TR&C Pennsylvania Workers' Compensation Bulletin

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UTILIZATION REVIEW

In pertinent part, the Pennsylvania Workers' Compensation Act provides:

"The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retroactive utilization review at the request of the employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review…."[1]

When utilization review is requested, the <u>only</u> issue is whether the treatment being rendered to the claimant is reasonable or necessary. Please keep in mind that the URO does not render a determination as to whether the treatment is causally related to the work injury. If the employer or insurer wants to dispute the causal relationship, it may either 1) file a Petition for Review; or, 2) simply deny payment and take the risk that the claimant will file a petition and seek the imposition of penalties.

As set forth in the Act, the URO has the ability to consider treatment that is currently being rendered to the claimant, treatment that has been rendered in the past, and treatment that may be rendered in the future. Regardless of when the treatment has or will be provided, the URO may only consider the treatment provided by "<u>a</u> health care provider" – which may be interpreted to mean a single health care provider. Consequently, if a claimant is receiving the same or similar treatment from two providers, two separate requests for utilization review ought to be filed unless the purpose is to stop duplicative treatment. In that case, only one request is necessary. If, however, the treatment itself is to be questioned, two requests will need to be filed.

Additionally, a favorable determination from the URO that the treatment is neither reasonable nor necessary may not prevent the claimant from seeking the same or similar treatment from a new health care provider.[2] Arguably, if that happens, a new utilization request should be filed.

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Commonwealth Court Case Reviews

William H. Bensing v. Workers' Compensation Appeal Board (James D. Morrissey, Inc.), No. 2933 C.D. 2002, filed August 21, 2003.

(Failure to File Timely Answer - Facts alleged in claim petition are admitted by employer's failure to timely answer; however, questions of law are fully reviewable.)

Claimant filed a petition alleging that he sustained injuries in an automobile accident while traveling to work. Employer failed to file a timely answer, and also failed to appear at the first hearing before the Workers' Compensation Judge. The WCJ issued an interlocutory opinion deeming the facts alleged in the claim petition to be admitted, but noting that employer still had the right to raise legal defenses to the petition.

At the conclusion of the proceedings, the WCJ found that claimant's employment contract did not include transportation to and from work, that claimant was not on a special mission for employer, and that claimant was not furthering employer's business at the time of the accident. Accordingly, claimant was not in the course and scope of his employment. Benefits were denied.

Claimant appealed, arguing that employer could not challenge whether he was in the course and scope of employment after it failed to file a timely answer.

The Court noted that, under §416 of the Act, the failure to file a timely answer precludes an employer from presenting any evidence in rebuttal or as an affirmative defense with respect to the alleged facts. However, the claimant is still required to prove all elements necessary to satisfy an award. Further, questions of law are fully reviewable and cannot be waived by the failure to file a timely answer.

Here, employer cannot dispute that claimant suffered injuries as a result of the accident. Whether those injuries, however, were sustained in the course and scope of his employment is a conclusion of law subject to review. Therefore, the WCJ was not precluded from deciding that question of law. Because the WCJ appropriately applied the law to the facts of the case, the decision of the WCJ was affirmed.

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Faulkner Cadillac v. Workers' Compensation Appeal Board (Tinari), No. 572 C.D. 2003, filed September 4, 2003.

(Specific Loss Benefits - Concurrent payments of specific loss benefits and partial or total disability compensation is not limited by the claimant's pre-injury earning power.)

Claimant sustained chemical burns to both hands in July of 1993. Employer acknowledged liability by issuing a Notice of Compensation Payable. Claimant then returned to work in August, 1993, and his benefits were suspended. A second work-related injury, in the form of a concussion, was sustained in April of 1994. Again, an NCP was issued and claimant began receiving weekly compensation benefits.

On December 23, 1996, claimant filed a petition seeking compensation for the loss of use of both hands due to the July 1993 work injury. The Workers' Compensation Judge found that claimant had, in fact, lost the use of both hands for all practical intents and purposes due to the July 1993 work injury. Consequently, 735 weeks of specific loss benefits were awarded, to be paid simultaneously with the total disability benefits for claimant's 1994 work injury.

Employer appealed, arguing among other things that the WCJ erred in ordering simultaneous payment of compensation for claimant's separate injuries where the total of the two awards exceeds the maximum weekly compensation payable under the Act.

The Court noted that, under workers' compensation law, the term "disability" is synonymous with loss of earning power. Because a claimant's injury may not cause more than a total loss of a claimant's earning power, a claimant may not be more than totally disabled.

Specific loss benefits, however, are payable without regard to a claimant's earning capacity. Thus, a claimant may receive specific loss benefits concurrently with awards for total disability compensation, partial disability compensation, and other specific loss injuries. A claimant is even entitled to receive specific loss benefits while receiving full wages. Under such circumstances, a claimant may receive a combination of wages and benefits that exceed his pre-injury wage.

The Court was not persuaded by employer's argument that claimant is not entitled to receive more than the weekly maximum of compensation. Because specific loss benefits are payable without regard to a claimant's resulting wage loss, concurrent payments of specific loss benefits and partial or total disability compensation cannot rationally be limited by reference to a claimant's pre-injury earning power or by the statutory maximum.

The decision of the WCJ was affirmed.

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Patricia Gallie v. Workers' Compensation Appeal Board (Fichtel & Sachs Industries), No. 1138 C.D. 2003, filed September 10, 2003.

