TR&C

Pennsylvania Workers' Compensation Bulletin

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Dear Santa...

Dear Santa,

I was an *awfully* good employer this year. No layoffs. No cutbacks. No reduction of benefits. And, most importantly, NO WORK INJURIES!! Since I've been *so* good, can't you *PLEASE* reduce my workers' compensation costs?

This is one item found on almost every employer's wish list. Unfortunately, it it is not that simple.

While there may very well be a Santa Claus, he cannot change your responsibilities to your employees. With few exceptions, all Pennsylvania employers are required by law to insure their workers' compensation liability by purchasing a policy of insurance or by securing the approval of the Department of Labor and Industry to self-insure individually or as a group.

Santa Claus cannot reduce the costs associated with maintaining workers' compensation coverage. As an employer, *you*, on the other hand, can take some action to reduce your costs. For instance:

1. Develop a certified workplace safety program. A 5% annual policy premium discount is available to employers with a workplace safety committee that has been certified by the Bureau.

Inside This Issue...

2. Offer job openings to injured workers. Not only does the Act now require an employer to offer available jobs to its injured employees, doing so reduces or eliminates the need to pay wage loss benefits.

3. Have a list of designated medical providers. Given appropriate notice to employees, an employer may be able to limit the medical expenses for which it may be liable for the first 90 days of treatment by an injured employee. Or, if the employee fails to treat with a panel physician, an employer may be relieved of responsibility for any medical care received during the first 90 days. Remember, though, that an injured employee must be pro-

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Commonwealth Court Case Reviews

Michael Edwards v. Workers' Compensation Appeal Board (MPW Industrial Services, Inc.), No. 428 C.D. 2004, filed August 24, 2004.

(Modification/Suspension - Under Act 57, an employer need only establish a claimant's earning power; there is no need to show jobs were actually offered to claimant.)

Claimant suffered a work injury on March 25, 1998. As a result, he received total disability benefits at the rate of $190.20 per week based upon his average weekly wage of $211.33.

Employer subsequently sought to suspend claimant's benefits based upon a labor market survey, which revealed that claimant could earn between $230 to $280 per week.

Employer presented medical testimony to show that claimant was capable of working at a modified duty level, or at a heavy duty level provided no lifting over 50 pounds was required. Employer further presented testimony from its regional manager to establish that employer did not have work available to offer claimant for two reasons: 1) claimant had been fired for a violation of company policy, and 2) the only positions available required lifting of up to 80 pounds. Finally, employer presented testimony from a vocational expert who never met with claimant, but who nevertheless performed an earning power evaluation. Based upon the claimant's educational background, training, past employment and the IME report, appropriate jobs within the claimant's usual employment area were identified.

The Workers' Compensation Judge found all three of employer's witnesses to be credible,and rejected the testimony of claimant and his treating physician. Consequently, employer's petition was granted.

Claimant argued to the Commonwealth Court that the WCJ erred in granting the suspension because no jobs were actually offered to him as required by Kachinski v. WCAB (Vepco Construction Co.), 516 Pa. 240, 532 A.2d 374 (1987). The Court disagreed. Act 57 eliminated this requirement. Under the standard now applicable, an employer need only establish a claimant's earning power. Earning power may be proven by expert witness testimony as employer did in this case. Although the jobs upon which the earning power assessment is based must be available, "the Act contains no clear indication that a claimant actually receive an offer of employment in order to establish earning power."

Accordingly, the order of the WCJ was affirmed.

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Ronald Steinmetz v. Workers' Compensation Appeal Board (Cooper Power Systems), No. 875 C.D. 2004, filed September 16, 2004.

(Offset - When calculating offset for severance benefits, use the gross amount (before deduction of taxes) to determine the offset amount.)

Claimant sustained a work-related injury in February of 2000. He returned to work in a modified duty capacity until employer closed its doors on November 22, 2002. At that time, claimant was entitled to reinstatement of his total disability benefits. Claimant also received severance pay due to employer's closure totaling $9,750. From that amount, deductions were made for federal, state and local taxed such that claimant received a check in the amount of $6,001.12.

Employer, a self-insured corporation, began taking an offset for the severance pay in the amount of $375 per week against claimant's reinstated workers' compensation benefits.

Claimant filed a Review Petition, alleging the employer improperly took the offset based upon the gross amount of severance benefits he received as opposed to the net amount after withheld taxes.

The Workers' Compensation Judge denied claimant's petition relying upon the decision of the Commonwealth Court in Ferrero v. WCAB (CH&D Enterprises), 706 A.2d 1278 (Pa. Cmwlth. 1998) *(TR&C Workers' Compensation Bulletin, Vol. VI, No. 2, p. 3*). The Workers' Compensation Appeal Board affirmed.

Claimant then filed an appeal with the Commonwealth Court. The Court noted that Section 204(a) of the Act provides that: "The severance benefits paid by the employer directly liable for the payment of compensation...which are received by an employe shall also be credited against the amount of the award."

