



The Medicare, Medicaid and SCHIP Extension Act of 2007: Tips to Avoid Compliance Confusion

On December 29, 2007 President Bush signed into law the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). Section 111 of the MMSEA will change the way in which worker's compensation practitioners process claims in 2009. Section 111 requires practitioners to report detailed information to Medicare in the very early phases of a worker's compensation claim in order to avoid later hassles and monetary penalties.

Section 111 aims to determine the Medicare entitlement of all claimants early in a worker's compensation case, ensuring that Medicare is treated as the payer of last resort when an employee is primarily covered under an active group health plan. The penalty is \$1,000 per day that the insurer is out of compliance with the Section 111 reporting guidelines. While this penalty seems harsh, the new rules do not take effect until late 2009, so early planning and registration can eliminate a scramble towards compliance during the next 6 months.

The effective dates for these new rules are January 1, 2009 for group health plan arrangements (GHPs) and July 1, 2009 for liability insurance including self-insurance, no-fault insurance, and worker's compensation plans (non-GHPs). After July 1, 2009, non-GHPs must (1) determine whether a claimant is entitled to Medicare bene-

fits; and if he is, (2) to submit certain information about the claimant to CMS, the administrative agency of Medicare and Medicaid.

A Supporting Statement was released by CMS in August 2008 explaining what type of information needs to be reported. Applicable reporting entities will submit this information by first registering online with a secure website. Collection of claimant info will be on a quarterly basis. Non-GHP data will be on an ongoing basis for non-fault insurance and worker's compensation for non-contested claims and on a one-time basis for contested cases where there is a single settlement, judgment, or award. CMS will require early notice via input into the secure website of the claimant's full name, address, date of birth, gender, social security number, insurance type, name and address of primary plan, policy and claim number, policy holder name, date of injury, state of venue, and specific information regarding claim resolution.

An Implementation Guideline was released by CMS in September 2008. For worker's compensation plans, the recommended systems development period is between January 1 and June 30, 2009. From May 1 to June 30, 2009, worker's compensation responsible reporting entities (RRE) are to electronically register via the Coordination of Benefits

(Continued on page 11)

<i>Inside This Issue...</i>	
Commonwealth Court	
Case Reviews.....	page 2

COMMONWEALTH COURT CASE REVIEWS

Lori Jamison v. Workers' Compensation Appeal Board (Gallagher Home Health Services), No. 399 C.D. 2008, Filed August 19, 2008.

(Traveling Employee—A claimant may work for more than one employer and still be a traveling employee covered under the Act; the inquiry will focus on what claimant was doing at time of injury.)

Claimant was employed as a home health nurse by Gallagher, which required her to travel to visit between one and eight of Gallagher's clients per day. Claimant was not required to go into Gallagher's office before or after any visits. Claimant completed all paperwork at home. Employer paid claimant a fixed wage for the time she spent with a patient and reimbursed claimant for her mileage after she left the first patient's home. Employer did not pay claimant's mileage to the first patient's home and did not pay claimant's mileage from the last patient's home each day.

Gallagher permitted claimant to engage in other activities between patient visits. As such, she also worked for two other employers. On any given day, she could be working for all three employers.

On Thanksgiving Day in 2005, claimant was scheduled to visit two patients for Gallagher. While traveling from her home to the first patient visit, claimant was involved in a motor vehicle accident, in which she sustained injuries.

Claimant filed a claim petition alleging that she suffered a work-related injury. Employer denied that claimant was a traveling employee or that she was in the course of her employment when

the accident occurred. The Workers' Compensation Judge agreed that claimant was not a traveling employee because on any given day she could be working for any one of, or all three of, her employers. The claim was denied and claimant appealed to the Board, which affirmed.

Claimant then sought review by the Commonwealth Court. The Court noted that what constitutes "scope and course of employment" is broader for traveling employees than for stationary employees, and it includes driving to any appointments for the employer. The determination of whether an employee is a traveling employee is based on the following factors: 1) whether the claimant's job duties include travel; 2) whether the claimant works on the employer's premises; or 3) whether the claimant has no fixed place of work. Here, the WCJ concluded that a person who works for several employers on any given day cannot be a traveling employee.

The Court noted that, but for the multiple employer issue, there would have been no doubt that claimant was a traveling employee. Because she was a traveling employee, claimant was entitled to a presumption that she was working for employer during her drive from home to the patient visit. To rebut that presumption, employer had to establish that claimant had abandoned her employment at the time of injury. Here, there is no evidence that claimant could have been found to have abandoned her duties. To the contrary, she was on her way to the home of one of employer's clients.

The order of the WCAB was reversed.

National Fiberstock Corporation (Greater New York Mutual Insurance Company) v. Workers' Compensation Appeal Board (Grah),

No. 1456 C.D. 2007, Filed August 29, 2008.

(Reinstatement—Claimant's reinstatement petition following termination order is not barred by res judicata or collateral estoppel.)

Claimant, a machine operator, suffered a work-related injury to her wrist on April 23, 1992. Following carpal tunnel surgery, claimant returned to work without a loss of wages until 1994, when employer closed its plant. Employer then resumed payment of claimant's total disability benefits.

On November 7, 1997, employer filed a termination petition. The Workers' Compensation Judge ultimately found that claimant had fully recovered as of October 20, 1997. Claimant appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's decision.