(Utilization Review - Petition for Review of Utilization Review Determination is timely filed if filed within 30 days of the Department's receipt of the URO report.)

Claimant suffered a work-related back injury, for which she sought chiropractic treatment. Employer requested a utilization review of that treatment. The Utilization Review Organization (URO) issued a report concluding that while the chiropractic adjustments were reasonable and necessary, the massage and ultrasound therapy were not.

Claimant received the URO report on May 21, 2001. She testified that she mailed a review petition on June 18, 2001; however, the envelope was postmarked June 22, 2001, more than 30 days after her receipt of the URO report.

Employer asserted that the claimant's review petition was untimely because it was filed beyond the 30 day period contained in §306(f.1)(6)(iv) of the Act, which provides:

> "If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report."

The Workers' Compensation Judge found that although claimant received the URO report on May 21, 2003, the Bureau of Workers' Compensation (Department) did not receive it until May 24, 2001. The WCJ determined that it was the date of the Department's receipt of the URO which triggers the 30 day petition period. Therefore, claimant's appeal was sustained.

The Workers' Compensation Appeal Board vacated the WCJ's decision and dismissed the petition, concluding that the petition was untimely. The WCAB noted that §306(f.1)(6)(iv) refers only to the provider, employer, employee or insurer, and contains no reference to the Department.

Claimant appealed the WCAB's order. The Commonwealth Court agreed with claimant that §306(f.a)(6)(iv) is ambiguous and does not specify whose receipt of the URO determination begins the 30-day petition period. The Court noted that the Act, however, must be liberally construed to effectuate its humanitarian purposes with borderline interpretations resolved in favor of the injured employee.

Thus, because §306(f.1)(6)(iv) makes reference to the Department's role in the utilization review process, and because the URO report originates outside the Department from a third party source, the Department's receipt of the report acts as "an easily-ascertained, objective landmark from which the appeal period may be measured."

The decision of the WCAB was reversed and the decision of the WCJ reinstated.

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Jeremiah Schemmer v. Workers' Compensation Appeal Board (U.S. Steel), No. 1143 C.D. 2003, filed September 24, 2003.

(Specific Loss - Where claimant lost foot in a non-work related accident, and then suffers work injury causing loss of lower leg, the weeks attributable to the loss of the foot is deducted from the weeks attributable to the loss of the lower leg.)

In 1977, claimant's lower left leg was amputated seven inches below his knee as a result of a motorcycle accident. In 1990, claimant slipped and fell at work and, because his prosthesis came loose, he landed on the stump of his left leg, causing a contusion and infection. Consequently, an additional three inches was amputated from his lower left leg.

On June 29, 2001, employer filed a petition alleging that claimant's injury had resolved into a "specific loss" of his lower left leg.

Accepting employer's medical expert's testimony as credible, the Workers' Compensation Judge found that the 1990 injury had resulted in a specific loss of the lower left leg. While claimant was entitled to 350 weeks of compensation under §306(c)(5) of the Act for the loss of his lower left leg, the WCJ deducted 250 weeks for the non-work related loss of his left foot in 1977, and granted employer a credit for the benefits already paid.

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

Claimant then sought review by the Commonwealth Court, arguing that the WCJ and the WCAB erred by deducting 250 weeks of his specific loss benefits because he did not have a left foot.

The Court disagreed, reasoning that the loss of a limb includes as part of that compensation loss of other parts of the body. At the time of the work injury, claimant did not have a foot. Because claimant cannot recover for that which he did not have, the WCJ's determination that employer was obligated to compensate claimant for 100 weeks, the difference between 350 weeks of compensation for the lower leg and 250 weeks for the foot, was proper.

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

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PNC Bank Corporation v. Workers' Compensation Appeal Board (Stamos), No. 860 C.D. 2002, filed September 17, 2033.

(Survivor's Benefits - Common law spouse is not entitled to benefits *after* this case inasmuch as common law marriage in Pennsylvania is hereafter abolished.)

Employer appealed the order of the Workers' Compensation Appeal Board affirming the grant of Kretz's fatal claim petition after concluding that the Workers' Compensation Judge properly concluded that Kretz was the common law spouse of the decedent, Stamos.

Stamos was killed in a plane crash in 1994 while working for employer. The nature of Kretz's relationship with Stamos was the subject of hearings before the WCJ.

Kretz offered into evidence an affidavit that both he and Stamos had signed that had been submitted to his employer so as to obtain benefits for Stamos. The affidavit stated that: "...we, the undersigned, having the capacity to marry, did unite ourselves in marriage through the mutual exchange of words which expressed our present intent to live together as husband and wife..."

Kretz also testified that he and Stamos began living together in June of 1989 and that they subsequently exchanged rings as a sign of their marriage.

Based upon this evidence of *verba de praesenti*, the WCJ and the WCAB found that Kretz was married via common law marriage to Stamos at the time of her death and awarded surviving spouse's benefits to Kretz. Employer appealed.

The Commonwealth Court noted that the Supreme Court articulated skepticism regarding the continued viability of the common law marriage doctrine in the case of *Staudenmayer v. Staudenmayer, 552 Pa. 253, 714 A.2d 1016 (1998).* The Court further noted that many sound reasons exist to abandon the doctrine. Requiring statutory marriages with witnesses and licensing "... provides a bright line standard to guide the courts in adjudicating disputes and the public in conducting and defining their relationships with some measure of certainty and stability. It furthers the beneficial provisions of the Marriage Law, and reduces the need for litigation to settle rights and the opportunity for fraudulent claims....Accordingly henceforth, this court will recognize as valid only those Pennsylvania marriages entered into pursuant to the Marriage Law procedures."