The Court further noted its prior decision in Ferrero. In that case, the Court held that, in the case of unemployment compensation benefits, the "amount so received" by the employee is the gross amount. Because no taxes are withheld from UC benefits, the claimant received the gross amount even though it was later taxed. The amount of tax would depend upon the employee's tax bracket, deductions and filing

status. Finally, the Court noted that the General Assembly did not specify an offset of the "net" amount of UC benefits, but rather provided for an offset of the "amounts so received."

The Court stated that the situation here involving the receipt of severance benefits is directly analogous to the situation in Ferrero. The severance benefit that claimant received was the gross amount. As with unemployment compensation benefits, §204(a) makes no provision for an offset of the net amount of severance benefits received, but rather provides only for an offset for the amount received by claimant, and he received the gross amount. Therefore, under the plain language of §204(a0 and Ferrero, employer correctly took an offset for the gross amount of severance benefits received by claimant.

The order of the WCAB was affirmed.

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DPW/Norristown State Hospital v. Workers' Compensation Appeal Board (Reichert), No. 978 C.D. 2004, filed September 28, 2004.

(Disfigurement Benefits - there are no binding written guidelines prescribing specific periods of compensation for each type of disfigurement; rather, the WCAB may rely upon its own experience in determining an acceptable range of benefits.)

(Jurisdiction - The Commonwealth Court does not have de novo jurisdiction in scar claim cases under the Workers' Compensation Act.)

On September 9, 2001, claimant was injured when attacked by a mentally incompetent adult patient. A Notice of Compensation Payable was consequently issued.

Thereafter, employer sought to terminate claimant's benefits effective January 31, 2002. In addition, claimant filed a claim petition alleging that she sustained facial disfigurement from the work injury.

The Workers' Compensation Judge observed the scar on claimant's face and described it as a "noticeable line 2 3/4 inches long, ...from the top of her ear to the bottom of her chin." The WCJ further noted the discoloration of the scar. He then granted claimant's petition and awarded 5 weeks of benefits. The WCJ also accepted employer's expert testimony and found that claimant had fully recovered from the work injury as of January 31, 2002.

Claimant appealed to the Workers' Compensation Appeal Board, which affirmed the grant of employer's termination petition, but modified the WCJ's award of disfigurement benefits from 5 weeks to 75 weeks.

Employer then petitioned for review by the Commonwealth Court, contending that the WCAB erred by increasing the WCJ's award of disfigurement benefits by 1400% without articulating the range of awards most WCJs would select for that type of disfigurement.

The Court noted that, after viewing claimant's scar, the WCAB accepted the WCJ's description and then stated that "[b]ased on the location, size and discoloration of claimant's work-related scar, we believe that most judges would award between 65 and 85 weeks of benefits." Therefore, the Court concluded that, contrary to employer's assertions, the WCAB stated adequate reasons for its modification of the WCJ's award.

Employer also filed a motion for an evidentiary hearing by the Commonwealth Court to view claimant's scar. The Court denied the motion, noting that the Court does not have de novo jurisdiction to view scars in workers' compensation cases, but rather is limited to an appellate review of whether findings of fact are supported by substantial evidence, whether an error of law was committed or whether constitutional rights were violated.

The decision of the WCAB was, therefore, affirmed.

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The Baby's Room v. Workers' Compensation Appeal Board (Ryan and Kathleen Stairs), No. 73 C.D. 2004, filed October 13, 2004.

(Course and Scope of Employment - A minor deviation from employment will not remove claimant from course and scope of employment.)

Claimant, a furniture delivery person, had finished delivering baby furniture to a customer's residence with his supervisor. While walking back to the delivery truck, claimant jumped up to touch a basketball rim that was on the driveway of the property, but his hand slipped off the rim, he fell backwards striking his head on the concrete pavement. As a result, he suffered a traumatic brain injury.

Employer denied claimant's Claim Petition, alleging that claimant had finished working for the day at the time of his injury.

At the hearing, claimant's supervisor testified that claimant's action in running and jumping up to the basketball rim was very sudden and without warning, but as his supervisor, he did not find it to be inconvenient or bothersome. He testified further that, had the claimant not hit his head, they would have returned the delivery truck to the warehouse and signed their timesheets before going home.

Relying upon the supervisor's testimony, the Workers' Compensation Judge concluded that claimant was in the course and scope of his employment at the time of injury. Employer appealed to the Workers' Compensation Appeal Board, which affirmed the WCJ's

decision. Employer then sought further review by the Commonwealth Court.

The Court noted that "neither small temporary departures form work to administer to personal comforts or convenience, nor inconsequential or innocent departures break the course of employment," citing U.S. Airways v. WCAB (Dixon), 764 A.2d 635 (Pa.Cmwlth. 2000). Each case is fact specific and will be determined by its particular facts. The term "course of employment" embraces intervals of leisure. "Leisure" is defined as "freedom or spare time provided by the cessation of activities" and "free time as a result of temporary exemption from work duties."

Because an interval of leisure would certainly include a short cessation from work duties, the Court found claimant's actions of running from the delivery truck and jumping up to touch the rim of a basketball hoop to be an inconsequential departure from delivering furniture for employer.

