiVerniero's testimony was not competent and, as such, the Judge of Compensation erred by relying upon it. In affirming the judge's ruling, the Appellate Division found that the judge considered Dr. Cataldo's contrary opinion, but found Dr. DiVerniero's opinion on causation to be more credible and persuasive. As the judge stated:

> Dr. DiVerniero's education, training and experience along with his very clear and detailed testimony clearly reveals that he is an accomplished orthopedic surgeon who has specialized knowledge with regard to knee pathology, the causes for such pathology and the types of surgery to address it. Dr. DiVerniero's explanation of petitioner's treatment, his use of the anatomic model to describe the knee condition and his explanation of the age-related breakdown of the prior, partial knee replacement hardware was credible and easy to understand.

The judge noted that Dr. DiVerniero had been personally involved in the petitioner's post-accident care. The Appellate Division referenced a prior decision where it held that a treating physician is often in a better position to express opinions as to causal relationship than an expert who is merely examining the patient in order to give expert testimony. See *Bird v. Somerset Hills Country Club*, 309 N.J. Super. 517, 522-23 (App. Div.). Accordingly, the Appellate Division concluded that:

> Dr. DiVerniero's testimony provided ample support for the judge's conclusion that while petitioner required a total right knee replacement, this was not due to the January 21, 2014 incident but rather to the wear of petitioner's partial knee replacement device and the related progressive arthritis in her knee. II

Side Bar

On appeal, the petitioner also argued that the Judge of Compensation erred by accepting Dr. DiVerniero's testimony because Dr. DiVerniero, purportedly, did not understand the standard for admission of expert medical testimony. Although during *voir dire* Dr. DiVerniero indicated that he understood the standard that is typically expected of a doctor to testify as an expert in court, he indicated that he did not know what the standard was called. The Judge of Compensation informed Dr. DiVerniero that the standard was "a reasonable degree of medical certainty" and asked Dr. DiVerniero if his testimony would be to that standard. Dr. DiVerniero indicated that it would.

The Appellate Division found that Dr. DiVerniero's opinions were in accord with the applicable standard, i.e., to a reasonable degree of medical certainty. The Appellate Division reasoned that when an expert offers an opinion on causation, the expert need not use the phrase "reasonable degree of medical certainty." *Eckert v. Rumsey Park Assocs.*, 294 N.J. Super. 46, 51 (App. Div. 1996) (citing *Aspiazu v. Orgera*, 535 A.2d 338, 343 (Conn. 1981).

Moreover, the Appellate Division reasoned that the opinion of a medical expert on causation should not be assessed based on "a single verbal straightjacket" but, rather, should be considered in its entirety and admitted if it "reflects an acceptable level of certainty." Id. at 52 (quoting *Matott v. Ward*, 399 N.E.2d 532, 534 (N.Y. 1979). The Appellate Division concluded that: "Dr. DiVerniero expressly stated that his opinion was offered to a reasonable degree of medical probability and explained his opinions were consistent with those generally accepted by the medical community. We therefore conclude the judge did not err by admitting and relying on Dr. DiVerniero's testimony."

News from Marshall Dennehey

Keri Morris-Johnston (Wilmington, DE) successfully defended a motion filed against the defense medical expert and the employer seeking fines and sanctions. This was an issue of first impression before the Industrial Accident Board. The claimant argued the defense expert fee was too high and violated the Workers' Compensation Act and Regulations. She also argued that the employer should be fined for paying the expert fees. The claimant argued the regulations restricted any physician testifying in a workers' compensation case from charging more than $2,000 for the testimony. After considering the competing arguments, the Industrial Accident Board found in favor of the employer and refused to impose a fine against the defense expert. The Board agreed with the employer that the regulations at issue were to limit the amount the carrier was required to pay for a claimant's expert fees, if awarded by the Board, and were not meant to limit an employer from choosing to pay more for its defense expert testimony.

Tony Natale (Philadelphia, PA) successfully defended a transportation authority in the litigation of a claim petition arising out of a trolley accident. The claimant, a trolley driver, was video-taped sleeping on the job in the back of a trolley. When he finally awoke, he realized that he was then behind schedule. He darted to the front of the trolley and began operating the vehicle while keeping his cell phone in hand (against regulations). He failed to stop at a stop sign and then exceeded the posted speed limit for the rail line. The claimant then ran through a rail stop light and struck another trolley. The video-tape inside the trolley was recording the entire time. At the moment of impact, the claimant barely moved and showed no traumatic injury. After a thorough review of the accident, the claimant was disciplined and set for discharge for cause. It was at this point that the claimant alleged horrific injuries that permanently disabled him from working. The video-tape was admitted into evidence, along with the claimant's testimony and medical expert testimony. The Workers' Compensation Judge found that the claimant did not sustain any injuries. The claim was dismissed.

Tony Natale (Philadelphia, PA) successfully represented a New Jersey-based auto insurance product management company. The claimant sustained injuries while working for this company in the form of thoracic outlet syndrome and right upper extremity maladies. She began incessant treatment with a chiropractor and was provided modalities such as adjustments, massage, manual traction, electrical stimulation and cold laser treatment. The carrier filed an application for utilization review, claiming the chiropractic treatment was no longer reasonable and necessary. The UR Determination found the treatment to be unreasonable on an ongoing basis. The claimant filed a petition to review the Utilization Review Determination, and litigation ensued. Both parties presented expert and fact testimony in support of their positions. The Workers' Compensation Judge thoroughly reviewed the evidence and found that the chiropractic treatment was unreasonable and unnecessary. As a matter of first impression in Pennsylvania, the judge also awarded attorney's fee against the claimant, stating that counsel for the claimant must reimburse Tony's time and expense to attend a hearing where the claimant's attorney did not appear in a timely fashion. II