Because this ruling is prospective and will affect only future cases, the decision of the WCAB affirming the decision of the WCJ awarding benefits to Kretz was affirmed.

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SWIF v. Workers' Compensation Appeal Board (Hering, American Eagle Express, and Liberty Mutual Insurance Company), NO. 741 C.D. 2003, filed October 8, 2003.
(Coverage - Where SWIF accepted a small premium for a class of employees which employer denied having, and did not remove that class despite the Bureau's authority to do so, SWIF could not deny coverage.)

The State Workers' Insurance Fund provided coverage to employer prior to 1992. Employer's business was headquartered in Philadelphia. In August of 1992, employer moved to Delaware, but still had employees and independent contractors in Pennsylvania. After moving to Delaware, employer obtained workers' compensation insurance through Liberty Mutual, but continued to insure in Pennsylvania through SWIF.

Claimant was hired as an employee in Pennsylvania in 1995. While in the course and scope of his employment, he was involved in an accident rendering him a quadriplegic.

Claimant filed a claim petition naming SWIF as the responsible carrier. SWIF filed a petition to join Liberty Mutual. The issue before the Workers' Compensation Judge was whether the policy issued by SWIF covered claimant's injuries.

SWIF contested that claimant was covered because his job duties fell within the risk classification of parcel-delivery (category 808) and employer had misrepresented the nature of its workforce to SWIF by indicating that it did not have any category 808 employees. Based upon the misrepresentation, SWIF assessed a nominal increase in employer's annual premium. SWIF contended that it relied on employer's misrepresentation to its detriment and, hence, the policy was void.

Based upon the policy in question, the past relationship between employer and SWIF and documents from the Pennsylvania Compensation Rating Bureau, the WCJ found that SWIF issued a policy to employer that covered category 808 employees. Additionally, the WCJ found that SWIF could not assert a defense of misrepresentation because it failed to comply with former §308 of the Insurance Act, which required that all insurance policies have attached to them the insured's constitution, by-laws or other company rules.

The Workers' Compensation Appeal Board agreed that §318 of the Insurance Act precluded SWIF from relying on the policy to show employer's alleged misrepresentation. However, the WCAB did determine that SWIF could rely on other evidence to prove its assertions. Therefore, the case was remanded to the WCJ for consideration of additional evidence.

On remand, the WCJ determined that SWIF did not rely on the misrepresentations made by employer. SWIF once again appealed to the WCAB, which affirmed the WCJ's decision.

The Commonwealth Court noted that when employer first applied for coverage with SWIF, employer's application was returned because category 808 coverage was required by the Bureau. Thereafter, when employer moved to Delaware and no longer needed the category 808 classification for its employees, the Bureau noted that it should be deleted from the policy. SWIF engaged the services of an outside auditing firm to determine if the 808 category should be deleted from employer's policy. The results of that audit confirmed that employer had no payroll for category 808 employees during 1994. Therefore, the Court noted that SWIF relied on representations of

various sources, not merely the employer, to conclude that employer had no category 808 employees. Moreover, SWIF failed to demonstrate that employer knew its representations were false or were made in bad faith.

SWIF argued that it could not remove the classification 808 coverage from employer's policy without the Bureau's approval. The Court noted, however, that SWIF had authority from the Bureau to remove the category 808 employees from the policy, and yet failed to do so. Thus, the Court concluded that SWIF maintained employer's category 808 employee coverage at its own discretion.

Because SWIF provided employer with a policy that maintained coverage for category 808 employees, SWIF assumed a risk inherent in the insurance industry. The Court concluded that the policy issued by SWIF was not void and that SWIF was the responsible carrier.

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Charles E. Havenstrite v. Workers' Compensation Appeal Board (Tobyhanna State Park), No. 2812 C.D. 2002, filed October 15, 2003.

(Utilization Review - WCJ is free to accept opinion of reviewer, even if reviewer indicates that the documentation provided to him was insufficient.)

Claimant sustained a work injury in June of 1999 when he slipped and fell. A Notice of Compensation Payable was issued, describing the injury as a strain of the left bicep muscle.

Employer subsequently filed a utilization review request questioning whether the treatment provided by claimant's chiropractor, Dr. Intelisano, on and after August 1, 2000 was reasonable or necessary. The URO, through Dr. Kollars, determined that the treatment in question was neither reasonable nor necessary. One of the reasons given by Dr. Kollars in support of his conclusion that the treatment was not reasonable or necessary was that Dr. Intelisano' s documentation was insufficient, that his office notes were "weak and sketchy" and that his "objective findings were handwritten and difficult to determine."

Claimant sought review of the UR Determination by a Workers' Compensation Judge. The WCJ rejected Dr. Intelisano's opinions, and found the opinions of the Dr. Kollars and Dr. Hubbard, who had performed an IME, to be credible. Therefore, the WCJ denied claimant's review petition. The Workers' Compensation Appeal Board affirmed.

Claimant appealed to the Commonwealth Court alleging that the WCJ erred because Dr. Kollars did not initiate discussions with Dr. Intelisano. Under 34 Pa.Code §127.469, the URO has the duty to initiate discussion with the provider under review when such a discussion will assist the reviewer in reaching a determination. Claimant asserted that, because Dr. Kollars could not understand some of Dr. Intelisano's notes, he had a duty to contact Dr. Intelisano to clarify the information in the notes of treatment.

