Pennsylvania Workers' Compensation Bulletin

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An Assault on the IRE

By Harry W. Rosensteel, Esquire

Act 57 was enacted by the Pennsylvania legislature to help reduce the cost of workers' compensation in the Commonwealth of Pennsylvania. Consistent with trends in many states across the country, Act 57 contained a provision at Section 306(a.2) which provided a method of evaluating a claimant's permanent partial disability, and limiting the benefits available for wage loss to 500 weeks. Clearly, the intention of the legislature was to limit benefits and thereby achieve the purpose of Act 57 to reduce the costs of workers' compensation in the Commonwealth of Pennsylvania. Section 306(a.2)(1) states:

> When an employee has received total disability compensation pursuant to clause (a) for a period of one hundred four weeks, unless otherwise agreed to, the employee shall be required to submit to a medical examination which shall be requested by the insurer within 60 days upon the expiration of the one hundred four weeks to determine the degree of impairment due to the compensable injury, if any. The degree of impairment shall be determined based upon an evaluation by a physician who is licensed in this Commonwealth, who is certified by an American Board of Medical Specialties approved Board or its osteopathic equivalent and who is active in clinical practice for at least twenty hours per week, chosen by agreement of the parties, or as designated by the department, pursuant to the most recent edition of the American Medical Association "Guides to the Evaluation of Permanent Impairment".

The assault on this section of the statute by claimant's bar and the courts began almost immediately. The first attack on this section of the Act began with the Supreme Court's decision in *Gardner v. WCAB (Genesis Health Ventures) and Walmart Stores, Inc. vs. WCAB (Ryder)*, 888 A.2d 758 (Pa. 2005). In that decision, the Commonwealth Court limited the availability of the automatic status change under Section 306(a.2) (from temporary total to permanent partial), even ignoring the Bureau's interpretation of the statute in the process. Keying on the word "shall" (as it related to employer's request for an impairment rating evaluation), the Court determined that the automatic change of status could only be achieved if the employer requested the IRE within that very brief 60-day window. The Court held that an employer's failure to do so did not entirely prevent the employer from requesting an impairment rating evaluation, but did result in the employer only being able to modify benefits down to partial benefits through the use of the "traditional administrative process." Nothing in the language of the statute itself created that duty. Hence, from the time *Gardner* was decided forward, if an employer failed to request an impairment rating evaluation within 60 days of the claimant's receipt of 104 weeks of benefits, it could no longer change the status of benefits by simply sending out a Notice of Change in Status, but rather, had to go through the expensive process of a modification petition before a Workers' Compensation Judge. Clearly, if the goal of Act 57 was to reduce the cost of workers' compensation in the Commonwealth of Pennsylvania, this interpretation did not help to achieve that purpose as the Court merely created a new layer of litigation and cost associated with changing the claimant's status.

Following *Gardner*, the Commonwealth Court took a second major step toward gutting the value of 306(a.2) in its decision last year in *Protz v. WCAB*. In this recent attack on the process, the Commonwealth Court has held that the use of the most recent edition of the AMA Guides to the evaluation of permanent impairment (as required under 306(a.2)) is unconstitutional. The Court held that the legislature could not

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Commonwealth Court Case Reviews

Geisinger Health System and Geisinger Clinic v. Bureau of Workers' Compensation Fee Review Hearing Office (SWIF), No. 1627 C.D, 2015, Filed April 21, 2016.

(Medical Bill Fee Review—"Provider's usual and customary charge" as set forth in 34 Pa. Code §127.128(c) has same meaning as "usual and customary charge" in other sections and does not mean provider's "actual charge.")

Claimant suffered a work related injury requiring treatment at a Level I trauma center for life threatening or urgent injuries. Provider then submitted HCFA-1500 claim forms to Insurer seeking payment for its physicians' treatment of claimant. Provider sought full payment for services rendered in a Level I trauma center at its usual and customary chargers, i.e., its actual charges, without reference to how other trauma centers in the geographic region reimbursed charges for similar treatment.

Insurer responded with an explanation of benefits (EOB) which recognized that Provider rendered inpatient services at a Level I or II trauma center to a patient with immediately life threatening or urgent injuries. Insurer's EOB also stated: "As such 'usual, customary and reasonable rates for this geographic area have been utilized as the reimbursement methodology."

Provider filed applications for fee review under §306(f.1) of the Workers' Compensation Act seeking reimbursement based on its actual charges. The Medical Fee Review Section determined that provider was to be reimbursed at 100% of the billed charges. Insurer filed a timely request for a hearing.

At the hearing, insurer submitted testimony of Linda Lengle, a repricing manager for Hoover Rehabilitation Services. Lengle testified that, to determine the appropriate amount of reimbursement, she uses a "usual and customary database." In trauma cases, rather than applying the workers' compensation fee schedule, she applies the usual and customary information at the 85th percentile of the MDR (market date retrieval) database, published by Ingenix.

