TR&C

Pennsylvania Workers' Compensation Bulletin

Thomson, Rhodes & Cowie, P.C. Two Chatham Center, 10th Floor, Pittsburgh, PA 15219 (412) 232-3400

HARRY W. ROSENSTEEL, Editor • MARGARET M. HOCK, Associate Editor

Do it right the first time! No second chances allowed!

The story of an "ill-fated" IME opinion.

Independent medical evaluations may be one of the most valuable tools available to employers and carriers in handling workers' compensation claims. Whether or not the IMEs are valuable, however, depends upon not only the proper choice of physician, but also upon the proper "preparation" of and by that physician.

For instance, in the case of Natrona Long v. Workers' Compensation Appeal Board (Integrated Health Service, Inc.), No. 2529 C.D. 2003, filed May 12, 2004, the claimant, a certified nursing assistant, alleged that while assisting a patient to wash on April 10, 1999, the mirror over the sink fell, striking her on the head and causing her to suffer a cervical spine injury.

In order to defend the petition, the employer had the claimant examined by Dr. Murray Robinson. Initially, Dr. Robinson issued a report stating that the work injury aggravated the claimant's pre-existing C5-6 herniated disc. Further, he recommended surgery and limited the claimant to sedentary duty work.

Thereafter, the employer provided Dr. Robinson with pictures of the mirror in question and asked if the pictures would cause his opinion as to the cause of the claimant's condition to change. Dr. Robinson then revised his opinion and issued an amended report stating that the mirror could not have caused the claimant's cervical spine injury. Instead, he opined that the cause of the progression of the claimant's C5-6 disc herniation was her pre-existing degenerative disc disease.

On cross-examination, Dr. Robinson admitted that he had no information upon which to base his conclusion. He stated that he had no idea how much the mirror weighed that struck the claimant, of what material it was made, the rate of speed it fell, or the distance it fell.

Despite these shortcomings, the Workers' Compensation Judge found Dr. Robinson's revised opinion to be credible. The Workers' Compensation Appeal Board did not disturb that determination. The Commonwealth Court, however, found Dr. Robinson's issuance of an "amended" report to be, at best, "troubling." In rejecting the competency of Dr. Robinson's testimony and opinion, the Commonwealth Court noted:

> "Rather than accept Dr. Robinson's candid

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Commonwealth Court Case Reviews

Motor Coils MFG/WABTEC v. Workers' Compensation Appeal Board (Bish), No. 2732 C.D. 2003, filed June 11, 2004.

(Modification/Suspension of Benefits - Where employer seeks modification of benefits based upon specific job offer, to be actually available, the offered job must be within reach of claimant's current residence.)

Employer issued a Notice of Compensation Payable acknowledging that claimant suffered a work injury in 1997 in the form of bilateral carpal tunnel syndrome. Claimant eventually returned to a light duty position with employer at wages greater than her time of injury wage, such that benefits were suspended.

During the summer of 2000, employer laid off 126 employees, including claimant and her husband. Thus, claimant and employer executed a Supplemental Agreement reinstating total disability benefits as of August 2, 2000.

Thereafter, claimant's husband secured employment in Oklahoma at wages nearly twice that he had received from employer. Claimant and her husband then relocated to Oklahoma.

Four months later, employer advised claimant that her previous light duty job was again available to her at wages greater than her time of injury wage. Claimant refused the position.

Employer then filed a petition to suspend claimant's benefits as a result of her refusal to accept the offered job. Claimant filed an answer alleging that the job was not actually available to her inasmuch as her family had relocated to Oklahoma.

The Workers' Compensation Judge denied employer's petition. Despite finding that the offered job was available to the claimant given her medical and vocational capabilities, her refusal of the job was in good faith as a result of her move to Oklahoma with her husband.

On appeal, the Workers' Compensation Appeal Board likewise determined that the offered job was not available to claimant because claimant had relocated for "valid reasons."

Employer then sought review by the Commonwealth Court. Employer argued that the WCJ and WCAB erred in utilizing the standards of Kachinski v. WCAB (Vepco Construction Co.), 516 Pa. 240, 532 A.2d 374 (1987) and in failing to apply §306(b)(2) of the Act.

Section 306(b)(2), which defines 'earning power,' provides, *inter alia*, "If the employee does not live in this Commonwealth, then the usual employment area where the injury occurred shall apply."

Despite that language of the Act, the Court stated that the requirements of Kachinski still apply. In other words, an offered job must still be actually available to a claimant. That means that the offered job must be within reach of a claimant's current residence.

Here, the job in Pennsylvania was not actually available as it was not within reach of her current residence. The WCJ did not err in utilizing the standards of Kachinski, or in failing to follow the plain language of §306(b)(2) of the Act.

Accordingly, the order of the WCAB was affirmed.

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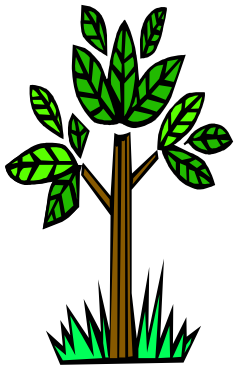
Asplundh Tree Expert Company v. Workers' Compensation Appeal Board (Humphrey), No. 1445 C.D. 2003, filed June 22, 2004.

(Violation of Positive Work Orders - A violation of rules by employee will not render the injury non-compensable if the violation is not so disconnected from employee's duties so as to render him a "stranger" or "trespasser."

Claimant was employed as a tree trimmer. Employer had safety rules, including a "ground-to-sky" policy which requires employees to not leave the ground before they are tied-in around the crotch of the tree. On January 11, 2001, claimant fell from a tree, sustaining a broken right arm and damage to the nerves in his arm and hand. At the time, claimant did not have his safety line in the crotch of the tree.