The Court noted that the holding of the case of *Solomon v. Workers' Compensation Appeal Board (City of Philadelphia), 821 A.2d 215 (Pa.Cmwlth. 2003),* is that a utilization reviewer's failure to obtain a claimant's entire medical file does not automatically preclude a utilization reviewer from assessing the reasonableness and necessity of a particular treatment. This is true even where there was no substantive contact between the reviewer and the treating health care provider.

The Court further noted that the claimant had a full and fair opportunity to present his evidence to the WCJ, and the WCJ rejected Dr. Intelisano's testimony as to the reasonableness and necessity of his treatment. Based upon the reports of Dr. Kollars and the IME physician, the WCJ had substantial evidence upon which to base his conclusion that the treatment at issue was neither reasonable nor necessary.

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

Editor's Note: Judge Friedman filed a dissenting opinion, noting that the Reviewer effectively admitted that he needed additional information in order to be able to render a determination as to the reasonableness and necessity of the treatment. Therefore, Judge Friedman opined that the Reviewer was bound to resolve the issue in favor of the provider under 34 Pa. Code §127.471. While her analysis of the provisions of the Code is correct, the Judge noted in a footnote that the majority erred in considering the IME report as substantial evidence. Judge Friedman would find the IME report to be incompetent, stating that "[d]isputes as to the reasonableness and necessity of treatment must be resolved through the UR process," citing §306(f.1)(6) of the Workers' Compensation Act.

According to Judge Friedman's literal reading of the Act, the only evidence that could then be considered would be the URO report itself. The Act, however, has never been interpreted as such a means to exclude IME evidence in proceedings before a WCJ.

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Michael Haynes v. Workers' Compensation Appeal Board (City of Chester), No. 131 C.D. 2003, filed October 16, 2003.

(Utilization Review - The opinions of the UR reviewer (a physical therapist) and another physical therapist were competent evidence upon which to find the physical therapy in question to be unnecessary.)

In February of 1995, Claimant, a city detective, sustained a work-related injury to his right shoulder and elbow while removing snow from a police car. In August of 1999, employer filed a UR request seeking a determination that

"aquatic therapy: and "cervical range of motion and body masters isotonics" received by claimant from Dynamic Physical Therapy was unreasonable and unnecessary.

The URO determined that the therapy was, indeed, unreasonable and unnecessary as of June 7, 1999. The UR reviewer, a licensed physical therapist, stated that the treatment consisted of repetitive exercises that did not require skilled care and that claimant should have been able to follow an independent exercise program at a health club or YMCA.

Claimant filed a petition to review the UR determination, and the Workers' Compensation Judge appointed another licensed physical therapist to make an independent evaluation of the therapy. That therapist found the treatment to be incomplete because it was not focused on restoring motor skills and because claimant was not given any instructions on a rest position, cervical spine management or a home exercise program. The independent therapist concluded that the treatment was not reasonable or necessary, stating that a brief physical therapy program of 4-6 sessions would be reasonable for the purpose of giving claimant instructions on a home exercise program.

The claimant presented testimony from his physician, Dr. Grossinger, who stated that claimant had restricted neck mobility and that the therapy provided by Dynamic Physical Therapy was reasonable and necessary to treat the condition.

The WCJ accepted the opinions of the two physical therapists as more credible than the testimony of Dr. Grossinger. Therefore, claimant's petition was denied. The Workers' Compensation Appeal Board affirmed the WCJ's decision.

Claimant appealed to the Commonwealth Court, arguing that it was error to accept the opinions of physical therapists, who are not medical doctors, as competent testimony.

The Commonwealth Court noted that an employer seeking to avoid payment for medical services has the never-shifting burden of establishing that the treatment is unreasonable and unnecessary. The Court further noted that, under §306(f.1)(6) of the Act, utilization review is to be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider under review. Further, a "health care provider" is defined by the Act to include a physical therapist.

Therefore, the licensed physical therapists were competent to render an opinion regarding the reasonableness and necessity of the therapy provided by Dynamic Physical Therapy. Accordingly, the order of the WCAB was affirmed.

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Maple Creek Mining Company v. Workers' Compensation Appeal Board (Bakos), No. 941 C.D. 2003, filed October 17, 2003.

(Specific Loss Benefits - Testimony that claimant lost his ankle is not akin to losing his foot.)

Claimant, a laborer in employer's mine in 1996, was working in deep mud and carrying a bag of cement on his shoulder. When he tried to turn to dump the cement into a wheelbarrow, he found that he could not lift his leg from the mud. As a result, he twisted, pulling his left ankle.

Since the injury, claimant has pain, swelling and instability of his left ankle. He wears a special brace to bear weight and to walk. He also uses a cane.

Employer filed a petition contending that claimant's ankle injury resolved into a specific loss of his foot, thereby justifying suspension of his benefits.

Testimony was presented from three orthopedic physicians. All agreed that claimant suffered the loss of use of his left foot.

The Workers' Compensation Judge found the employer's expert, Dr. Tucker, to be credible to the extent that Dr. Tucker opined that claimant's ankle prevents him from resuming his pre-injury occupation. The WCJ, however, found that claimant did not sustain a specific loss of his left foot as a result of the work injury. Despite the testimony of the medical experts, the WCJ observed that the Workers' Compensation Act does not recognized the loss of use of an ankle as being a compensable specific loss, nor does the Act recognized the ankle as a part of the foot. Therefore, the WCJ determined that claimant's ongoing problems with his left ankle cause him to remain totally disabled due to the work injury.