The Hearing Officer found Lengle to be credible and reversed the Medical Fee Review Section's determination, notated that the Regulations define "actual charge" as: 'The provider's usual and customary charge for a specific treatment, accommodation, product or service," By comparison, "usual and customary charge" is defined as: "The charge most often made by providers of similar training, experience or licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided." As such, insurer's payment to provider should be based on "100% of the usual and customary charge" as defined in 34 Pa. Code §127.3 rather than 100% of provider's "actual charge."

Provider sought review by the Commonwealth Court arguing that, because the services were provided by a Level I trauma center, the Act provides that payment "shall be the usual and customary charge." Provider argued further that insurer is not permitted to reduce provider's usual and customary charge using any method, including a "usual and customary charge *database*." Moreover, §127.128(c) of the Regulations provides that: "the amount of payment *shall be at the provider's usual and customary charge* for the treatment and services rendered."

The Court did not agree. Section 109 of the Act provides:

> "Usual and customary charge" means the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.."

Nothing in the language of §306(f.1) of the Act indicates that "usual and customary charge" is other than how it is defined in §109 of the Act. A regulation, such as §127.128(c) , that is at variance with a statute is ineffective to change the statute's meaning. Accordingly, the Order of the Hearing Officer was affirmed.

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Commonwealth of Pennsylvania, Department of Labor and Industry, Uninsured Employers Guaranty Fund, v. Workers' Compensation Appeal Board (Kendrick and Timberline Tree & Landscaping, LLC). No. 1849 C.D. 2014, Filed May 9, 2016.

(Uninsured Employer Guaranty Fund—Medical Expenses—If claimant fails to notify Fund of claim within 45 days of learning employer is uninsured, wage loss and medical benefits are only payable as of date notice is provided to Fund.)

Claimant was injured on November 7, 2011 in the course and scope of his employment with Tmberline Tree & Landscaping. A Claim Petition was filed and, at a hearing held on December 21, 2011, it was determined that employer was not insured for workers' compensation purposes. As such, claimant filed a Notice of Claim against the Uninsured Employers Guaranty Fund and a Claim Petition against the Fund. The Fund agreed to pay the claim and the parties entered into a Stipulation which provided that claimant sustained a compensable injury, for which the Fund was liable, in the form of an orbital fracture as well as a traumatic brain injury with ongoing post-concussion symptomatology.

The parties could not reach an agreement as to when claimant's benefits were to commence. The Fund maintained that claimant was not entitled to compensation until Notice of the claim was provided to

the Fund on February 8, 2012. Claimant asserted that he was entitled to benefits retroactively to the date of injury, November 7, 2011.

The Workers' Compensation Judge reviewed §1603(b) of the Act, which provides:

> Time—An injured worker shall notify the fund **within 45 days** after the worker knew that the employer was uninsured. The department shall have adequate time to monitor the claim and shall determine the obligations of the employer. **No compensation shall be paid from the fund until notice is given** and the department determines that the employer failed to voluntarily accept and pay the claim or subsequently defaulted on payments of compensation. **No compensation shall be due until notice is given.**

Nevertheless, the WCJ, finding no controlling precedent foreclosing the retroactive payment of benefits by the Fund when notice was given outside the 45-day period, concluded that claimant was entitled to both medical and wage loss benefits as of the date of injury. The Fund appealed to the Workers' Compensation Appeal Board.

The WCAB concluded that, because claimant did not notify the Fund until 48 days after learning that employer was uninsured, the Fund did not owe claimant wage loss benefits prior to the date notice was given; however, the WCAB affirmed the WCJ insofar as the WCJ held that medical benefits were due as of the date of injury.

The Fund then sought review by the Commonwealth Court. The Fund argued that, given the Court's opinion in the case of Lozado v. WCAB (Dependable Concrete Work & Uninsured Employers Guaranty Fund), 123 A.3d 365 (Pa.Cmwlth. 2015), which interpreted §1603(b), claimants who do not meet the 45-day statutory deadline to provide notice of a claim to the Fund are prohibited from receiving both medical and indemnity benefits prior to notice being provided. The Fund argued that the Lozado decision is consistent with the plain language of the Act, such that the term "compensation" as defined in §1601 of the Act includes both disability and medical benefits.