On February 2, 2005, claimant filed a reinstatement petition, alleging that as of January 3, 2005, she suffered a recurrence of her disability in the nature of a worsening of her condition. Following hearings and the submission of contradictory expert testimony, the WCJ reinstated claimant's benefits, concluding that claimant had experienced a worsening of her injury in the form of muscle wasting, pain, as well as tingling and numbness in her fingers. Employer appealed to the WCAB, which affirmed.

On appeal before the Commonwealth Court, employer argued that claimant's reinstatement petition was barred by the doctrine of res judicata or collateral estoppel given the prior decision which found claimant to have fully recovered.

The Court agreed that the doctrine of res judicata prevents relitigation of claims and issues that have been previously decided. The Court further noted that, in order to have her benefits reinstated after termination, claimant had to prove a causal connection between her current condition and

the prior work injury by establishing that (1) her work injury has recurred and (2) her physical condition has changed since the prior decision. In contrast, in the termination petition, employer had the burden of proving that claimant's disability had ceased. Because the issues are not identical, the Court held that claimant's reinstatement petition was not barred by res judicata or collateral estoppel.

The Court noted that claimant's medical expert, who was found credible by the WCJ, opined that, assuming claimant had fully recovered in 1997, her carpal tunnel syndrome had recurred because it was present in 2005 when he saw her. The difference in her condition in 1997, i.e., the absence of carpal tunnel syndrome, and in 2005, i.e., the presence of carpal tunnel syndrome, constitutes a physical change in her condition.

The decision of the WCAB affirming the WCJ's order reinstating benefits was affirmed.

Erisco Industries, Inc. and In-servco Insurance Services, Inc. v. Workers' Compensation Appeal Board (Luvine), No. 657 C.D. 2008, Filed September 3, 2008.

(Collateral Estoppel—Where employer fails to establish chain of custody of drug test sample during claim petition, employer may not rely upon that same drug test in subsequent suspension petition.)

In February of 1997, claimant suffered amputations of three of his fingers, as well as a knee injury, while working as a machine operator. After the injury, claimant underwent a drug test pursuant to employer's policy. Based on positive results for cocaine and marijuana, employer terminated claimant's employment and issued a notice of compensation denial, asserting that claimant did not suffer the injury within the scope of his employment.

Claimant filed a claim petition, which was denied. The Workers' Compensation Appeal Board affirmed the Judge's decision. The Commonwealth Court reversed, concluding that employer failed to independently establish the required chain of custody for claimant's urine sample and that the WCJ's denial of the claim petition was, thus, not supported by substantial evidence. The Supreme Court denied employer's petition for allowance of appeal.

In March of 2004, employer filed a suspension petition. Employer argued that claimant had been released to full-time heavy duty work and that, were it not for his criminal conduct resulting in his termination, claimant's regular duty job would have been available to him. Claimant argued that employer was estopped from asserting that he was discharged due to criminal conduct given the prior decision of the Commonwealth Court.

The WCJ accepted the testimony of employer's witnesses and found that claimant was capable of returning to his time of injury position. The WCJ stated that the position, however, was not available to him due to his own actions and not as a result of the work injury. Consequently, the WCJ entered an order suspending claimant's benefits.

The WCAB reversed, concluding that employer was collaterally estopped from relitigating the drug test issue and that employer was not entitled to present more conclusive evidence to establish the chain of custody.

On appeal to the Commonwealth Court, employer argued that the WCAB erred in its application of the doctrine of collateral estoppel. Under that doctrine, factual and legal determinations are conclusive between the same parties in a subsequent action involving different causes of action. The Court was not persuaded by employer's argument.



Employer had a full opportunity to establish the results of the drug test during the prior claim petition proceeding and failed to do so. Hence, employer failed to meet the burden of establishing its entitlement to suspend claimant's benefits.

Accordingly, the order of the WCAB was affirmed.

Christopher Combine v. Workers' Compensation Appeal Board (National Fuel Gas Distribution Corporation), No. 539 C.D. 2008, Filed August 14, 2008.

(Impairment Rating Evaluation—Section 306(a.2) of the Act requires a claimant to have reached MMI before his impairment rating may be calculated.)

Claimant suffered a work injury to his knee in the form of a torn medial meniscus on December 4, 2000. Employer issued a Notice of Compensation Payable and began paying total disability benefits.

Claimant underwent an impairment rating evaluation (IRE) on June 20, 2006 and was found to have a 20% impairment. Consequently, employer filed a Modification Petition seeking to change claimant's disability status from total to partial. Claimant filed a timely answer asserting that modification is not appropriate inasmuch as he had not reached maximum medical improvement (MMI).

The Workers' Compensation Judge rejected claimant's argument and granted employer's petition.

Claimant appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's decision.

Claimant then sought review by the Commonwealth Court, arguing that Section 306(a.2) of the Act provides that "the degree of impairment shall be determined based upon an evaluation by a physician...pursuant to the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment." The Guides provide that permanent impairment may only be rated after the person reaches MMI. As such, claimant argued that Section 306(a.2) of the Act request a claimant to have reached MMI before his impairment rating may be calculated.

The Court agreed, noting that the General Assembly precluded an employer from obtaining an IRE until the claimant has obtained 104 weeks of total disability. The Court viewed this "waiting period" as a reasonable period of time for healing or recovery to occur and, therefore, as synonymous with MMI.

The decision of the WCAB was reversed.