The Workers' Compensation Judge found that employer had the "ground-to-sky" safety policy, that claimant was aware of that policy and that claimant violated that policy. Despite those findings, the WCJ found that climbing is an essential and material job function of a tree trimmer, and that the prohibited activity of not being tied-in while climbing, was an activity connected with claimant's work duties. Accordingly, the claim petition was granted. The Workers' Compensation Appeal Board affirmed that decision.



On appeal to the Commonwealth Court, employer argued that the WCJ erred inasmuch as benefits should not be granted where claimant violated a positive order of employer. Employer argued that climbing a tree without a safety line in place is an activity so disconnected from claimant's job duties so as to render him a "stranger" or "trespasser" ineligible for workers' compensation benefits.

The Court disagreed. Claimant

was clearly required by the nature of his job to climb trees. Although he violated employer's policy, his violation was not so disconnected from his duties so as to render him a stranger or trespasser at the workplace. The WCJ thus did not err in awarding claimant benefits.

The Court did note that if employees can violate safety policies and still receive compensation for their injuries, employers will have little incentive to continue such policies. However, given the fact that the Workers' Compensation Act is intended to benefit the injured worker, the Court felt its holding in this case to be consistent with the humanitarian objectives of the Act.

The order of the WCAB was affirmed.

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Tong Kan v. Workers' Compensation Appeal Board (Budd Company), No. 386 C.D. 2004, filed July 1, 2004.

(Costs - Costs incurred by claimant for his nurse to attend IMEs are not recoverable costs.)

Employer filed a termination petition, in support of which employer presented testimony from Dr. Mandel, an orthopedic surgeon. In opposition to the petition, claimant presented testimony from Dr. Lefkoe, an orthopedic surgeon, and Margaret Griffiths, R.N., who accompanied claimant to the employer's IMEs. Ms. Griffiths did not render opinions, but merely testified concerning her observations during the IMEs.

The Workers' Compensation Judge credited claimant's witnesses and denied employer's petition. With regard to claimant's bill of litigation costs, however, the WCJ refused to compensate claimant for the cost of Ms. Griffiths' attendance at the IMEs. The WCJ found the costs for the nurse's attendance not to be compensable under §440 of the Act.

Claimant appealed to the Workers' Compensation Appeal Board. The WCAB agreed with the WCJ that the Act precludes claimant's recovery of the costs of his nurse's attendance at the IME. The WCAB noted that §314(b) provides that an employee is entitled to have a health care provider participate in an IME *at his own expense.*

The Commonwealth Court agreed. The express language of §314(b) provides that a claimant must bear his own costs if he chooses to have a health care provider present at an IME. Further, the WCJ correctly determined that the costs for the nurse to attend the IMEs are not recoverable under §440 as a "witness" cost. There is no authority for awarding as costs time spent by a witness observing and preparing to testify to facts.

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

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Marcella Stiles v. Workers' Compensation Appeal Board (Department of Public Welfare), No. 1440 C.D. 2003, filed July 13, 2004.

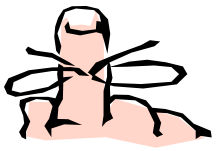
(Compromise and Release Agreement - Collateral estoppel bars setting aside of C&R Agreement absent circumstances such as fraud, misrepresentation, concealment or mutual mistake of fact.)

In April of 2000, claimant's attorney filed a petition seeking approval of a Compromise and Release Agreement. The petition was assigned to a Workers' Compensation Judge, who approved the agreement, which provided for payment of $100,000 for future wage loss claims. Employer remained liable for claimant's reasonable and necessary medical expenses.

At the hearing, claimant was questioned by both counsel with regard to the C&R Agreement. Claimant agreed that she understood and accepted the terms of the C&R, and that she had been fairly represented by her attorney. The WCJ credited claimant's testimony and specifically found that claimant 'understands the full legal significance of the C&R Agreement which she signed."

No appeal was filed from the WCJ's order approving the C&R. In August of 2001, however, claimant filed a petition to set aside the C&R and reinstate compensation. She alleged that, at the time she entered into the C&R, she was suffering from severe psychological, psychiatric and physical injuries which gave her post-traumatic stress syndrome and that, as such, she did not understand the economic value of the claim. Employer denied the petition.

A hearing before a different WCJ was subsequently held. Employer offered a copy of the prior WCJ's decision approving the



REMINDER!!!

As part of the Bureau's ongoing automation process, the Utilization Review Request LIBC-601, is now a scanned, automated, CIMS form. Effective September 1, 2004, prior versions of the form became unacceptable to the Bureau. Requests filed on an old form will be returned to you!

The new form may be found at: www.state.pa.us, PA Keyword "workers comp." Then click on the Downloadable Forms link.

C&R, as well as a copy of the signed Agreement. Both were admitted into evidence. Employer then moved for dismissal of claimant's petition under the doctrine of collateral estoppel. The WCJ granted the motion.

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

Claimant then sought review by the Commonwealth Court. The Court noted that the doctrine of collateral estoppel forecloses relitigation of an issue of law or fact that has been finally decided when (1) the legal or factual issues are identical; (2) they were actually litigated; (3) they were essential to the judgment; and (4) they were material to the adjudication.

Claimant argued that collateral estoppel does not apply since the question of her mental competence was not actually litigated in the proceeding relative to the C&R Agreement. The Court disagreed. The WCJ presiding over a C&R hearing must determine if the claimant understands the full legal significance of the agreement. Inherent in that responsibility is a requirement that the WCJ determine if the claimant is mentally competent to comprehend the legal ramifications of entering into such an agreement, which is exactly what the WCJ did in this case.