The order of the WCAB was, thus, affirmed.

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Lesco Restoration v. Workers' Compensation Appeal Board (Mitchell), No. 1152 C.D. 2004, filed October 15, 2004.

(Jurisdiction - Claimant who is receiving or has received benefits in another jurisdiction may also file a petition in Pennsylvania for the same period covered by the other jurisdiction's benefits and thus recover the more generous benefits available in Pennsylvania.)

Claimant was injured on January 21, 2000 and received workers' compensation benefits under New Jersey law until May 2002, at which time employer was no longer required to pay benefits given the New Jersey statute. Claimant then filed a petition in Pennsylvania, alleging the same injuries sustained in the January 21, 2000 work-related accident.

The Workers' Compensation Judge awarded claimant benefits under Pennsylvania law from the date of the work injury less a credit for the payments employer made under the New Jersey law.

The Workers' Compensation Appeal Board affirmed the WCJ's decision, concluding that §322 of the Act is intended to prevent two payments for the same injury, whereas in this case, the award provided the difference between the benefits claimant received under New Jersey law and the benefits to which he would have been entitled had he originally filed his claim in Pennsylvania at the outset.

Section 322 of the Act provides: "It shall be unlawful for any employe to receive compensation under this act if he is at the same time receiving workers' compensation under the laws of another state for the same injury."

Employer appealed the WCAB's decision, arguing that claimant is entitled to compensation under the Pennsylvania Act only from the date his New Jersey benefits terminated.

The Court disagreed. By waiting until after his New Jersey benefits were terminated, claimant was not "receiving" Pennsylvania benefits "at the same time" he was receiving New Jersey benefits.

The Court further noted that §305.2 of the Act relates to injuries occurring outside the territorial limits of Pennsylvania. It provides that payment of benefits under the law of another state does not bar a claim for benefits under the Pennsylvania Act "if the total amount of all income benefits paid or awarded the employe under such workmen's compensation law shall be credited against the total amount of income benefits which would have been due the employe under this act, had claimant been made solely under this act."

Consequently, the Court concluded that the purpose of §305.2(b)(2) is: "...to provide a claimant who is receiving or has received workers' compensation benefits from another jurisdiction with the right to file a petition under the Act for the same period covered by the other jurisdiction's benefits with the right to recover the more generous benefits available in Pennsylvania."

The Court noted that while §322 and §305.2 appear to conflict, they actually do not. Section 305.2 provides a claimant with the highest level of benefits possible. Section 322 dictates only that a claimant may not receive benefits from Pennsylvania at the same time he receives them from another state. Because §322 does not clearly foreclose a claimant's right to benefits under the Pennsylvania Act subsequent to the termination of another jurisdiction's award, even if for the same period of time covered by the other jurisdiction's benefits, the WCAB did not err in affirming the WCJ's decision.

The order of the WCAB was affirmed.

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Theodore Barszczewski v. Workers' Compensation Appeal Board (Pathmark Stores, Inc.), No. 680 C.D. 2004, filed October 18, 2004.

(Compromise and Release - Where a claim is settled by a C&R Agreement, claimant cannot later reopen the case or set

aside the C&R because the Average Weekly Wage was improperly calculated.)

Claimant suffered a work-related knee injury on May 14, 1999. On April 24, 2000, he filed a claim petition, which employer did not answer. A hearing was held on May 31, 2000. Employer did not appear at the hearing, nor was it represented by counsel. Consequently, the Workers' Compensation Judge issued a decision granting the claim, in which he found as fact that claimant had an average weekly wage of $616.00. Neither claimant nor employer appealed the decision.

Claimant subsequently filed a petition for penalties and a petition to reinstate, both of which were assigned to a WCJ before whom hearings were conducted.

On March 21, 2002, by agreement of the parties, the penalty and reinstatement petitions were amended to a petition to seek approval of a compromise and release agreement.

The agreement stated that claimant had an average weekly wage at the time of injury of $616.00 and that he would receive a lump sum payment, based on this average weekly wage, as a settlement for his compensation benefits. The WCJ adopted the agreement as the findings of fact and issued an order approving the agreement.

On July 18, 2002, claimant filed a petition to review alleging that his average weekly wage was actually $830.00, not $616.00.

The WCJ issued a decision noting that claimant had at least 4 opportunities to challenge the calculation of his average weekly wage and failed to avail himself of any of those opportunities. The WCJ concluded that the two prior unappealed decisions, both of which found as fact that the average weekly wage was $616.00, were *res judicata* and, as such, he dismissed the review petition.

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

On appeal to the Commonwealth Court claimant argued that the WCJ erred in applying the doctrine of res judicata and that he was entitled to have the compromise and release agreement set aside based upon a mutual mistake of fact with respect to his average weekly wage.

The Court disagreed, noting the public policy that encourages settlements and stresses finality. The Court did acknowledge that a compromise and release agreement may be set aside upon a clear showing of fraud, deception, duress or mutual mistake. Underestimating damages or entering into a settlement before damages are adequately assessed, however, is not a mutual mistake of fact.