(Editor's Note: The employer has filed a Petition for Allowance of Appeal with the Supreme Court. As of the date of this publication, the Supreme Court has not addressed the employer's petition. If the Supreme Court refuses to consider the issue, the Commonwealth Court's decision will be final and will severely limit the ability



of employers to make use of IREs in the future.)

Robert Scott v. Workers' Compensation Appeal Board (Ames True Temper, Inc.), No. 647 C.D. 2008, Filed September 29, 2008.

(Violation of Work Order—Where claimant is performing a job duty but violates a safety rule doing so, benefits are still due despite violation of positive work order.)

Claimant filed a claim petition alleging he sustained a specific loss of his index finger on his right hand. He alleged that the injury occurred while he was attempting to remove a piece of metal that became stuck in a machine he was using.

Before the Workers' Compensation Judge, claimant testified that he fed a coil of steel through the machine and the steel entered a portion of the machine where a "die" goes back and forth, shearing the steel to size and punching holes in the steel. The steel caught onto the die and buckled. Claimant attempted to correct the problem as he had done in the past, i.e., he placed the machine on "jog," reached up underneath the die to pull out the steel. When he did so, the die moved severing his finger.

Employer presented testimony from the press operator who trained claimant to work on the machine. He denied that claimant was instructed to reach up underneath the machine to unjam it and to press the "jog" button while his hand was still in the machine. Rather, removing the guards on the machine prevents power from going to the press. According to the employer's witnesses, the claimant should have cut all power to the press before trying to correct the malfunction. Employer's witnesses also established that employees are told not to bypass the safety guards.

The WCJ credited employer's

witnesses and denied claimant's petition concluding that claimant's injury occurred as a result of a violation of a positive work order, i.e., he failed to follow safety rules in attempting to fix the jam. The Workers' Compensation Appeal Board affirmed.

Claimant argued before the Commonwealth Court that the WCJ erred in finding that employer met its burden of proving that he was not entitled to benefits based on his violation of a positive work order. The Court agreed.

In order to meet its burden of proof, the employer must show that the injury was caused by the violation of the work rule, the employee actually knew of the order or rule, and the rule implicated an activity not connected with the employee's work duties. Here, the third element was not met. In attempting to remove the steel that had become stuck, the claimant was not engaged in an activity that was disconnected from his work duties so as to remove him from the course and scope of his employment, thereby precluding an entitlement to benefits. The WCJ erred in denying his petition.

The decision of the WCAB was reversed and the case remanded to the WCJ for an assessment of costs and counsel fees, if appropriate, as well as an assessment of benefits for an appropriate healing period.

Donald Crawford, as personal representative of Josephine Crawford, Deceased, v. Workers' Compensation Appeal Board (Centerville Clinics, Inc.), No. 2331 C.D. 2007, Filed October 10, 2008.

(Compromise and Release Agreement—Claimant's death rendered C&R null and void where the requirements of §449 of the Act were satisfied prior to claimant's death but where the WCJ did not issue a decision

approving the C&R until after claimant's death.)

On August 27, 2001, claimant sustained a work-related low back injury. On August 24, 2005, claimant and employer entered into a Compromise and Release Agreement under which they agreed to a full resolution of the workers' compensation claims stemming from claimant's work injury. At the August 24, 2005 hearing, claimant appeared in a wheelchair but answered the questions posed to her such that the Workers' Compensation Judge found that claimant "had a full knowledge and understanding of all provisions of the C&R and had fully reviewed the same with her lawyer and had all questions answered."

On August 28, 2005, claimant died of Stage IV cervical cancer. By decision and order dated August 29, 2005, the WCJ approved the C&R, which required employer to pay claimant a lump sum of \$45,000, less deductions for attorneys' fees and domestic relations obligations.

Employer appealed the WCJ's decision after becoming aware that claimant had passed away. Employer argued that because claimant died prior to the circulation of the WCJ's decision and order, the C&R was void. Thereafter, the parties stipulated that the matter should be remanded to the WCJ to develop and consider the after-discovered evidence of claimant's death and its implications on the C&R. The Workers' Compensation Appeal Board granted the stipulation.

On remand, the WCJ found that, although claimant was in a wheelchair at the time of the hearing, she did not impress the WCJ as being in poor health. The WCJ noted, however, that paragraph 18 of the C&R provided: "Claimant certifies that she is suffering from no known life-threatening or terminal illness(es) unrelated to her work injury and agrees that this C&R is null and

void upon her death if not approved by a judge."

As such, the WCJ found the C&R to be null and void. The WCAB affirmed.

The Commonwealth Court also noted the language of the C&R which plainly rendered the agreement null and void inasmuch as the decision and order was issued after claimant passed away. The Court noted that, had the agreement not included such language, or had the WCJ indicated on the record during the hearing on the C&R that he was approving the C&R, a different holding may have resulted. Here, however, the WCJ did not err in declaring the C&R null and void.

The decision of the WCAB affirming the order of the WCJ was, thus, affirmed.

Scot Costa v. Workers' Compensation Appeal Board (Carlisle Corp.). No. 822 C.D. 2008, Filed October 14, 2008.

(Unemployment Compensation Credit—Employer need not raise as a defense the unemployment compensation credit inasmuch as §204(a) of the Act requires the credit as a matter of law.)

Claimant was employed as a truck driver and sustained injury when he hit his head on the top door jam of his truck. He fell and landed on his feet, but suffered pain to his back, neck and side. Claimant returned to work at light duty until July 16, 2004, when he began receiving unemployment compensation benefits at the rate of \$422 per week.