The Court further noted that there is a strong public policy favoring voluntary settlements and finality. While a C&R may be set aside upon a clear showing of fraud, deception, duress or mutual mistake, there are strong public policy reasons that militate against allowing persons to disavow such agreements absent those circumstances.

Consequently, the decision of the WCAB affirming the order of the WCJ dismissing the claimant's petition was affirmed.

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Laundry Owners Mutual Liability Insurance Association v. Bureau of Workers' Compensation (UPMC Presbyterian and Smolter), No. 1882 C.D. 2003, filed July 14, 2004.

(Fee Review - Where claimant is injured and admitted to a level I trauma center for acute care of life-threatening injury, the provider will be paid at 100% of its usual and customary rate for all "acute" care even if the condition is no longer life threatening and is stabilized.)

Claimant suffered multiple injuries in a head-on motor vehicle collision and was admitted to provider's facility via the emergency room. Multiple surgical procedures were performed over the following few weeks.

Provider billed insurer for services rendered to claimant from March 12 through April 2, 2001. Provider's claim reported charges totaling $229,686.75 and indicated provider's status as a Level I trauma center. Provider also submitted an itemized billing statement ins support of its total charge.

In response, Insurer advised provider via an Inpatient Explanation of Benefits (IEOB) that its bill was payable at 100% for the dates of March 12 through March 16, 2001 and that a total of $159,040.50 would be paid. A second IEOB was issued for the period of March 17 through April 2, 2001, and advised that of the total charge of $70,646.25, the Act 44 amount of $9,851.21 would be paid.

Provider subsequently submitted two fee review applications to the Fee Review Section of the Bureau. With regard to the first IEOB, provider sought review of the timeliness of the payment. With regard to the second IEOB, provider sought review of both the amount and the timeliness of payment.

The Bureau issued administrative decisions granting provider an additional payment of $60,795.04, with interest. Insurer then requested a fee review hearing with the Fee Review Hearing Officer, asserting that after the first 5 days, claimant was no longer an acute care patient with an immediately life-threatening or urgent injury.

Based upon the credible medical testimony provided, the FRHO found that, as of March 28, 2001, claimant was stable for discharge and did not need acute care. The FRHO further noted that under §306(f.1)(3)(i) of the Act, a provider shall not accept payment in excess of the 113% of the applicable Medicare reimbursement amount. Section 306(f.1)(10) of the Act, however, further provides for payment of 'the usual and customary charge" if acute care is provided to a patient with an immediately life-threatening or urgent injury by a Level I or Level II trauma center.

The FRHO determined: 1) that provider, a Level I trauma center, rendered continuous inpatient care from March 12 through April 2, 2001, 2) that said care was related to claimant's life-threatening or urgent injuries, and 3) that provider was thus entitled to full payment of its usual and customary rate for the care rendered during that entire period of time.

Insurer then sought review by the Commonwealth Court, arguing that provider should no longer be paid 100% if the patient's condition has stabilized. The Court agreed.

All parties agreed that claimant was cleared for discharge from provider's facility on March 29, 2001, but was not transferred until April 2, 2001 because North Hills Manor Care lacked available space or would not accept claimant without a guarantee from insurer that it would receive its full rate. Even though insurer could not guarantee North Hills payment of its full rate, that does not mean that insurer should have to pay provider its usual and customary charge for ser-

vices provided to claimant after he was cleared for discharge to a non-acute care facility.

The Court emphasized that it was not imposing any requirement that an immediate determination must be made as to when a claimant's condition has "stabilized" in order to indicate that his condition is no longer "immediately life-threatening or urgent" for imposing the Act 44 fee caps. Rather, the Court stated it was simply recognizing that, based on the facts of this case, claimant's discharge was delayed for reasons unrelated to any need for continued acute care services and, as such, provider is not entitled to payment of its usual and customary charge for services rendered from March 29 through April 2, 2001.

The decision of the FRHO was reversed to the extent provider was awarded its usual and customary charge for services rendered from March 29, 2001 through April 2, 2001, and remanded for a recalculation of provider's fee consistent with the Court's opinion. The decision of the FRHO was affirmed in all other respects.

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James Wallace v. Workers' Compensation Appeal Board (Bethlehem Steel/Pa Steel Tech), No. 2644 C.D. 2003, filed May 11, 2004, reported July 15, 2004.

(Compromise and Release Agreement - Despite claimant's stipulation in C&R Agreement that he suffered no work injuries other that an inhalation injury, he is not precluded from filing a subsequent claim for prior back injury.)

On March 1, 2001, employer submitted a Compromise and Release Agreement to the Workers' Compensation Judge for approval. The C&R Agreement described the injury as an inhalation injury. Further, it released employer from all claims for benefits arising out of that injury. Finally, it stated that claimant suffered no other injuries related to his employment. The WCJ approved the C&R Agreement by a decision and Order circulated on March 1, 2001.

On July 24, 2001, claimant filed a petition for benefits alleging that he suffered a low back injury while working on August 3, 1998. Employer defended the petition on the basis of claimant's representation in the C&R Agreement that he suffered no work injury other than the inhalation injury.

At hearings before the WCJ, claimant testified that paragraph 4 of the C&R Agreement was incorrect because he did, in fact, sustain a work related back injury on August 3, 1998. He testified that he believed the C&R did not affect his back injury claim based upon what his attorney told him at that time.

The WCJ granted the Claim Petition, finding that claimant did suffer a work-related back injury and that the C&R did not address that injury. However, the WCJ also suspended benefits based on his conclusions that claimant voluntarily took himself out of the workforce and that suitable work was available to the claimant. Employer was directed to pay claimant's medical expenses.