The order of the WCAB was, therefore, affirmed.

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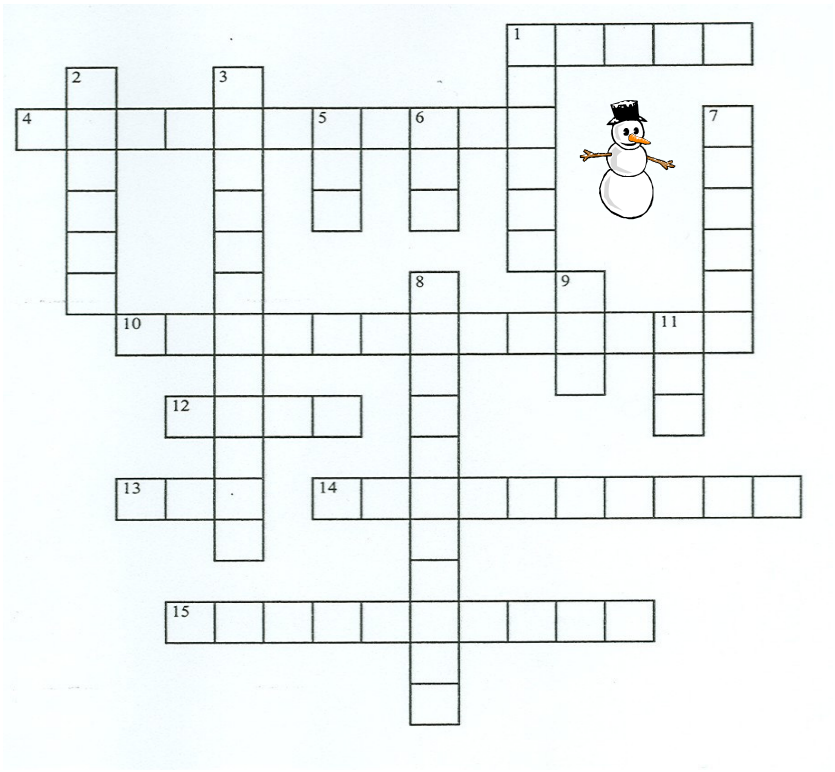
City of Philadelphia v. Workers' Compensation Appeal Board (Smith), No. 530 C.D. 2004, filed October 18, 2004.

(Reasoned Decision - WCJ's finding rejecting as incredible the testimony of employer's expert be-

WORKERS' COMPENSATION PUZZLE



ACROSS

1. Illegal collection of benefits
4. Right of recovery against third party
10. Specific loss benefit
12. Notice of Temporary Compensation Payable
13. Utilization Review Organization
14. No wage loss but medicals still open
15. Compromise and release agreement

(Solution on page 11)

DOWN

1. Subsidized employment
2. Agency responsible for WC claims
3. Wage loss and medical benefits
5. Average weekly wage
6. Impairment rating evaluation
7. Possible effect of receipt of pension benefits
8. Suspension of benefits during litigation
9. Independent medical evaluation
11. Acknowledgement of injury

cause he saw claimant on only one occasion does not meet standard of a reasoned decision.)
(Description of Injury - Absent a claim petition, a WCJ may not change the NCP to expand the definition of the injury to include condition that did not exist at time NCP was issued.)

On June 11, 1998, employer issued a Notice of Compensation Payable acknowledging that claimant suffered a "lower back strain." On October 12, 1998, employer filed a termination petition asserting that claimant had fully recovered as of September 9, 1998.

In support of its petition, employer presented testimony from Dr. Bonner, who had examined the claimant on July 7, 1998. Thereafter, he reviewed an EMG and an MRI. Dr. Bonner then opined that claimant suffered from degenerative joint disease which was not caused by the work injury and that claimant had a history of a lumbar strain that had resolved.

Employer also presented testimony from Dr. Levin, who saw claimant on September 17, 1998. Like Dr. Bonner, he reviewed the MRI and EMG studies. He too concluded that claimant was fully capable of returning to his pre-injury duties without restrictions.

In response, claimant presented testimony from Dr. Avart, who first saw the claimant on November 2, 1998. He also reviewed the same MRI reviewed by employer's experts, but found that it showed a small disc herniation at L5-S1. Dr. Avart agreed that the EMG was normal. It was Dr. Avart's " impression" that claimant had "post-traumatic lumbar radiculopathy and two herniated discs at L5-S1." He felt it unlikely that claimant would be able to go back to medium or heavy duty work in the future.

Claimant also presented testimony from Dr. O'Brien, who first saw claimant on November 18, 1999. He never reviewed any records or reports from claimant's other treating physicians. A discogram on claimant's L4-L5 was negative. Nevertheless, Dr. O'Brien performed surgery to treat claimant's subjective back pain. He opined that claimant would be capable, at most, of sedentary duty work.