On July 19, 2004, claimant underwent a C6-7 discectomy, which did not improve his complaints of pain. He continued to experience numbness when driving or sitting too long. He advised employer of his post-surgical restrictions and asked to be put back to work, but employer could not accommodate his restrictions.

Both claimant and employer filed petitions. On June 6, 2005,

the Workers' Compensation Judge issued a decision that granted claimant's claim petition, denied claimant's penalty petition, and dismissed employer's physical exam petition. Both parties appealed. Claimant argued that the WCJ erred in failing to award attorneys' fees, and employer argued that the WCJ erred in failing to specify that claimant's compensation award was to be reduced by the \$422 weekly unemployment compensation benefits he received.

The Workers' Compensation Appeal Board affirmed the WCJ's determination that employer's contest was reasonable. The WCAB remanded the case to the WCJ, however, for a determination as to the credit to be allowed due to claimant's receipt of unemployment compensation benefits.

On remand, the WCJ held employer was entitled to the credit. The WCAB affirmed that determination and claimant appealed to the Commonwealth Court.

The Court noted claimant's argument that employer waived its ability to offset claimant's weekly workers' compensation payments by the amount of his unemployment compensation by not presenting evidence on that issue. In response, employer argued that §204(a) of the Act is self-executing and, because claimant's own testimony established that he was receiving \$422 per week in unemployment compensation benefits, it was not necessary for employer to also present evidence.

The Court noted that §204(a) of the Act directs the WCJ to credit the amount of a claimant's unemployment compensation benefits against the amount of the compensation awarded by the WCJ. The Court also noted that the WCJ can rely on evidence in the record regardless of which party presented the evidence or which party is benefited by the evidence. Finally, the Court noted

that the WCJ was required to reduce claimant's award by the amount of his unemployment compensation benefits regardless of whether employer had requested the offset because the mandate of §204(a) cannot be waived by an employer.

For these reasons, the decision of the WCAB was affirmed.

Joseph Nickel v. Workers' Compensation Appeal Board (Agway Agronomy), No. 719 C.D. 2008, Filed October 22, 2008.

(Medical Bills—A provider may not collect the difference between the re-priced amount of the provider's charge and the amount paid by DPW from the employer or its workers' compensation carrier.)

Claimant injured his low back while at work. Employer denied liability and a claim petition was filed.

During the litigation, claimant underwent two back surgeries and other treatments. The bills were sent to employer's carrier, which refused to pay the bills pending the outcome of the litigation.

Because claimant had no other insurance, the medical provider billed claimant's secondary insurer, the Department of Public Welfare (DPW). DPW's payment schedule was less than the workers' compensation schedule for these services. DPW paid \$12,278.38, which the provider accepted.

Thereafter, the parties entered into a Compromise and Release Agreement pursuant to which employer agreed to pay all medical bills in accordance with §306 of the Act (Act 44). DPW then asserted a lien for payment of \$12,278.38, which employer paid.

Claimant subsequently filed a Penalty Petition alleging that claimant failed to pay for reasonable and necessary medical expenses. Claimant asserted that employer violated the Act by sat-

isfying only the DPW lien rather than pay the bills at the Act 44 re-priced amount.

At hearings before the Workers' Compensation Judge, claimant presented testimony from a representative of one of his medical providers. He testified that claimant did not owe the provider any money, and that it was not the provider's intention to "balance bill" the claimant. He maintained, however, that employer was responsible for paying the difference between the amount paid by DPW and the amount that employer would otherwise have been required to pay according to the higher Act 44 re-priced payment schedule.

The WCJ agreed and granted penalties, noting that employer unfairly benefited by initially denying the claim, causing claimant's healthcare providers to accept payment at the lower DPW schedule. The WCJ found that employer violated the Act and the C&R Agreement by failing to pay in accordance with the Act 44 fee schedule.

The Workers' Compensation Appeal Board reversed, holding that the WCJ lacked jurisdiction to resolve a fee dispute. Claimant then sought review by the Commonwealth Court.

The Court disagreed with the WCAB and found that the WCJ did have jurisdiction to hear the matter. The Court also disagreed with the WCJ that employer violated the Act because it did not reimburse the provider in accordance with the Act 44 fee schedule.

The Court noted that federal law requires that Pennsylvania prohibit its Medicaid agency (here the DPW) from seeking to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service if the total of the amount of the liabilities of third parties is at least equal to the amount payable for that service under the plan. Like-

wise, the federal regulations explicitly limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency.

The Court noted that the clear import of the federal regulations is that the Medicaid payment is the total amount owed to the provider for the services rendered and the provider may not attempt to recover any additional amounts elsewhere.

Accordingly, employer did not violate the Act or the C&R Agreement by refusing the provider's demand for additional payment. The WCAB correctly denied and dismissed claimant's Penalty Petition.

Neil Folmer v. Workers' Compensation Appeal Board (Swift Transportation), No. 596 C.D. 2007, Filed October 22, 2008.

(Termination Petition—In a subsequent termination petition, the employer may show a change in the claimant's physical condition by presenting medical testimony that there is no objective evidence to support claimant's subjective complaints and that the claimant is engaging in symptom magnification.)