The Workers' Compensation Appeal Board reversed the WCJ based on the doctrine of collateral estoppel. The WCAB stated: "...that claimant, having represented that he had no other work injuries in the course of obtaining approval and the benefits of a C&R Agreement, may not turn around and file a claim petition for an alleged injury occurring approximately 2 and 1/2 years earlier. The WCJ should have dismissed that claim petition in light of the approved C&R Agreement stipulating to no other work injury."

On appeal to the Commonwealth Court, claimant argued that the C&R did not meet the requirements of §449 of the Act because none of the required information regarding his back injury was included and it did not release employer from liability for that specific injury.

The Court agreed. The C&R, by its express terms, only referred to and compromised the inhalation injury. The compensation claimant received under the C&R was for past and future medical bills and costs associated with the inhalation injury only. Consequently, claimant agreed only to release employer from liability for the inhalation injury.

The Court noted that, generally speaking, a party to an action is judicially estopped from assuming a position inconsistent with his or her assertion in a prior action. Here, claimant did sign a C&R stating that he sustained no work-related injury other than the inhalation injury. He subsequently filed the claim petition, which was inconsistent with the C&R Agreement. The Court, however, will look to see if claimant offered a sufficient explanation for his contradiction.

Here, claimant testified that his attorney, whom he trusted, advised him to sign the C&R and also advised him that it did not affect his back injury claim. Accordingly, claimant offered a sufficient explanation for any inconsistency between the C&R and the subsequent claim petition.

Accordingly, the order of the WCAB was vacated and the decision of the WCJ granting the claim petition was reinstated.

(Editorial Note - As a common practice, C&R Agreements usually contain language similar to the following: 'The claimant hereby stipulates and agrees that all benefits heretofore due to him/her for *any work injury* she may have suffered in the service of the employer have been paid, and that no benefits of any kind are due."

Given the Court's decision in Wallace, such language may no longer protect employers from subsequent claims. If the claimant files a petition at a later date and credibly testifies that,

based upon his or her private conversations with counsel, that he or she did not believe that the C&R actually resolved all claims, then the employer may be faced with defending claims it previously thought to have been resolved.

Under the circumstances, it would be wise to set forth in the C&R, with as much specificity as possible, any and all claims an employee may have made during the course of employment. In that way, it could then be shown that the claimant was aware that he or she was resolving any and all claims and was releasing the employer of any and all liability.

As set forth above, failure to do so may result in subsequent liability being imposed!)

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Joseph Donahue v. Workers' Compensation Appeal Board (Philadelphia Gas Works), No. 457 C.D. 2004, filed July 22, 2004.

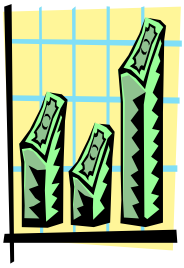
(Suspension - Suspension of benefits may be appropriate if combined wages and partial disability benefits exceed wages of employees performing time of injury job.)

After consulting with the Bureau, the union, including the union president, and with its employees, employer developed an adjustment procedure to eliminate disparities in compensation between employees doing the same work. Employer had noted that, oftentimes, employees on disability, who had been brought back to light duty, were being compensated more than their fellow employees because of the combination of wages and partial disability benefits. This caused resentment among the employees.

Therefore, employer developed a weekly report to document the earnings of each employee for each week in each job classification. This report included an average weekly wage for all employees in the same job classification. In any case where partial disability benefits plus actual earnings did not coincide with the average weekly wage earned by others with the same job classification, adjustments were made. If wages plus partial disability benefits were less than the average per classification, the employee then received two-thirds of the difference between the average weekly wage and the actual earnings. If wages alone exceeded the average compensation per classification, partial disability benefits were suspended. Employees were notified of the changes and given the opportunity to challenge the calculations. A letter was sent with each paycheck for the week in question, explaining the calculation.

Claimant suffered a work injury on December 19, 1999. Pursuant to a Notice of Compensation Payable, claimant received total disability benefits at the rate of $588 based upon an average weekly wage of $1,133.30. On November 20, 2001, he returned to his pre-injury position. He was then notified that his benefits would be suspended. Claimant filed a Petition to Challenge the Notification of Suspension, and also filed a Penalty Petition alleging that employer improperly terminated claimant's benefits and filed a fraudulent notification of suspension.

The Workers' Compensation Judge denied claimant's petitions, concluding that employer's procedure designed to eliminate disparities in wages for the same work was authorized by §306(b)(1) of the Act, which states: "[I]n no instance



shall an employe receiving compensation under this section receive more in compensation and wages combined than the current wages of a fellow employe in employment similar to that in which the injured employe was engaged at the time of the injury."

The Workers' Compensation Appeal Board affirmed that decision.

The Commonwealth Court also agreed with the WCJ's interpretation. The Court noted that claimant was entitled to continuing partial indemnity benefits, subject to adjustment under §306 of the Act. What is determinative under §306 is the current rate of compensation for a claimant's time-of-injury job. Absent employer's adjustments, claimant would be paid more than he would be paid if he had never been injured, in violation of §306.

The decision of the WCAB was, therefore, affirmed.

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Ivan Zuvich v. Workers' Compensation Appeal Board (Department of Public Welfare/Bensalem Youth Development Center), No. 2790 C.D. 2003, filed July 28, 2004.

(Review - Notice of Compensation Payable which is materially incorrect may, *at any time,* be reviewed and modified by Workers' Compensation Judge.)

Claimant, a counselor at the Youth Development Center, was attacked by several juvenile inmates, and beaten with a baseball bat. As a result, claimant became totally disabled.

A Notice of Compensation Payable was issued, recognizing his injuries as "right and left upper extremity fractures, scalp and facial lacerations, multiple contusions."