The Workers' Compensation Judge issued a decision denying employer's petition. The WCJ further redefined claimant's injury to include post-traumatic lumbar radiculopathy and two herniated discs at L5-S1. Employer appealed to the Workers' Compensation Appeal Board and it affirmed. Employer then filed a petition for review with the Commonwealth Court.

The Court noted that, under the Supreme Court's decision in Daniels v. WCAB (Tristate Transport), 574 Pa. 61, 828 A.2d 1043 (2003), while the WCJ has exclusive authority to make credibility determinations, where the witnesses have testified by deposition, the WCJ must do more than simply announce one expert more credible and convincing than another.

Here, the Court found the WCJ's credibility findings failed to meet the Daniels standard. The WCJ discredited Dr. Levin because he only saw claimant one time. The WCJ dismissed Dr. Bonner's testimony because he admitted that a trauma could aggravate degenerative bone disease. The Court found this general "admission" that trauma may injure healthy bones did not contradict Dr. Bonner's opinion with respect to claimant's condition as of September 9, 1998.

The WCJ found Dr. Avert to be credible because he saw claimant on a number of occasions from November 1998 through March of 1999. The WCJ offered no reason for accepting the testimony of Dr. O'Brien.

The Commonwealth Court found two problems with the WCJ's decision:

1) The WCJ did not explain his reasons for assigning credibility to claimant's experts rather than employer's experts. Consequently, appellate review is impeded.

2) Even if the WCJ correctly found claimant's experts to be credible, their testimony does not relate to the issue raised in the termination petition, i.e., whether claimant had fully recovered from the back "strain" as of September 9, 1998. Claimant's experts testified about a medical condition not contained in the NCP, namely the herniated discs and lumbar radiculopathy. Because these conditions were not accepted on the NCP, the testimony of claimant's experts was irrelevant.

The Court went on to state that before claimant's herniated discs and lumbar radiculopathy could be found compensable, claimant had to file either 1) a review petition to amend the NCP because the conditions existed at the time of injury, or 2) a claim petition to establish that the conditions subsequently resulted from his original work injury. In the absence of either petition, the testimony of claimant's experts was irrelevant to the question as to whether claimant had recovered from the work injury.

A "low back strain" is not the same as "disc herniation and lumbar radiculopathy." They are separate and distinct conditions and, as such, a claim petition must be filed before benefits may be granted for these conditions.

The order of the WCAB affirming the WCJ's decision was vacated and the case remanded for further proceedings in accordance with the Court's opinion.

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Delilah Anderson v. Workers' Compensation Appeal Board (Washington Green Alternative), No. 502 C.D. 2004, filed October 25, 2004.

(Mental Injury - A claimant need only show a physical stimulus resulted in a mental disability for physical/mental standard to apply, unless the physical contact is a normal and expected part of job; if so, mental/mental standard will apply.)

Claimant worked as a residential program worker in a group home, taking care of 6 mentally and physically handicapped young adults. She filed a claim petition alleging two separate work injuries.

According to the petition, on August 28, 1995, claimant was required to subdue a combative individual. Thereafter, she felt that she could not breathe and thought she was having a heart attack. Her physician consequently prescribed Prozac and Ativan.

On September 8, 1995, while trying to subdue an aggressive individual, another individual began pulling at her hair and blouse. After this incident, claimant did not return to work.

In support of her petition, claimant presented testimony from her psychiatrist, who testified that claimant had a major depressive and anxiety disorder and that there was an obvious connection between her work and her symptoms.

Claimant testified that she did not expect to encounter combative patients when she was hired. She did acknowledge, however, that she had been provided with training in how to deal with combative patients during the first year of her employment.

Employer presented testimony of claimant's supervisor, who stated that claimant was informed that the patients might become aggressive. She further admitted however that, while mentally impaired patients can and will become combative, direct physical attack on the staff is not common.

The Workers' Compensation Judge found that claimant suffered a physical trauma which caused a psychological injury. As such, the WCJ applied the physical/mental standard, such that claimant did not need to prove abnormal working conditions. Accordingly, the petition was granted.

The Workers' Compensation Appeal Board found that neither incident described by claimant involved a physical disability or treatable injury and, as such, found that the mental/mental standard should have applied. The case was then remanded to the WCJ to make a factual finding as to whether claimant was exposed to abnormal working conditions.

The WCJ then found that claimant was, in fact, exposed to abnormal working conditions based upon the testimony of claimant's supervisor that direct physical attacks on staff members was not common. Again, the claim petition was granted.

On appeal, the WCAB again reversed the WCJ's decision, stating that while the incidents were rare, a direct attack on a staff member was foreseeable behavior given the individuals claimant supervised.

Claimant then sought review by the Commonwealth Court. The Court noted that, under the physical/mental standard, a claimant need not prove that he or she suffered a physical *disability* that caused a mental disability for which he or she may receive benefits, nor must a claimant show that the physical disability continues during the life of the psychic disability. Rather, a claimant need only show that a physical *stimulus* resulted in a mental disability.

However, there are certain exceptions to this rule. Where, as here, the physical stimulus is a normal and expected part of her job for which she was trained, the case will be analyzed under the mental/mental standard. As such, claimant was required to prove abnormal working conditions.