Claimant, a truck driver, suffered a work injury when he was hit in the face by a box of crowbars while unloading a truck. Claimant's injury was defined as "positional vertigo" and "cervical disc syndrome or cervical myalgia and tension headache."

Six years later, employer filed a Termination Petition. Employer's medical experts testified that claimant had fully recovered from his work-related injury as of May 31, 2001. Claimant's medical experts testified to the contrary.

The Workers' Compensation Judge denied the termination, although the WCJ did note that he was troubled by the fact that the claimant's medical evidence was stale and that claimant had not

undergone any recent diagnostic testing.

On August 9, 2004, employer filed a second termination petition, alleging that claimant had fully recovered as of December 11, 2003. In support of this petition, employer presented testimony from Dr. Howard Senter, a neurological surgeon. Dr. Senter performed a battery of tests and, although some of the results were not normal, Dr. Senter explained that claimant was faking. Overall, Dr. Senter opined that claimant was fully recovered and capable of returning to his prior job without restrictions. Employer also presented testimony from John B. Talbott, M.D., a neurologist who examined claimant on September 20, 2005. Dr. Talbott confirmed that there were no objective findings to support claimant's numerous subjective complaints.

The WCJ granted employer's second petition, noting: "*I am now convinced that the claimant has symptom magnification and is a malingerer as testified to by Dr. Senter and as corroborated by the testimony of Dr. Talbott.*"

Claimant appealed, and the Workers' Compensation Appeal Board affirmed. The WCAB determined that the credible testimony of Dr. Senter and Dr. Talbott was legally competent and sufficient to support a termination of benefits.

On appeal before the Commonwealth Court, claimant argued that the WCJ and WCAB erred given the Supreme Court's decision in Lewis v. WCAB (Giles & Ransome, Inc.), 591 Pa. 490, 919 A.2d 922 (2007). In Lewis, the Court held that in a second termination petition, an employer must show that the claimant's physical condition has changed since the prior denial of a termination.

The Court disagreed with claimant's argument. Employer failed in its first termination petition because the WCJ credited claimant's subjective complaints of pain. In order to prevail in its



second petition, employer had to present medical evidence to show that after May 31, 2001, claimant's condition changed. In other words, employer's case had to begin with the adjudicated facts as found by the WCJ in the first termination petition and work forward in time in order to show the required change.

Here, both Dr. Senter and Dr. Talbott, who examined the claimant in 2003 and 2005, testified that claimant's complaints were either false or not related to the work injury. During the prior litigation, the objective findings of mild nystagmus and taut neck muscles supported claimant's subjective complaints. Dr. Senter and Dr. Talbott did not find any nystagmus, and they found claimant's neck muscles to be normal, not taut. Accordingly, employer presented medical evidence that showed a change in the claimant's physical well being that affects his ability to work. The court noted that any other holding would mean that an employer could never terminate benefits where, as here, the claimant's injuries consist primarily of subjective complaints, and the credited evidence shows that the claimant is faking.

The decision and order of the WCAB was affirmed.

Patricia Waronsky v. Workers' Compensation Appeal Board (Mellon Bank), No. 367 C.D. 2008, Filed October 22, 2008.

(Course and Scope of Employment—When not actually engaged in activities furthering the employer's business at the time

of injury, claimant must show that he or she was on premises occupied or controlled by the employer when the injury occurred in order to be eligible for benefits.)

Claimant sought total disability benefits beginning January 28, 2005. On that date, she was struck by a motor vehicle while crossing Sixth Avenue in downtown Pittsburgh prior to the start of her work shift.

The parties agreed to bifurcate the issues of compensability and disability, and first sought a determination as to whether claimant was within the course and scope of her employment when she was injured.

Claimant testified that she was assigned to work at employer's Service Center on Sixth Avenue and worked the 6:00 pm to 2:00 am shift. Claimant could not take public transportation because no buses were available to take her home. As such, she drove to work and parked in employer's parking garage, which is located on the opposite side of Sixth Avenue from the Service Center. As claimant crossed Sixth Avenue at approximated 5:40 pm, she was struck by a motor vehicle.

Witnesses to the accident testified that claimant crossed in the middle of the block (no cross walk) and that she stepped directly into the path of the motor vehicle.

As a result of the accident, claimant sustained numerous injuries including a head injury, which caused claimant to have headaches, tension pressure and vision problems.

Claimant used pre-tax earnings to pay for transportation related expenses such as her parking pass for employer's garage. Claimant acknowledged that she was not required to park at employer's garage and was free to park anywhere. Claimant asserted, however, that her supervisor encouraged employees to use employer's garage for safety reasons.

Employer's representative tes-

tified that employer does not pay for its employees' parking, but does administer the transportation program for employees, thereby allowing participating employees to use tax-free dollars for parking. The representative further confirmed that employer had no policies requiring claimant to park in any designated lot.

The Workers' Compensation Judge denied and dismissed claimant's Claim Petition, finding that she did not suffer her injuries in the course and scope of employment. The WCJ concluded that claimant was commuting to work and was injured on a public street, not on a part of employer's premises.

Claimant appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's decision.

On appeal to the Commonwealth Court, claimant again argued that she was acting within the course and scope of her employment at the time of her injury.

The Court noted that injuries may be sustained in the course of employment where the employee, although not actually engaged in the furtherance of the employer's business or affairs, is (1) on the premises occupied or under the control of the employer; (2) required by the nature of his employment to be present; and (3) sustains injuries caused by the condition of the premises or by operation of the employer's business thereon.