Claimant filed a petition to review, seeking to amend the NCP to include "head injuries which includes cognitive deficits, severe concussion, memory loss, closed head injury and post-traumatic headaches."

The Workers' Compensation Judge credited the testimony of claimant's experts, who opined that claimant suffered cognitive difficulties as a result of the injury. According to claimant's treating physician, his diagnosis when hospitalized was "cerebral contusion, cerebral concussion, post-concussive syndrome and cervical

radiculopathy." His symptoms included headaches, personality changes, and various cognitive deficits.

The WCJ, however, dismissed claimant's petition, finding that it was time barred. Relying upon the case of Jeanes Hospital v. WCAB (Hass), 819 A.2d 131 (Pa.Cmwlth. (Pa.Cmwlth. 2003), the WCJ concluded that: 1) a review petition may raise only injuries which are a natural consequence of the original work injury, and 2) injuries that are related to an original work injury but that do not arise until a later time are subject to the time provisions of §315 of the Act.

The Workers' Compensation Appeal Board affirmed the WCJ's decision, concluding that claimant was seeking benefits for disabilities that were related to, but distinct from, the injury described in the NCP.

The Commonwealth Court, however, disagreed stating that §315 and Jeanes Hospital are not applicable in this case. Claimant situation fits squarely within §413 of the Act, which allows a WCJ to review, modify or set aside an NCP **at any time** if it is shown that the NCP was in any material respect incorrect.

Here, claimant's treating physician testified as to the claimant's diagnosis upon admission to the hospital. Thus, the NCP was materially incorrect because it omitted the concussion and post-concussion injuries, despite the fact that they were part of claimant's original diagnosis. Thus, the WCJ and the WCAB erred in failing to grant claimant's petition to review the NCP.

The order of the WCAB was, therefore, reversed.

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Bryan Coker v. Workers' Compensation Appeal Board (Duquesne Light Company), No. 28 CD 2004, filed August 3, 2004.

(Specific Loss Benefits - Claimant may not receive concurrent payments of both total disability benefits and specific loss benefits even though the total disability benefits are reduced by a disability pension offset.)

Claimant sustained catastrophic injuries when he came in contact with a high voltage electrical wire while working as a linesman. Employer recognized that claimant was entitled to specific loss benefits for the loss of his left arm as well as facial disfigurement. In addition, claimant was entitled to total disability benefits.

Because claimant subsequently received a pension funded by employer, employer then offset the workers' compensation benefits.

Claimant then filed a Review Petition, in which he sought to receive specific loss benefits in addition to temporary total disability benefits, up to a combined maximum of $588.00. The Workers' Compensation Judge concluded that claimant was not entitled to receive stacking of specific loss benefits and net total disability benefits, following a credit, up to a maximum of $588.00 per week.

Claimant appealed to the Workers' Compensation Appeal Board, which affirmed. The WCAB explained that although claimant is entitled to specific loss benefits for the loss of his arm and facial disfigurement, he is not entitled to receive them until his total disability benefits have ended. Further, a claimant who is receiving benefits below the statutory maximum may not supplement those benefits with specific loss benefits.

The Commonwealth Court agreed. Section 306(d) of the Act provides that specific loss benefits do not begin until after an individual's receipt of total disability payment ends.

Claimant argued that his total disability payments had ended because he was not receiving the full amount per week. His payments were reduced by the pension offset, such that he was not receiving a total disability payment. While sympathetic to claimant's plight, the Court stated it was bound by the express language of the statute. Because claimant's total disability had not ended and he was receiving in full the amount of employer funded payments to which he was entitled under the Act, he could not collect, concurrently, the specific loss bene-

EMPLOYER'S CORNER

NEW HIRES REPORTING PROGRAM

The New Hires Reporting Program is a federal and state program designed to increase compliance with child support orders and detect UC fraud overpayments. All employers, regardless of size or type of business, must report newly hired employees within 20 days of their hire date to the state New Hire Reporting Program.

The information required to be reported is:

1) Federal Employer Identification Number (FEIN);
2) employer name;
3) employer address;
4) employer contact name;
5) contact phone number;
6) employee name;
7) employee Social Security number;
8) hire date; and,
9) birth date (optional).

Employers may submit the information via standard mail to:

Commonwealth of Pennsylvania
New Hire Reporting Program
P.O. Box 69400
Harrisburg, PA 17106-9400

The information may also be submitted by fax (717) 657-4473*, electronically (via e-mail attachment of an Excel or ASCII file) to* reporting@panewhires.com*; on the Internet at* www.panewhires.com*; or by calling* 1-888-724-4737 *to register and report using FTP, magnetic tape, or floppy disk.*

Additional information may be found at www.panewhires.com.

fits to which he was entitled. This was true even though his disability benefits had been offset by payments he received from an employer-funded disability pension.

Accordingly, the order of the WCAB was affirmed.

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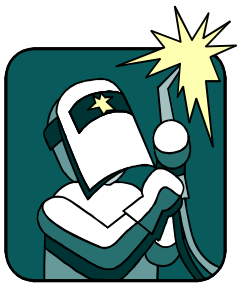
Cerro Metal Products Company and Engle-Hambright & Davies, Inc. v. Workers' Compensation Appeal Board (Plewa), No. 696 C.D. 2004, filed August 5, 2004.

(Burden of Proof - Termination - Where the NCP described the manner in which an injury was suffered rather than the physical injury itself, then all physical injuries which could flow therefrom are part of the NCP.)

Claimant was employed as a welder when he inhaled noxious chemical fumes in the work place. A Notice of Compensation Payable was issued, which described the injury as "chemical fume exposure."



Employer subsequently filed a termination petition alleging claimant had fully recovered and was able to return to work without restrictions. Claimant denied these allegations and contended that he continued to suffer from pulmonary, cognitive and neurological problems.