The Court agreed with the WCAB that, just because an event is not common does not necessarily mean that when the event occurs it is abnormal. Here, combativeness

EMPLOYER'S CORNER

Q. What is a "Return-to-Work" program and why should my company have one?

A. A formal Return-to-Work program is a process that has been adopted by many Pennsylvania employers to facilitate injured workers back to their pre-injury status. The process involves the cooperative efforts of workers, union representatives, employers and healthcare providers. All work together to help restore injured workers to their former lifestyle in the safest and most cost effective manner possible.

Return-to-Work programs can reduce the financial burden on employers and workers. In addition, by reducing the length of time an injured worker may be off work, such programs improve the individual worker's self-esteem, as well as the overall morale in the workplace. Finally, healthcare providers are able to develop more specialized treatment plans, thereby providing for the safe and early return of the injured worker to work.

The Pennsylvania Department of Labor & Industry has developed a web site designed to assist employers in establishing Return-to-Work programs. Samples of power point presentations, forms, letters and more are available. This information may be found at:

http://www.dli.state.pa.us/landi

Go to the "Workplace and Community Safety" Quick Link, and click on "Return-to-Work Programs."

from the mentally handicapped individuals was a situation with which employees were trained to deal precisely because such conduct is foreseeable and anticipated.

Therefore, even though the incident complained of by claimant may have been rare, it was not abnormal. Claimant's mental injury is thus not compensable under the Act.

The decision of the WCAB was affirmed.

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Garrett Hannigan v. Workers' Compensation Appeal Board (O'Brien Ultra Service Station), No. 2076 C.D. 2003, filed November 1, 2004.

(Subrogation - Employer is entitled to subrogate against uninsured motorist benefits received by claimant under third party's motor vehicle insurance policy.)

Claimant, who worked as a mechanic, sustained injuries when he was involved in a car accident while driving a customer's car. The other motorist was not insured. Thereafter, claimant received total disability benefits.

Claimant subsequently made a claim under the customer's motor vehicle insurance policy and received $275,000 in uninsured motorist benefits. Employer then filed a petition for modification, seeking to subrogate against that third party recovery.

The Workers' Compensation Judge concluded that, since employer had not paid for the motor vehicle insurance and the insurance was intended to protect the owner of the car rather than employer, employer was not entitled to subrogate against the recovery.

The Workers' Compensation Appeal Board reversed citing City of Meadville v. WCAB (Kightlinger), 810 A.2d 703 (Pa.Cmwlth. 2002), alloc. denied, 852 A.2d 313 (2004) *(TR&C Workers' Compensation Bulletin, Vol. VIII, No. 5, pp. 5-6).* In Meadville, the Court held that "where a third party's negligent conduct causes injury to an employee actually engaged in the business of his employer, there is a clear, justifiable right to subrogation under §319 of the Act."

The Commonwealth Court took note of the fact that "uninsured motorist coverage" is defined under the Motor Vehicle Financial Responsibility Law as "protection for persons who suffer injury arising out of the maintenance or use of a motor vehicle and are *legally entitled to recover damages therefor from owners or operators of uninsured motor vehicles...*" Thus, by definition, the recovery of uninsured motorist benefits is premised on the negligent conduct of a third party.

The language of §319, which provides that "the employer shall be subrogated to the right of the employe...against such third party" must be construed to include both direct recoveries from third party tortfeasors as well as recoveries paid on behalf of or for the liability of that third party.

Consequently, employer here is entitled to subrogate against the uninsured motorist benefits claimant received under the customer's motor vehicle insurance policy. Accordingly, the order of the WCAB was affirmed.

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J. G. Furniture Division/Burlington and Liberty Mutual Insurance Company v. Workers' Compensation Appeal Board (Kneller), No. 2320 C.D. 2003, filed November 8, 2004.

(Specific Loss Benefits - Where injury progressively worsens into a specific loss, the employer's carrier at the time the specific loss occurs is liable for benefits based upon the average weekly wage at that time, not the carrier liable for initial injury.)

Claimant suffered a work-related injury to his left index finger on January 21, 1976. Employer's insurer at the time was Liberty Mutual. On September 6, 1984, claimant's finger was amputated due to circulatory problems. Employer's insurer at that time was Federal Kemper Insurance Company.

Following extensive litigation, in October of 1997, employer and Liberty Mutual filed a petition alleging that claimant's left index finger injury resolved into a specific loss as of September 6, 1984, the date of the amputation, and that claimant was entitled to specific loss benefits based upon his 1976 average weekly wage (AWW). The Workers' Compensation Judge agreed and awarded benefits based on the claimant's 1976 AWW.

Claimant appealed to the Workers' Compensation Appeal Board, arguing that his benefits should be based upon his 1984 wages, the date his injury resolved into a specific loss. The WCAB agreed, and

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If you would be interested in scheduling such an event, please contact: Margaret M. Hock, Thomson, Rhodes & Cowie, P.C., 1010 Two Chatham Center, Pittsburgh, PA 15219, (412) 232-3400, mmh@trc-law.com.

remanded the case to the WCJ for a calculation of the appropriate benefit rate.