The Workers' Compensation Appeal Board affirmed the WCJ's order, noting that the the WCJ did not err in concluding that employer did not prove claimant sustained a specific loss of use of his left foot. Claimant never suffered an injury to his foot, and none of the experts discussed a loss of use of claimant's foot separate from his ankle problems.

Employer filed an appeal with the Commonwealth Court, arguing that the WCJ committed reversible error when she refused to find a specific loss occurred despite the unanimous testimony of the medical experts. The Court disagreed. The Act does not provide for specific loss of an ankle. The Act does not define "foot." Given the lack of statutory guidance, the Court adopted an interpretation of the Act most favorable to the employee.

Therefore, the Court affirmed the WCJ's determination that the loss of use of the ankle is not a specific loss of a foot as a matter of law.

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Welliver McGuire, Inc. v. Workers' Compensation Appeal Board (Padgett), No. 919 C.D. 2003, filed October 22, 2003.

(Pension Offset - Where the employer has a retro policy and must pay benefits up to a specific amount before insurer pays, then

offset credit is due for pension received by claimant up to amount paid by employer.)

Claimant, who had sustained a work injury in 1998, began receiving pension benefits in May 2001.

On October 16, 2001, employer sent claimant LIBC Form 761, Notice of Workers' Compensation Benefit Offset. The form advised claimant that his workers' compensation benefits would be reduced given employer's assertion of a credit for the full amount of the claimant's pension benefits.

Claimant filed a Petition for Review alleging that employer was not entitled to an offset. At the hearing before the Workers' Compensation Judge, the parties stipulated that 46.3% of the funds in claimant's pension plan were the result of contributions made by employer. The parties also stipulated that, although employer carries workers' compensation insurance coverage, employer has a $250,000.00 aggregate deductible, such that the first $250,000.00 paid to claimant and other injured employees is paid directly by employer.

Between claimant's date of injury and June 1, 2000, all benefits paid to claimant were paid directly by employer. All benefits paid after June 1, 2000 were paid by Travelers.

The WCJ concluded that employer was not entitled to an offset because claimant's benefits were paid by the insurance carrier and not by employer. On appeal, the Workers' Compensation Appeal Board affirmed.

Employer sought review by the Commonwealth Court. The Court noted that the plain language of §204(a) of the Act provides that 'the severance benefits paid by the employer directly liable for the payment of compensation and the benefits from a pension plan to the extent funded by the employer directly liable for the payment of compensation...which are received by an employee shall also be credited against the amount of the award made..." Here, employer was directly liable to claimant. Claimant received pension benefits of which 46.3% was funded by employer and employer was directly responsible for the payment of claimant's workers' compensation benefits from February 4, 1998 through June 1, 2000. Accordingly, during that time period, claimant's monthly wage loss benefits should have been reduced by 46.3% of the claimant's monthly pension benefits. Consequently, the case was remanded for a determination of credit due employer.

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Ralph H. Williams v. Workers' Compensation Appeal Board (Hahnemann University Hospital), No. 609 C.D. 2003, filed October 23, 2003.

(Evidence - Opinion evidence contrary to facts as previously found by WCJ is incompetent evidence.)

Claimant sustained a work-related back injury on February 24, 1987 and a Notice of Compensation Payable was issued.

On December 23, 1991, WCJ Olin circulated a decision modifying claimant's benefits because he found as fact that, lacking good faith, claimant failed to apply for an available position within his capabilities as an instructor with C.H.I. Institute.

On May 8, 1995, WCJ Olin dismissed claimant's reinstatement petition, concluding that claimant did not establish a worsening of his condition and that claimant's continued loss of earnings was self-imposed.

In October of 1998, claimant filed a second reinstatement petition, alleging a worsening of his condition and decreased earning power as of May 9, 1995, the day after WCJ Olin's decision on the first reinstatement petition. The second reinstatement petition was assigned to WCJ Devlin.

In support of his petition, claimant offered testimony from Dr. Kambin who opined that claimant's condition had continuously worsened since 1987. Dr. Kambin admitted on cross-examination that he disagreed with WCJ Olin's finding in 1991 that claimant was capable of sedentary duty work.

In addition, claimant presented testimony from a vocational counselor, who opined that claimant was not capable of performing any type of gainful employment. In addition, he opined that claimant was not vocationally capable of performing the instructor position at C.H.I. Institute because he did not have a high school diploma.

WCJ Devlin found claimant's experts to be credible and reinstated claimant's benefits. Employer filed an appeal to the Workers' Compensation Appeal Board, which reversed the WCJ's decision. The WCAB concluded that the opinions of Dr. Kambin and the vocational expert were incompetent because they were based on facts contrary to the 1991 decision of WCJ Olin.

The Commonwealth Court agreed. Contrary to WCJ Olin's 1991 decision, Dr. Kambin and the vocational expert indicated their belief that claimant could never perform the instructor position at C.H.I. Institute. It is well settled that where an expert's opinion is based upon an assumption which is contrary to the established facts of record, that opinion is worthless. Consequently, claimant did not satisfy his burden with regard to the second reinstatement petition. The order of the WCAB reversing the decision of the WCJ was affirmed.