Both parties presented testimony from numerous experts. The Workers' Compensation Judge found the opinions of claimant's experts to be more credible than employer's experts. Consequently, the WCJ found the inhalation incident to be a substantial contributing factor to claimant's complaints of headaches, dizziness, lightheadedness, balance problems, fatigue and cognitive impairment. Further, the diagnosis of reactive airway disease syndrome could not be ruled out. Thus, the termination petition was denied. The Workers' Compensation Appeal Board affirmed the WCJ's decision.

On appeal to the Commonwealth Court, employer argued that the WCAB erroneously expanded the description of the injury. Further, in so doing, the WCAB misapplied the burden of proof by requiring employer to prove that claimant's exposure was not sufficient to cause the additional symptoms rather than requiring claimant to prove that the exposure was the cause of the additional symptoms.

The Court disagreed. The NCP described the injury as "chemical fume exposure." However, that description did not specify the physical injury, but instead described the manner in which it was acquired. The Act places the responsibility for completing the NCP upon the employer. A fair reading of this description provides coverage for any physical injuries caused by the chemical fume exposure. Hence, the WCJ and the WCAB did not improperly "expand" the injury beyond the NCP or impose an improper burden on employer. There was no shift in the burden of proof.

Consequently, the order of the WCAB, which affirmed the decision of the WCJ, was affirmed.

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Larry Readinger v. Workers' Compensation Appeal Board (Epler Masonry), No. 520 C.D. 2004, filed August 6, 2004.

(Modification - Earning Power Assessment - In order to modify benefits based upon a labor market survey, the employer must demonstrate that the jobs are actually open and available to the claimant, not merely that the jobs exist in the labor market.)

Employer sought to modify claimant's benefits on the basis that work was generally available to the claimant. At hearings, both parties presented testimony from a rehabilitation counselor.

The Workers' Compensation Judge denied employer's petition inasmuch as the employer's earning power market survey did not include any positions from agencies of the Department of Labor and Industry or private job placement agencies.

Employer appealed to the Workers' Compensation Appeal Board asserting that it was not required to include job listings from the Department or private agencies. The WCAB agreed and reversed the decision of the WCJ.

On appeal to the Commonwealth Court claimant argued that the Act requires an earning power market survey to include job listings from 3 sources: 1) agencies of the Department; 2) private job placement agencies; and 3) advertisements.

The Court noted that the statute states that earning power is to be based upon opinion evidence. The statute then lists 3 examples of sources to be used by the expert. Thus, the expert is free to use any of the 3 sources, or other sources, in its market survey.

The Court went on to state, however, that modification of benefits is not available on the basis of jobs which were *potentially* available to a claimant. Rather, the employer must show that the jobs were *actually* available to the claimant. Thus, an employer may not merely show that the jobs exist in the relevant market, but that the jobs are vacant and open to the claimant given the claimant's physical limitations.

Because the Court concluded that the WCAB did not err in determining that employer's labor market survey complied with the Act, the decision of the WCAB reversing the decision of the WCJ was affirmed.

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Geoffrey Pugh v. Workers' Compensation Appeal Board (Transpersonnel, Inc.), No. 2131 C.D. 2003, filed August 11, 2004.

(Extra-territorial Jurisdiction - Pennsylvania did not have jurisdiction where claimant worked for New Jersey company as over the road driver and was injured in Minnesota, even though claimant was assigned to work for one of employer's customers which had a Pennsylvania terminal .)

Employer, a New Jersey corporation, is a driver recruiting and screening company that leases its employee truck drivers to customers that need such drivers.

In 1992, claimant, a Pennsylvania resident, responded to employer's advertisement in a local newspaper for drivers. After taking a driving test in Bensalam, Pennsylvania, he then attended a week-long safety training class in New Jersey. During that week, he was given an employment application and agreement, which he filled out and signed. At the end of the week, the manager of employer's Haslet, New Jersey office directed claimant to "call dispatch" for his first assignment. Thereafter, claimant worked as an over-the-road truck driver for employer, delivering loads all over the United States and Canada.

On January 26, 1996, claimant was injured while unloading a shipment in Minnesota. He collected benefits in accordance with Minnesota's workers' compensation statute. After exhausting those benefits, claimant filed a petition for benefits under the Pennsylvania Workers' Compensation Act. Employer denied the allegations of the petition.

The Workers' Compensation Judge determined that claimant's employer was not principally located in Pennsylvania at the time of his injury and, therefore, denied the claim. The Workers' Compensation Appeal Board affirmed that decision.

Claimant then sought review by the Commonwealth Court. The Court noted that this case is governed by §305.2 of the Act. An employee who suffers an out-of-state injury must establish that:

(1) His employment is principally localized in this State, or

(2) He is working under a contract of hire made in this State in employment not principally localized in any state, or

(3) He is working under a contract of hire made in this State in employment principally localized in another state whose workmen's compensation law is not applicable to his employer, or

(4) He is working under a contract of hire made in this State for employment outside the United States and Canada.

Here, because claimant was working under a contract for hire entered into in New Jersey, he had to show that his employment was principally localized in Pennsylvania in order to be eligible for benefits under the Act.

The jurisdiction where a claimant's employment is "principally localized" may be determined as that state in which his employer has a place of business at which or from which the claimant regularly works. Here, employer did not maintain a place of business in Pennsylvania. Rather, employer's customer owned and operated the terminal from which claimant worked. There is no evidence that employer exercised any right or control over the facility, or used any office space or terminal space at the facility. Employer did not even have an agent assigned to work from the facility or any other facility in Pennsylvania. In sum, claimant failed to establish that employer maintained a place of business in Pennsylvania.