Here, claimant was not actually engaged in activities furthering employer's business when she was struck while crossing Sixth Avenue. As such, claimant was required to show that she was on premises occupied or controlled by employer when she sustained her injuries.

The Court noted that the issue was whether the employer's parking garage was an integral part of employer's business such that it was a part of employer's premises. The fact that the garage was sepa-

rated from employer's facility by a public thoroughfare does not preclude a determination that the parking garage is a part of employer's premises within the meaning of the Workers' Compensation Act.

However, employer's employees were not required to park at employer's garage. As such, the garage was not integral to employer's business and therefore, it was not a part of employer's premises. Consequently, it may not be said that claimant was traversing across Sixth Avenue between two parts of employer's premises. Hence, the WCJ and the WCAB correctly concluded that neither employer's parking garage nor Sixth Avenue was an integral part of employer's premises and claimant was not injured in the course and scope of her employment.

The decision of the WCAB affirming the dismissal of claimant's Claim Petition was affirmed.

Dart Container Corporation v. Workers' Compensation Appeal Board (Lien), No. 550 C.D. 2008, Filed October 23, 2008.

(Disfigurement—There is no “rule of thumb” by which a disfigurement claim may be valued; instead, a scar is to be evaluated based on its location, length, appearance and overall severity, and an award is to be entered consistent with the range most WCJs would select for a similar scar.)

Claimant suffered a neck and back injury while employed by employer on October 8, 2002. A Notice of Compensation Payable was issued.

Claimant then underwent cervical spine surgery that left a scar on her neck. She later filed a review petition for disfigurement benefits. The Workers' Compensation Judge noted that: “*From approximately 15-20 feet this Judge readily saw a scar estimated to be 1 1/2 inches long and*

1/4 inch wide...pink or red and in a straight line...” The WCJ concluded that claimant proved she suffered permanent and unsightly disfigurement as a result of her work injury and awarded her 22 weeks of benefits.

Claimant appealed, claiming that the award was low and outside the range that most WCJs would select. The Workers' Compensation Appeal Board agreed, stating: “*The visual impact of her disfigurement, the location and relative severity of her scarring, and the interests of uniformity in disfigurement awards, warrant a determination that the WCJ's award...was below the proper range of benefits, which other WCJs would award for similar disfigurements. Based on our experience, the range of awards that most WCJs would select...is between 60 and 75 weeks.*”

The WCAB modified the WCJ's award to reflect 70 weeks of compensation. Employer appealed to the Commonwealth Court, arguing that the WCJ's award was made within his discretion and that the WCAB erred in disturbing the award absent any evidence of deviation from the WCJ's discretionary powers. Employer further argued that the WCAB's award of 70 weeks is not supported by case law in that the WCAB did not explain the range that it set for the award.

The Court disagreed. The WCAB is not required to cite written guidelines or other awards to support its modification of the WCJ's award. The WCAB considered the visual impact of claimant's disfigurement, its location and relative severity of her scarring and explained that based upon its experience the range that most WCJs would select for a similar scar is between 60 to 75 weeks.

However, the WCAB did not describe claimant's scar, did not state whether it rejected the WCJ's description and did not explain why most WCJs would award within the 60 to 75 weeks' range.

Thus, the case was remanded to the WCAB. The WCAB was free, however, to reach the same result provided an adequate explanation is given.

The Bullens Companies v. Workers' Compensation Appeal Board (Hausmann), No. 409 C.D. 2008, Filed October 23, 2008.

(Notice—In occupational disease claim, claimant's suspicion that his condition is work-related does not trigger the 120-day notice requirement of §311 of the Act; the 120-day notice period begins to run when a doctor advised that claimant is disabled by a disease and that it is related to claimant's work.)

Claimant worked for 17 years at employer's Malvern plant where it manufactured cleaning products by mixing solvents in open tanks. Employer did not provide claimant with any ventilator, mask or other breathing protection so he inhaled the fumes while performing his duties. In late 2001 he began to experience frequent urination and to see doctors. He stopped working on June 1, 2002 when employer closed the plant. During the last two weeks of his employment, he cleaned the tanks repeatedly until the solvents could no longer be smelled. In July 2002 he was referred to a kidney specialist who recommended a kidney transplant. Claimant began receiving dialysis, taking many medications and having frequent blood work.

By late 2002, claimant suspected that his kidney condition was related to his employment and retained an attorney. In July 2004 he notified employer that he had sustained a work injury in May 2002, and he filed a Claim Petition stating that he had sustained an occupational disease by virtue of exposure to chemicals. At that time, he had not yet secured a medical expert. Claimant first learned that his kidney problems

were work-related in March 2005 from Arthur L. Frank, M.D., who specializes in internal and occupational medicine.

Dr. Frank testified that claimant suffered from glomerulonephritis, a disease that claimant contracted due to his solvent exposure at work.

The Workers' Compensation Judge credited the testimony of claimant and Dr. Frank and granted claimant's petition. The Workers' Compensation Appeal Board affirmed.

Employer appealed to the Commonwealth Court. Employer argued that claimant's petition should have been denied because claimant failed to give timely notice under §311 of the Act.

Section 311 requires an employee to give notice of his or her injury to the employer within 120 days after the occurrence of the injury. Failure to do so results in a denial of benefits.