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Pittsburgh Board of Education v. Workers' Compensation Appeal Board (Dancho), No. 354 C.D. 2003, filed October 30, 2003.

(Pension Offset - Employer is entitled to a credit only to the extent it funds a pension plan, not to the extent funded by a third-party contributor.)

Claimant sustained a work-

related injury for which he ultimately received temporary total disability benefits. While the claim petition was in litigation, claimant began receiving disability retirement benefits from the Public School Employees' Retirement System (PSERS).

Employer subsequently filed a petition alleging that it was entitled to a credit for the benefits received by claimant from PSERS under §204(a) of the Act. Even though all parties assumed that the Commonwealth and employer contributed separately to PSERS, the Workers' Compensation Judge found that employer was entitled to a credit for the amounts contributed by the employer and by the Commonwealth, reasoning that the school district was an agent of the Commonwealth.

Claimant filed an appeal to the Workers' Compensation Appeal Board, contending that employer was not entitled to a credit for the contributions made by the Commonwealth to PSERS. Section 204(a) provides that a credit is available "...to the extent funded by the employer directly liable for the payment of compensation..." Because the Commonwealth was not directly liable for the compensation, claimant argued that employer was entitled to a credit only to the extent that employer contributed to the pension. The WCAB agreed.

On appeal to the Commonwealth Court, employer argued that because a local school district is an agent of the Commonwealth created to carry out the Commonwealth's responsibility of providing education, employer and the Commonwealth are one and the same for purposes of defining "employer" under §204(a).

The Court rejected employer's argument, noting that the Commonwealth is clearly not the employer directly liable for the underlying workers' compensation claim. Because it was assumed that the Commonwealth contributed directly to the PSERS fund, employer is not entitled to a credit for the Commonwealth's contributions. Third-party contributors are not transformed into co-employers liable for the underlying compensation simply by virtue of their contributions to a pension fund.

The decision of the WCAB was affirmed.

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Lawrence Mahon v. Workers' Compensation Appeal Board (Expert Window Cleaning and State Workers' Insurance Fund), No. 2161 C.D. 2002, filed November 10, 2003.

(Correction of NCP - Correction of material mistake is allowed when employer or insurer, in good faith, initially issues a notice of compensation payable but then learns that facts previously unknown indicate that the injury is not compensable.)

(Intoxication - Compensation is not payable if the injury would not have occurred but for the employee's intoxication.)

Claimant, a window washer, was injured on July 16, 1999 after a ladder he was standing on fell 18 feet to the ground, causing both his ankles to break. At the hospital, claimant admitted that he had a history of being an alcoholic and consuming two six-packs per day, and that he had consumed some beers before coming to work that morning. Blood tests indicated that his blood alcohol level two hours after the injury was between .25 and .3.

Employer's carrier, SWIF, not having the hospital records at the time it evaluated the claim, issued an NCP on July 26, 1999, acknowledging the injury. Thereafter, SWIF obtained the hospital records and filed a petition to review, seeking to set aside the NCP alleging that claimant's intoxication was the actual cause of his injuries.

The Workers' Compensation Judge found that claimant's intoxication was, in fact, the cause of his injuries and, as such, he was not entitled to compensation benefits. The WCJ then relied upon §413 of the Act, which allows a WCJ to correct a notice of compensation payable if it is materially incorrect. The Workers' Compensation Appeal Board affirmed.

Before the Commonwealth Court, claimant argued: 1) SWIF was precluded from attacking the NCP because it could have avoided admitting liability by issuing a temporary notice of compensation payable; and 2) SWIF failed to carry its burden of proof to establish that intoxication caused claimant's fall because SWIF's medical expert supports only a finding that there is a statistical likelihood that claimant fell because of intoxication, rather than a finding that intoxication was the definitive cause of the fall.

The Court noted that the use of a NTCP is appropriate if there is uncertainty about the legitimacy of the claim. Here, at the time the NCP was issued, SWIF believed there was no question concerning the compensability of the claim. Consequently, SWIF acted reasonably in issuing the NCP rather than an NTCP. Under the Supreme Court's decision in *Barna v. WCAB (Jones & Laughlin Steel Corp.), 513 Pa. 518, 522 A.2d 22 (1987)*, an employer may challenge an initial admission of liability in an NCP where the employer begins prompt payment of benefits before completing an investigation of an alleged work-related injury and, upon completion of the investigation, determines that benefits are not payable. Consequently, SWIF is not estopped here from challenging the compensability of the injury designated on the NCP.

Further, §301(a) of the Act provides that, "[i]n cases where the injury...is caused by intoxication, no compensation shall be paid if the injury...would not have occurred but for employe's intoxication, but the burden of proof of such fact shall be upon the employer."

The phrase "but for" means that an employer or insurer must estab-

lish that intoxication was the cause in fact of an injury, without regard to proof that the intoxication was the proximate cause of or a substantial factor in causing the injury. The question of whether the act is the "cause in fact" of an injury is one for the factfinder.

Here, SWIF's expert testified, within a reasonable degree of medical certainty, that claimant's intoxication caused his fall. The WCJ found this testimony credible and convincing. SWIF was not required to establish that no other condition was the cause of claimant's fall. Claimant was in the best position to put forth evidence of another cause of his fall once SWIF offered credible, competent evidence that intoxication was the definitive cause of his fall. Claimant did testify as to the cause of his fall; however, his testimony was rejected by the WCJ as incredible.