Finally, the Court noted that the record is devoid of evidence to establish that claimant spent a substantial portion of his time working in Pennsylvania in the service of employer. Thus, claimant failed to meet his burden of proof necessary to establish entitlement to benefits under the Pennsylvania Act.

The decision of the WCAB affirming the decision of the WCJ was affirmed.

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Gem Brown v. Workers' Compensation Appeal Board (Knight Ridder, Inc./Philadelphia Newspapers, Inc.), No. 191 C.D. 2004, filed August 19, 2004.

(Earning Power - Where claimant actually works after an injury, his or her wages from that work can be used as evidence of "earning power" with no need to present expert testimony on that issue.)

Claimant was employed part-time as a mailer. After suffering a work injury to her right arm and elbow in January of 1998, she began receiving workers' compensation benefits.

Employer was aware of claimant's earnings with it prior to her injury, but did not know that claimant was simultaneously working full-time as a bookkeeper/accounting assistant for another company. Claimant did not report her concurrent employment on the LIBC-750 form. Nor did she inform the insurance company adjusters, the rehabilitation nurse, or her own doctor. During the entire period she was off work with employer, claimant continued her full-time employment.

Following surgery in August of 1998, claimant's physician released her to light duty work. Claimant informed the doctor that employer did not have light duty work available in its mailroom. In October 1998, claimant's physician released her to her pre-injury job as a mailer. Claimant returned to work for one day, but because she experienced numbness in her hand, she left and did not return.

After leaving her full-time position because of job dissatisfaction, claimant filed a petition to review

her compensation benefits, seeking to have her average weekly wage changed to reflect her concurrent earnings. Employer then immediately filed a petition to modify or suspend claimant's benefits, asserting that she was receiving total disability benefits while working full time and seeking reimbursement or a credit for the overpayment.

The Workers' Compensation Judge granted claimant's petition, finding that her average weekly wage at the time of her injury given her concurrent employment was $960.31. The WCJ denied employer's suspension petition, but granted the modification petition. The WCJ determined that employer made significant overpayments to claimant for which it was entitled to credit. The WCJ found that claimant had an earning capacity of $644.23 per week. This was based upon the earnings she had received from her full-time employment prior to voluntarily leaving that position.

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

Claimant then sought review by the Commonwealth Court, asserting that the WCJ erred in assigning her an earning capacity when employer failed to present evidence of job referrals or a report from a qualified vocational expert. In response, employer argued that there is no such requirement where, as here, the claimant performed actual jobs for which she was paid after the work-related injury.

The Court agreed with employer and held: "...wages actually received for work performed is competent evidence of earning power entitled to be considered by the fact-finder. As with other evidence, the fact-finder will determine credibility and weight. Thus, employer here was not required to submit evidence of job referrals or expert opinion to establish earning power in the amount of wages claimant actually received for work performed. Claimant's absurd argument to the contrary is rejected."

According, the decision of the WCAB was affirmed.

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Douglas Lewis v. Workers' Compensation Appeal Board (Wal-Mart Stores, Inc. and Claims Management, Inc.), No. 288 C.D. 2004, filed August 20, 2004.

(Impairment Rating Evaluation - An employer is entitled to timely request two IREs within a 12-month period. An employer is not, however, entitled to unilaterally select the IRE physician.)

Claimant was injured on March 1, 1999. A Notice of Compensation Payable was issued acknowledging claimant's injury as aggravation of pre-existing degenerative disc disease sustained while "pulling pallets."

On August 22, 2002, employer filed a Petition for Physical Examination, requesting that claimant undergo an Impairment Rating Evaluation (IRE) under §306(a.2) of the Act.

The Workers' Compensation Judge found that claimant had undergone an initial IRE on January 8, 2002, which resulted in a determination of claimant's whole person impairment of 53%. Because employer's second IRE request was not made within 60 days of the expiration of claimant's receipt of 104 weeks of temporary total disability benefits, the WCJ found employer's second IRE request to be untimely. Employer' petition was thus denied.

The Workers' Compensation Appeal Board concluded that the 60-day limitation applies only to an employer's initial IRE request, and not to a subsequent biannual IRE requested by an employer pursuant to §306(a.2). Consequently, the WCJ's order was reversed. The Board further concluded, however, that while the Bureau assumes responsibility for designating an IRE physician to perform an initial IRE, employer had the right to unilaterally select the IRE physician for the second IRE.

Claimant then filed an appeal with the Commonwealth Court. The Court noted: 'Simply put, §306(a.2) of the Act and the regulations enacted thereunder entitle an employer to the timely request of two IREs within a 12-month period without any prefatory showing." The employer need not demonstrate any change in the claimant' smedical condition, permanent impairments and/or disability. Therefore, the WCAB did not err in reversing the WCJ's denial of employer's petition.

The WCAB did err, however, in determining that employer has the right to select the physician to perform its requested second IRE. No provision or authorization exists in the Act or the regulations for a unilateral IRE physician selection by the employer. The unambiguous language of the statute is that the IRE physician shall be chosen by agreement of the parties or shall be designated by the department.

Therefore, the WCAB's order was affirmed, but modified for the selection of the IRE physician in accordance with the Act.

SUPREME COURT CASE REVIEWS

General Electric Company v. Workers' Compensation Appeal Board (Myers), No. 47 WAP 2002, decided May 27, 2004.

(Modification - Offer of a temporary light-duty position will result in modification of benefits only temporarily.)

Employer filed a petition seeking to modify claimant's benefits based upon his refusal of a job offer, which was a funded position

with Smart Telecommunications, Inc. Employer was to have paid for all of claimant's wages, insurance, taxes, equipment and training, as well as for rent on the facility where he would have worked.