Employer maintained that claimant's notice was not given within 120 days because he alleged that he contracted the disease in May 2002 but notice was not given until July 2004. Employer acknowledged that for "occupational diseases" which are latent, case law has established that the 120-day notice period begins when the claimant is advised by a doctor that he is disabled and that it is related to the claimant's work. Employer argued, however, that this rule did not apply here because claimant's disease is encompassed by §301(c)(1) of the Act.



The Court disagreed. The Pennsylvania Supreme Court addressed the issue of when the notice period begins to run for a §301(c)(1) disease in Sell v. WCAB (LNP Eng'g), 565 Pa. 114, 771 A.2d 1246 (2001). In Sell, the Supreme Court held that §311's discovery rule "calls for more than an employee's suspicion, intuition or belief; by its terms, the statute's notice period is triggered only by an employee's knowledge that she is injured and that her injury is possibly related to her job."

Here, claimant did not actually know that his disease was job related until Dr. Frank so advised him in March of 2005. Claimant suspected a causal relationship earlier, but a mere suspicion does not trigger the 120-day notice requirement.

The decision of the WCAB was affirmed.

Jerome Jones v. Workers' Compensation Appeal Board (City of Chester), No. 621 C.D. 2008, Filed November 12, 2008.

(Pension Offset—Employer may not be able to reduce claimant's pension benefit to reflect claimant's receipt of workers' compensation benefits, even if employer's right to do so was negotiated for between the parties as a part of a collective bargaining agreement.)

Claimant filed a Review Petition alleging that employer was improperly reducing his disability pension benefits in an amount equal to the amount of workers' compensation benefits he was receiving.

Before the Workers' Compensation Judge, the parties submitted a copy of the collective bargaining agreement (CBA) between the City of Chester (employer) and the Fraternal Order of Police, Lodge #19. Article XXIII of the CBA expressly states: "The City can claim as an offset from the afore-

said pension the following items: (a) 100% of whatever workers' compensation benefits the retired police officer is receiving as a result of his or her service connected disability." The evidentiary record also included an affidavit noting that claimant is receiving a monthly pension of \$3,891.04. No verbal testimony or other evidence was offered.

The WCJ determined that employer was taking an improper credit in relation to claimant's pension benefits. The WCJ noted that the CBA provides that a police officer who is injured in the line of duty is entitled to a service-connected disability pension equal to 100% of the offers earnings for the 52 week period prior to his injury. The WCJ found that the provisions of the CBA which allow employer to reduce that benefit due to the claimant's receipt of workers' compensation benefits were contrary to the Pennsylvania Workers' Compensation Act and were not binding. Moreover, the WCJ concluded that the CBA cannot supersede the Act. Claimant's petition was granted. The WCJ further held that employer was entitled to an offset of workers' compensation benefits to the extent that the pension benefits were funded by employer.

The Workers' Compensation Appeal Board reversed, concluding that there was no issue before the WCJ concerning claimant's workers' compensation benefits. As such, the WCAB concluded that the WCJ lacked jurisdiction to entertain claimant's petition.

Claimant then sought review by the Commonwealth Court. The Court noted that the workers' compensation authorities' responsibilities include guarding the workers' compensation system. As such, where the WCJ is responsible for addressing an alleged entitlement under the Act, the WCJ may be entitled to rule upon questions that would ordinarily be outside his jurisdiction. For example, the Court noted that

a WCJ does have the authority to determine paternity for the purposes of determining eligibility of a child for benefits upon the filing of a fatal claim petition.

Thus, the Court disagreed that the WCJ lacked jurisdiction to entertain claimant's Review Petition. The decision of the WCAB was reversed and the case was remanded to the WCJ for additional findings of fact to determine if claimant's pension benefits are, in fact, being reduced in an amount equal to 100% of his workers' compensation benefits. In addition, claimant must provide an explanation of his financial loss. Employer and its carrier must clarify whether they are solely reducing claimant's pension benefits in accordance with the CBA as well as reducing claimant's workers' compensation benefits in an amount equal to the extent that claimant's pension was funded by employer. In then determining whether to grant claimant's petition, the WCJ must keep in mind that a claimant's own funds, such as his or her pension funds, should not be used by an employer to satisfy its workers' compensation obligation.

Judith Miegoc v. Workers' Compensation Appeal Board (Throop Fashions/Leslie Fay and ITS Harford), No 948 C.D. 2008, Filed December 3, 2008.

(Notice of Ability to Return to Work—The notice requirement of §306(b)(3) is a prerequisite for the presentation of evidence in a suspension petition even if the work injury pre-dates the effective date of Act 57.)

Claimant suffered a work injury on December 28, 1992. In May of 2000, employer filed a petition seeking a suspension of benefits on the grounds that claimant had refused work within her medical restrictions. Claimant sought dismissal of the petition because employer failed to provide her with a Notice of Ability to

Return to Work, as required by §306(b)(3) of the Workers' Compensation Act. Under that section, an insurer that receives medical evidence that the claimant is able to return to work in any capacity must provide prompt written notice to the claimant that there has been a change in his or her condition, that he or she has an obligation to look for available employment, that proof of available employment opportunities may jeopardize his or her receipt of ongoing benefits, and that he or she has the right to consult with an attorney.

The Workers' Compensation Judge concluded that employer was required to provide claimant with the Notice of Ability to Return to Work form in order for evidence to be considered in support of a suspension petition. Because the Notice was not given to claimant, the WCJ dismissed employer's petition.