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

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Westinghouse Electric Corporation/CBS v. Workers' Compensation Appeal Board (Burger), No. 2820 C.D. 2002, filed November 17, 2003.

(Review Petition - When seeking compensation benefits for disabilities that are related to, but distinct from, an injury described in an NCP, and which are not the natural consequence of the work injury, a claimant must file a Claim Petition, not a Review Petition.)

Claimant suffered a work injury in 1992, which was described on the Notice of Compensation Payable as "internal injuries, knee strain." Seven years later, claimant filed a Review Petition, seeking to amend the NCP to include psychological injuries, including sexual dysfunction.

Crediting the claimant's expert witness, the Workers' Compensation Judge concluded that claimant sustained his burden of proof and ordered that the NCP be amended to include sexual dysfunction, chronic pain disorder and depression. Employer appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's order in this regard.

On appeal to the Commonwealth Court, employer argued that the WCJ did not have authority to modify the NCP given the Court's decision in *Jeannes Hospital v. Workers' Compensation Appeal Board (Hass), 819 A.2d 131 (Pa.Cmwlth. 2003).* In that case, the Court determined that, when seeking compensation benefits for disabilities that are related to, but distinct from, an injury described in an NCP, a claimant must file a claim petition, not a review petition.

Here, however, claimant acknowledged that he had the burden of relating his psychological difficulties to the work injury and specifically sought to amend the NCP. Because the evidence found credible by the WCJ established that claimant's physical injuries had additional, psychological consequences, the NCP was appropriately modified. The WCAB did not err in affirming the WCJ in this regard.

The decision of the WCAB was affirmed.

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SUPREME COURT CASE REVIEWS

Hannaberry HVAC and Donegal Mutual Insurance Companies v. Workers' Compensation Appeal Board (Snyder, Jr.), No. 99 MAP 2001, Decided October 22, 2003.

(Average Weekly Wage - Section 306(d) of the Act does not control the calculation where it would lead to a grossly and demonstrably inaccurate measure of a worker's average weekly wage.)

Claimant worked on a part-time basis for employer while he was a high school student. After graduating in June of 1996, he accepted a full-time position with employer. On September 20, 1996, he suffered a devastating work injury when a forklift fell on him, rendering him quadriplegic.

While employed part-time, claimant's work schedule varied greatly, such that his average weekly wage in the 3 quarters preceding his full-time employment were as follows:

09/20/95 - 12/20/95	$57.25
12/20/95 - 03/20/96	$96.87
03/20/96 - 06/20/96	$110.56

In contrast, his average weekly wage for the final quarter prior to his injury, 06/20/96 through 09/20/96, was more than four-fold, $473.65.

Employer issued a Notice of Compensation Payable, calculating claimant's average weekly wage under §309(d) of the Act to be $229.43 with a corresponding compensation rate of $206.49.

Claimant filed a Review Petition, contending that his average weekly wage should be calculated based solely upon the quarter coinciding with his full-time employment. He argued that including his part-time high school employment in calculating the average weekly wage artificially decreased the wages he actually earned as a full-time employee at the time of his injury.

The Workers' Compensation Judge agreed with claimant, and calculated his average weekly wage at $473.65, with a corresponding compensation rate of $315.76. The WCJ concluded it would be manifestly unfair to ignore the dramatic distinction between part-time and full-time employment in this context.

The Workers' Compensation Appeal Board affirmed the WCJ's

decision, recognizing the humanitarian intent of the Act.

The Commonwealth Court reversed, noting that the Act makes no distinction between part-time and full-time employment. *See TR&C Workers' Compensation Bulletin, Vol. VI, No. 6, p. 8.* The statute requires that the 3 highest of the last 4 quarters be averaged in calculating a claimant's wages. Therefore, the Court concluded that, as a matter of law, the periods of part-time employment could not be excluded form the calculation of his average weekly wage.

The Supreme Court noted that one obvious purpose of §309(d) was to prevent a claimant from receiving artificially inflated benefits by being able to select, as the measuring point for calculating his average weekly wage, a work quarter during which his pay was atypically high. Here, however, a strict application of the statute results in having claimant's full-time wages **artificially devalued** by including periods of an entirely different type of employment. The Court held that the Legislature could not have intended such an effect. The statute, as a whole, is obviously designed to ensure an **accurate** calculation of the injured workers' wages. Based upon that calculation, the statute then permits a **projection** of employee's expected future wages. The calculation is supposed to be a "fair ascertainment" of the employee's wages. Because a strict application of the statute will not result in a fair ascertainment of this claimant's average weekly wage at the time of his injury, subsection (d) will control.

The Court held that subsection (d) of §309 does not control the calculation in a circumstance, such as this one, where it would lead to a grossly and demonstrably inaccurate measure of a workers' average weekly wage.

The decision of the Commonwealth Court was reversed and the order of the WCJ reinstated.

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"Glacial" Disfigurement

EMPLOYER'S CORNER

Q. Must an employee covered by the ADA be granted reassignment to a vacant position to accommodate the employee's disability?

A. Maybe not. Generally speaking, an employer who fails to provide reasonable accommodation to the known physical or mental limitations of a qualified individual with a disability commits unlawful discrimination unless the accommodation can be shown to impose undue hardship. "Reasonable accommodation" may include:

a) making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and,

b) job restructuring, part-time or modified work schedules, *reassignment to a vacant position*, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities. 42 U.S.C. §12111(9).