This period of subsidization by employer was limited in duration and would last 90 days or less. Thereafter, if claimant met Smart's productivity levels, Smart would continue to employ him and place him on its own payroll. At that time, however, claimant's job may change, his hours may be reduced and his wages may decrease.

The Workers' Compensation Judge granted employer's petition in part. The WCJ concluded that claimant was capable of performing the job offered to him and that his refusal of the position was improper. The WCJ also found, however, that the position was only available for 90 days. Therefore, the WCJ ordered modification of claimant's benefits to reflect the wages he would have earned at Smart, but only for a period of 90 days.

Both the Workers' Compensation Appeal Board and the Commonwealth Court affirmed the WCJ's decision.

The Supreme Court noted that when an employer refers a claimant to a temporary job, it has clearly not attempted to fully return the claimant to productive employment as is required by Kachinski v. WCAB (Vepco Construction Co.), 532 A.2d 374 (Pa. 1987). Such a referral is only a short-term solution to claimant's disability. It does not relieve the employer of its responsibility to locate an ongoing light-duty position that would permit the claimant to return to productive employment indefinitely. Hence, the Court held that when an employer refers a claimant to a job, which will become unavailable to the claimant at a set date in the future, the claimant's benefits should only be modified for that period of time that the job was available regardless of whether or not the claimant accepts the position or improperly refuses it.

The decision of the Commonwealth Court was affirmed.

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Vitac Corporation v. Workers' Compensation Appeal Board (Rozanc), No. 38 WAP 2003, decided July 22, 2004.

(Attorney's Fees - Paraprofessional fees my be recovered as a component of an award of attorney's fees under the Workers' Compensation Act.)

Claimant suffered a work-related injury in the form of carpal tunnel syndrome of her right wrist in June of 1998. A Notice of Compensation Payable was issued. On September 30, 1998, employer filed a petition to suspend benefits inasmuch as claimant refused reasonable medical treatment, namely, carpal tunnel release surgery. The petition was further amended to request, alternatively, modification of benefits based upon a job offered to claimant. Claimant requested attorney's fees under §440 of the Act, asserting that employer's contest was unreasonable.

The Workers' Compensation Judge granted the modification petition, in part, denied the suspension petition, and awarded claimant' sattorney's fees based upon an unreasonable contest. The WCJ found that claimant had been willing to undergo carpal tunnel release surgery, but that employer and its insurer had effectively precluded such treatment by refusing to pay for the procedure.

The Workers' Compensation Appeal Board reversed the determination that the contest was unreasonable, noting employer ultimately prevailed on the modification petition. The WCAB, thus, remanded the matter to the WCJ for a determination as to that portion of the attorney's fees attributable to the defense of the suspension petition. Additionally, the WCAB directed that claimant should recover any paralegal and law clerk fees associated with the awardable portion of attorney's fees. On remand, the WCJ awarded attorney' s fees totaling $1,134.00, a sum which included $92.00 in law clerk and paralegal fees.

The matter was then taken up to the Commonwealth Court, which ultimately affirmed the WCJ's order except as to the inclusion of paraprofessional fees with the award of attorney's fees.

The Supreme Court granted claimant's petition for allowance of appeal to address the issue as to whether paralegal and law clerk fees fall within the term "attorney's fee" as used in §440(a) of the Act.

Claimant argued that the lower rates for paraprofessional fees are reasonable and should be compensated as part of the attorney's fee because the use of such services is a cost-efficient component of the modern practice of law. The Supreme Court agreed. Although §440(a) of the Act is silent with regard to such fees, the legislative intent of §440(a) is to protect claimants from defending against bad-faith filings challenging legitimate compensation for injuries sustained. If paraprofessional fees were excluded, a claimant might have to bear a substantial portion of such litigation costs, contrary to the intent of the General Assembly.

The order to the Commonwealth Court was reversed insofar as it held the paralegal and law clerk fees to be unrecoverable. The fee awarded by the WCJ was reinstated.

Mr. Justice Castille filed a dissenting opinion noting that the clear language of §440(a) does not support the majority's interpretation. In his opinion, the General Assembly did not authorize payment of fees generated by paraprofessionals and it would be up to the General Assembly to amend the Act if such fees are to become payable.

(Continued from page 1)

and apparently unsatisfactory medical opinion concerning Claimant's condition, counsel for the insurance company came perilously close to violating Disciplinary Rule 3.4(b) relating to assisting a witness to testify. The Court has reviewed the testimony of Dr. Robinson and notes that Dr. Robinson either had, or should have had, Claimant's complete medical records at his disposal at the time of the examination. While Claimant did not relate her complete medical history to Dr. Robinson, it is not the history with which there was concern, but rather, the mirror and the events of April 10, 1999. Based on a photo, Dr. Robinson recanted his previous statements. Since, at the time that Dr. Robinson rendered either of his medical opinions, he did not have Claimant's complete medical history, and on both occasions, he had only partial information relating to the April 10, 1999 incident, we disagree with the WCAB's conclusion that Dr. Robinson's testimony was competent. **An opinion that is rendered where the medical professional does not have a complete grasp of the medical situation and/or the work incident can render the proffered opinion incompetent."** (emphasis added.)

The moral of the story is: Make certain that the IME physician has available to him or her ***all*** relevant **medical records** and **actual facts** concerning the work injury ***at the time of the evaluation*** – not at a later date.

This means that a full and complete investigation must be completed *prior* to the IME. 35 Pa. Code §131.53(f) provides that "medical examinations shall be scheduled within 45 days after the first hearing actually held." Consequently, the investigation must be completely *quickly*. Failure to do so, or failure to provide the IME physician with all relevant documentation and information may very well render the IME physician's opinion to be "incompetent."

ATTENTION READERS, the editors of 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, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, PA 15219.