At hearings before the WCJ, Liberty Mutual attempted to join Kemper as a party, stating that if claimant's 1984 AWW applied, then Kemper is liable for the specific loss benefits. The WCJ refused to allow the joinder. Employer appealed to the WCAB, which agreed with employer and remanded the case to the WCJ so that Kemper could be joined and so that the WCJ could determine which insurer was liable.

On remand, the WCJ considered evidence from Kemper, but denied joinder of Kemper and again ordered Liberty Mutual to pay claimant's specific loss benefits based on his 1984 AWW. The WCAB affirmed that decision.

Liberty Mutual then sought review by the Commonwealth Court.

The Court noted that the Act defines wages as the employee's AWW at the time of the injury. Here, if claimant's specific loss occurred in 19765, the claimant's benefits would be based upon his AWW in 1976. If, however, the specific loss occurred in 1984, claimant's benefits must be based upon his AWW in 1984.

Here, claimant's finger was injured in 1976. Thereafter, he suffered a progressive diminution of the use of his finger due to circulatory problems. However, he did not lose the use of his finger completely for all intents and purposes until the amputation, which means that the specific loss did not occur until September 6, 1984. Therefore, the WCJ and the WCAB correctly determined that claimant is owed specific loss benefits based upon his 1984 AWW.

Liberty Mutual next argued that if claimant's specific loss occurred on September 6, 1984, then Kemper, employer's insurer in 1984, is responsible for the payment of the specific loss benefits. The Court agreed stating that, "once the date of a specific loss injury has been established, the carrier at risk on the date the specific loss occurred is the responsible carrier."

Consequently, the award of benefits based on claimant's 1984 AWW was affirmed, but the determination that Liberty Mutual was responsible for those benefits was reversed.

Judge Leadbetter filed a separate opinion. She believes that in all cases where an individual suffers a change in physical condition which naturally results from a work place trauma, that individual then has a new or renewed claim and, as such, the individual's AWW at the time the change occurs would apply.

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David Griffiths v. Workers' Compensation Appeal Board (Seven Stars Farm, Inc.), No. 1757 C.D. 2003, filed November 10, 2004.

(Orthopedic Appliance - Retrofitting of van for wheelchair accessibility, but not van itself, is an "orthopedic appliance" under the Act. Employer is responsible, however, for only 80% of the conversion cost.)

Claimant was rendered a quadriplegic as a result of his work injury. He subsequently purchased a van for $18,000. The van was retrofitted to make it wheelchair accessible for an additional $10,000, plus shipping and handling in the amount of $500. Prior to purchasing the van, claimant had rented wheelchair accessible vans at a cost of over $4,000.

Employer reimbursed claimant 80% of the cost of the conversion of the van and 80% of the van rental cost.

Claimant filed a petition seeking reimbursement of the entire purchase price of the van itself, plus reimbursement of the entire conversion cost and the full cost of the van rental.

The Workers' Compensation Judge granted claimant's petition and ordered employer to pay the full cost of the van, the retrofitting to make it wheelchair accessible, and the rental charges.

The Workers' Compensation Appeal Board affirmed in part and reversed in part. The WCAB noted that, under §306(f.1)(1)(ii), employer is responsible for "orthopedic appliances." The WCAB further noted that the van itself is not and orthopedic appliance and, therefore, employer is not required by the Act to pay for the van. The van rentals and conversion costs are, however, employer's responsibility. The WCAB agreed with the WCJ's interpretation of the Act that §306(f.1)(3)(i) does not apply. That section provides for the 80% limitation for products and services that are not calculated under the Medicare program. Consequently, the WCAB ordered employer to pay 100% of the conversion and rental costs, but did not order payment of the purchase price of the van.

Both parties sought review by the Commonwealth Court. Claimant argued that a specially equipped van constitutes an "orthopedic appliance" under the Act. The Court disagreed. The general use of a vehicle must be distinguished from the retrofitting of that vehicle. The modifications and additional "appliances," not the vehicle itself, are necessary to accommodate the claimant's work injury. Thus, the special retrofitting is an "orthopedic appliance" while the van itself is not.

Employer argued that the WCAB erred in requiring it to reimburse claimant for the total cost of retrofitting the van and for the total cost of the van rental. Under §306(f.1)(3)(i) of the Act, providers are limited from receiving more than 80% for products and services

that are not calculated under the Medicare program. Retrofitting the van and the van rental qualify as "treatment, accommodation, product or service" subject to the cost containment provisions of the Act. Consequently, employer's obligation is capped at 80% of the cost to retrofit the van and for the van rental.

The WCAB's order was affirmed insofar as it reversed the WCJ's determination that employer was required to pay for the van. The WCAB's order was reversed to the extent that it ordered employer to pay the total cost to retrofit the van and the van rental.