The 8th Circuit Court of Appeals, however, recently upheld judgment in favor of an employer who refused its employee's request for transfer to a less stressful position in order to accommodate the employee's depression.

In the case of *Burchett v. Target Corporation, 340 F.3d 510 (8th Cir. 2003)*, Lynn Burchett was diagnosed as suffering from depression. At first, she did not inform her employer of her depression, but simply requested a transfer to a less stressful position. Following a poor performance review, the employee took a leave of absence and withdrew her transfer request.

Subsequently, she returned to work on a part-time schedule with a reduced work load. Her performance, however, continued to decline. She again requested a transfer; however, Target has a policy to reject applications of employees who are not performing well in a current position. Consequently, she was denied reassignment to a vacant position. The employee then filed an action in federal court, alleging that Target discriminated against her under the ADA.

The Court found, however, that because the employee had been provided with accommodations to her original position which were consistent with her medical restrictions, transfer to another position was not required. Ms. Burchett failed to show that Target's refusal to reassign her was due to her disability. Consequently, the employer won.

(Continued from page 1)

However, it could also be argued that the initial UR Determination deemed the "treatment" to be unreasonable and unnecessary rather than the "treatment by a [specific] health care provider." Therefore, if the treatment itself is unreasonable and unnecessary, it should not matter which health care provider is providing the treatment. If it is *exactly* the same treatment, the employer or insurer could arguably deny payment on that basis. This will undoubtedly lead to a penalty petition. This issue has not yet been determined by the courts and, until it is, the outcome is unpredictable.

The URO, not a Workers' Compensation Judge, has original jurisdiction over issues concerning the reasonableness and necessity of medical care. A Request for Utilization Review may be filed before a Claim Petition is filed, during the pendency of a Claim Petition, or at anytime during the life of the claim. In any case, the request must be filed within thirty days after receipt of the bill or it will be deemed to be untimely. The only exception to this rule occurs during the litigation of a Claim Petition. The regulations provide that: "[I]f the insurer is contesting liability for the underlying claim, the 30 days in which to request retrospective utilization review is tolled pending an acceptance or determination of liability."[3]

Review of the URO's decision, however, falls within the power of the Workers' Compensation Judge. He or she may consider the URO's determination as evidence, but is not bound by it. When proceeding before the Judge, all parties, including the claimant, the employer/insurer, and the medical care provider are entitled to produce additional evidence in support of their position. Therefore, even if the employer or insurer obtains a favorable URO Determination, it may still be necessary to have an independent medical evaluation in order to succeed before the Judge. However, it is questionable as to whether or not an IME may be secured *after* the Petition for Review of Utilization Review Determination has been filed. Therefore, the best strategy is to have an IME performed before the utilization review is done.

Overall, the utilization process is an effective tool to use in cases in which physicians or other medical care providers appear to be providing the claimant with "questionable" treatment. For example, is an unusual or radical surgical procedure being recommended? Is the claimant being prescribed large doses of narcotics, or narcotic medication over an extended period of time? Is the claimant's condition deteriorating despite the treatment being rendered? In such cases, a request for utilization review may discourage inappropriate treatment being rendered at the expense of the employer or insurer.

Chiropractic care is often the target of utilization review. Prior case law consistently held that even treatment which is only palliative in nature, designed only to manage the claimant's symptoms rather than to cure or permanently improve the underlying condition, may be deemed to be reasonable and necessary.[4] Therefore, because chiropractic treatment frequently is administered solely to alleviate symptoms, the utilization review process can be rendered useless under such circumstances. A recent Commonwealth Court decision, however, states that even where palliative care is being rendered, if that care is effective over the short term but over time could actually prove to be <u>*detrimental*</u>, the

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Season's Greetings

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care is not reasonable or necessary.[5] Consequently, if an expert will testify that the treatment at issue will actually prove to be harmful in the long term, even palliative treatment may be found to be unreasonable and unnecessary.

The utilization review process may not necessarily be an effective tool for effectuating a settlement. As set forth above, a determination that the treatment at issue is neither reasonable nor necessary arguably only prevents the claimant from seeking that treatment from that provider. It does not limit the claimant's right to receive reasonable medical care necessitated by the work injury. Only an order from a Workers' Compensation Judge terminating the claimant's benefits will cut off the claimant's right to medical benefits. Consequently, if the goal of the employer or insurer is to stop a claimant's receipt of all medical benefits, utilization review should not be requested. The better course of action would be to secure an Affidavit of Recovery from an independent medical examiner and proceed with a Petition to Terminate Compensation Benefits.

Utilization review has been the subject of many recent appellate decisions. It is an effective tool when used properly. It can also be an expensive waste of time for the employer or insurer if review is requested in the wrong circumstance. Employers and insurers should make use of the process, but should make use of it wisely.

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[1] Section 306(f.1) of the Act, 77 P.S. §531(6)(i).

[2] Although this specific issue has not yet been addressed by the Workers' Compensation Appeal Board or an appellate court, at least one area Workers' Compensation Judge has stated that the URO's determination relates only to the specific provider whose treatment is at issue rather than to the treatment itself.

[3] 34 Pa.Code §127.404(b).

[4] See e.g., *Cruz v. WCAB (Philadelphia Club), 728 A.2d 413 (Pa.Cmwlth. 1999).*

[5] *Jackson v. WCAB (Boeing), 825 A.2d 766 (Pa.Cmwlth. 2003).*

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.

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