On appeal, the Workers' Compensation Appeal Board reversed, reasoning that the notice requirement of §306(b)(3) should not be applied retroactively to cases that precede Act 57.

The Commonwealth Court disagreed. The Court noted that §306(b)(3) is a procedural requirement, not a substantive provision and, hence, is applicable to all pending proceedings.

The notice requirement of §306(b)(3) does not alter the facts that an employer must provide in order to obtain a suspension. Rather, it merely requires an employer to share new medical evidence concerning claimant's physical capacity to work and to notify the claimant that this new information could affect the claimant's entitlement to benefits. Because the notice requirement does not affect the substantive rights of either party, it is a procedural provision that applies and precludes a suspension where, as here, employer fails to comply with the notice requirements.



Deciphering the Code:

CMS: Centers for Medicare and Medicaid Services
MMSEA: Medicare, Medicaid and SCHIP Extension Act.
GHP: Group Health Plan
RRE: Responsible Reporting Entity
COBSW: Coordination of Benefits Secure Website
COBC: Coordinator of Benefits Contractor

(Continued from page 1)

Secure Website (COBSW). From July 1 to September 30, 2009, a testing period for all worker's compensation RREs will take place. From October 1 to December 31, 2009, all worker's compensation RREs are to submit their first Section 111 production files based upon a predetermined schedule with the Coordination of Benefits Contractor (COBC). Hopefully, by January 1, 2010, all worker's compensation RREs will be submitting Section 111 production files electronically. It is important to note that until the electronic reporting process is completely operational, RREs should continue to place Medicare on notice of cases involving Medicare beneficiaries via the current reporting process either by phone or in writing.

Registration Process Guidelines were released by CMS on September 24, 2008, in which RREs will notify the COBC of their intent to report data and comply with Section 111. Registration *by the RRE* must be completed before testing between the RRE (or its agent) and the COBC can begin on July 1 through September 30, 2009. Although an RRE may use an agent for subsequent reporting purposes, the RRE *itself* must complete the registration process directly. Through registration, the COBC will obtain the information needed to (1) certify the registrant is a valid RRE under Section 111; (2) assign a Section 111 Reporter ID to each RRE; (3) develop a Section 111 reporting profile for each RRE, including estimates of the volume and type of data to be exchanged for planning purposes; (4) assign a production "live date" and file submission timeframe to each RRE; (4) establish the necessary file transfer mechanisms; and (5) assign a COBC Electronic Data Interchange Representative (EDI Rep) to each RRE to assist with ongoing communication and "trouble-shooting" questions. Workers' compensation RREs will register on the COBSW from May 1, 2009 through June 30, 2009. Once the registration application is submitted, the information provided will be validated by the COBC and the RRE will assign an Account Manager, who will return to the COBSW to complete set-up and obtain Login IDs for individual users associated with that account.

The Interim Record Layout was released by CMS in October 2008 and provides a detailed list of the data required to be reported by a worker's compensation RRE. The document is over sixty pages long, and RREs are encouraged to visit (www.cms.hhs.gov/MandatoryInsRep/Downloads/NGHPLayout111708.pdf) in order to read the document in its entirety. As a quick overview, the Layout explains reporting guidelines for RREs who still have responsibility for medical services as of July 1, 2009 regardless of an initial resolution date prior to July 1, 2009. It explains reporting requirements where the RRE has accepted on-going responsibility for medical payments and how to handle situations where an RRE has no new information to supply on a quarterly update file.

In conclusion, this article is intended only to act as a short overview of the new Section 111 reporting requirements of the MMSEA. Much of this information can be explained in greater detail by visiting the Secretary of Health and Human Services' website at (www.cms.hhs.gov/MandatoryInsRep/). With the enactment of this new law, a Medicare issue in a worker's compensation claim can no longer be swept under the rug until the end of the case. Medicare must be dealt with efficiently in the opening moments of a case in order to avoid penalties with non-compliance in 2009.

Thomson, Rhodes & Cowie, P.C.
1010 Two Chatham Center
Pittsburgh, PA 15219



TR&C



ATTENTION READERS: The editors of the Thomson, Rhodes & Cowie Pennsylvania Workers' Compensation Bulletin invite you to submit questions you may have dealing with workers' compensation issues. The editors will compile questions received and periodically provide answers to recurrent issues. Submission of a question is no guarantee that an answer will be provided, but we will make every effort to answer as many questions as possible. Of course, for specific legal advice the reader should seek counsel from a qualified workers' compensation attorney.

Send questions to: Harry W. Rosensteel, Esquire, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, PA 15219.

The Bulletin is a quarterly publication reviewing recent trends in Pennsylvania Workers' Compensation Law. All original materials Copyright 1993-1995 by Thomson, Rhodes & Cowie, P.C. The contents of this Publication may be reproduced, redistributed or quoted without further permission so long as proper credit is given to the Thomson, Rhodes & Cowie Pennsylvania Workers' Compensation Bulletin.

The Thomson, Rhodes & Cowie Pennsylvania Workers' Compensation Bulletin is intended for the information of those involved in the workers' compensation system. The information contained herein is set forth with confidence, but is not intended to provide individualized legal advice in any specific context. Specific legal advice should be sought where such assistance is required.

Prior issues are available on our web site at <http://www.trc-law.com> or upon request. Please direct inquiries to Harry W. Rosensteel, Esquire, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, Pennsylvania 15219, (412) 232-3400.