In response, claimant argued that the Act provides for liberal payment of medical expenses. Citing to the Supreme Court's decision in Giant Eagle, Inc. v. WCAB (Givner), 39 A.3d 297 (Pa. 2012), claimant argued that the term "compensation," as used in a different section of the Act, differentiated between medical and wage loss benefits. Claimant also argued that the majority of an injured worker's medical expenses are typically incurred when a claimant is initially treated following his or her injury and that the Fund's interpretation would preclude payment of the majority of medical expenses. Because the purpose of Article XVI of the Act is to provide benefits to injured employees of uninsured employers and to provide payment to medical providers who care for the injured workers, the term "compensation" as used in §1603(b) must be construed as excluding medial benefits.

The Commonwealth Court noted that how the term "compensation" is defined is dependent upon where in the Act the term is used and how it is defined for purposes of the particular section. The provisions regarding the fund are set forth in Article XVI. "Compensation" is specifically defined in §1601 as "benefits paid pursuant to §§306 and 307" of the Act. Sections 306 and 307 of the Act provide for compensation for both wage loss benefits and medical benefits.

Accordingly, the Court interpreted §1603(b) of the Act as including both wage loss and medical benefits and, in accordance with Lozado, because the claimant did not give notice to the Fund within 45 days after he knew the employer was uninsured, he will only receive compensation for wage loss and medical benefits for any expenses incurred after notice was given to the Fund on February 8, 2012. The Order of the WCAB was reversed insofar as it required the Fund to pay for medical expenses incurred prior to February 8, 2012.

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rely on serial updates of the AMA Guides to the evaluation of permanent impairment as to do so was to impermissibly delegate its legislative authority to the AMA. While this author thinks that decision is ridiculous, by reaching this decision, the Court has effectively caused any number of otherwise valid IRE evaluations currently in process to be defunct. Once again, this decision has done nothing but increase the cost and amount of litigation under the Act, and is completely contrary to the purpose of Act 57. This author cannot fathom how the Commonwealth Court would expect the legislature to do anything but rely on trained medical professionals who put together the AMA Guides in order to evaluate percentages of disability. Clearly, the ability to look at physical conditions and evaluate them for permanent impairment is well beyond the scope and the ability of any legislative body. Reliance on the Guides across the United States is commonplace. The effect of *Protz*, of course, *at this time* is only to now require the use of the fourth edition. All evaluations that have been previously accomplished under the sixth edition (for which cases are still pending) will now be defunct unless the employer can go through the cost of having the evaluation updated under the fourth edition. It should be noted that the *Protz* decision is currently on appeal to the Supreme Court, and if the claimants get their way, not only will the use of the most recent edition be invalid, but also the entire process of using the AMA Guides will be unconstitutional. If that occurs, then Section 306(a.2) will be effectively eliminated.

Since the *Protz* decision, the Supreme Court levied yet another blow on Section 306(a.2) in its recent decision in *IA Construction Corporation and Liberty Mutual Insurance Company v. WCAB (Rhodes)*, No. 18 WPA

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2015 (decided May 25, 2016). In the *Rhodes* decision, Chief Justice Saylor writing for the Court *en* banc determined that a Workers' Compensation Judge is free to reject the testimony of a Bureau selected IRE physician on the basis of credibility even where that opinion as presented by the employer is uncontradicted by any medical evidence adduced by the claimant. In the *Rhodes* case, the employer obtained an IRE which rated the claimant at less than 50% whole body impaired. Because the evaluation was not requested within 60 days of claimant's receipt of 104 weeks of benefits, the employer was forced to use the "traditional administrative process" to modify the claimant's benefit status. The employer filed the petition and presented the testimony of the IRE physician selected by the Bureau. The Judge then rejected that testimony on three grounds (two of which were rejected by the Court). Most notably, the Judge rejected the IRE physician's expert testimony on the basis that the claimant had a closed head injury and the IRE physician was a physiatrist (as opposed to a neurologist or neuropsychologist). The Judge was unconvinced by the doctor's testimony essentially stating that the doctor had not done a complete enough evaluation (or was not qualified to do a complete evaluation) of the claimant's psychological/closed head injuries. The Supreme Court upheld the decision finding that it was a reasoned decision, and that the employer failed, therefore, to produce substantial evidence. The Court seemed to pay little attention to the employer's argument that selection of an IRE physician is made by the Bureau of Workers' Compensation, and is outside the control of the employer. While the Court noted that selection of the IRE physician was made by the Bureau, a claimant would have even less control over selection of the physician than the employer. With this decision, the Court has now made it possible for a claimant to produce no contrary medical evidence and still prevail and defeat the employer's attempt to modify benefits. The Court would apparently not even review the matter using the "capricious disregard" standard normally applied where only one party produces evidence.

Clearly, the courts have significantly reduced the effectiveness and value of Section 306(a.2) through this series of decisions. Perhaps it is time for the legislature to step in with additional detailed legislation to reverse this alarming trend coming out of the appellate courts.

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Send questions to: Harry W. Rosensteel, Esquire, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, PA 15219, hwr@trc-law.com.

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