Judge Friedman filed a dissenting opinion. She would hold employer responsible for payment of the entire purchase price of the van as well as the retrofit cost and cost of van rental. Without a van, claimant is not able to obtain medical treatment or to enjoy any activity outside the home. As such, she deems the van itself, together with the modifications, to be an orthopedic appliance within the meaning of the Act. Furthermore, because the retrofitting of the van and the van rentals were not provided by a health care provider, she feels the cost containment regulations should not apply and would hold employer responsible for 100% of all costs.

SUPREME COURT CASE REVIEWS

Patricia Gallie v. Workers' Compensation Appeal Board (Fichtel & Sachs Industries), No. 278 MAP 2003, decided October 25, 2004.
(Utilization Review - Limitation of Actions - The 30-day time period to request review of a URO's determination begins to run upon receipt of the URO's findings by the provider, employer, employee or insurer, not by the Department.)

Claimant suffered a work-related back injury, for which she sought treatment from Dr. Primavera, a chiropractor. Thereafter, employer filed a Utilization Review Request, questioning the reasonableness and necessity of the chiropractic adjustments, ultrasound and massage therapy.

The Department assigned the matter to a URO by notice dated March 20, 2001. Thereafter, the URO reviewer issued its determination in a report mailed to all parties on May 18, 2001. The URO concluded that while the chiropractic adjustments were reasonable and necessary, ultrasound therapy and full body massage were not.

Claimant sought to challenge the URO's determination by filing a petition for review of the URO report. Employer objected to the petition for review on the basis that it was untimely filed. Specifically, employer argued that claimant

I'm sorry Dr. Rudolph, but I'm going to have to send this one out for "deer review!"

Happy Holidays!!!

failed to file her petition within 30 days of her receipt of the URO report as required by §306(f.1)(6)(iv) of the Act.

That section states: "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."

Claimant conceded that she received the URO report by regular mail on May 21, 2001. She stated that she "held onto" the report until her next appointment with Dr. Primavera so they could discuss it. Claimant testified that, at that point, she learned that it was her responsibility to challenge the URO report. Accordingly, she drafted a petition for review and mailed it at the post office. The envelope in which it was mailed was postmarked June 22, 2001.

The Workers' Compensation Judge found as fact that the Department received its copy of the URO report on May 24, 2001, three days after claimant. The WCJ further found that §306(f.1)(6)(iv) is ambiguous as to the commencement of the 30 days within which claimant had to file her review petition. Because the Department received the URO on May 24, 2001, or less than 30 days before claimant filed her petition for review, the WCJ concluded that claimant's petition was timely. The WCJ then found that claimant's ongoing ultrasound therapy and full body massage were reasonable and necessary.

Employer filed an appeal with the Workers' Compensation Appeal Board. The WCAB vacated the WCJ's decision and dismissed claimant's petition as untimely, reasoning that §306(f.1)(6)(iv) refers only to the "provider, employer, employe or insurer," and makes no reference to the Department. Therefore, there is no basis for the WCJ's conclusion that when the claimant and the Department receive a utilization review determination on different dates, the date of the latest receipt controls.

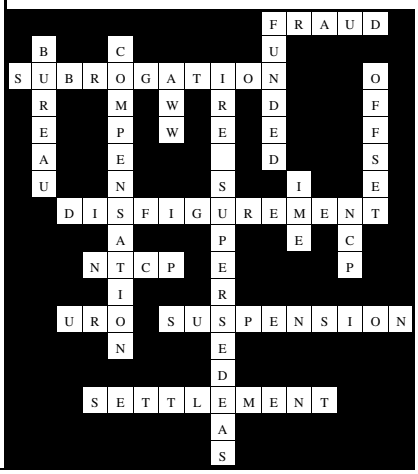
Claimant then sought review by the Commonwealth Court, which agreed with the WCJ. The Court held that §306(f.1)(6)(iv) is ambiguous because it does not specify whose receipt of the URO report triggers the start of the 30-day time period within which a petition must be filed. *(See TR&C Workers' Compensation Bulletin, Vol. VIII, No. 10, pp. 2-3)* Consequently, the Court held that the 30-day period begins to run from the date the claimant *or* the Department receives notice, whichever is later.

The Supreme Court disagreed, stating that the language of §306(f.1)(6)(iv) plainly and unambiguously specifies that the 30-day period set forth therein begins to run on the date of receipt by either "the provider, employer, employee or insurer," depending upon which of these parties files a petition for review.

Further, the Court noted that the Department has no mechanism to inform the public of the date it receives findings from a URO. Under the Commonwealth Court's interpretation, that date would be crucial to any provider, employer, employee or insurer that desired to file a timely petition for review. To meet this need, the Department would have to develop a publicly accessible docketing system for URO reports. Such was never the intent of the Legislature.

Given the plain language and clear meaning of ¨306(f.1)(6)(iv) of the Act, the order of the Commonwealth Court was reversed.

SOLUTION to Puzzle on Page 5



(Continued from page 1)

vided with notice of the need to treat with a panel physician both at the time of hire and as soon as possible after sustaining any injury. He or she should be asked to sign a written acknowledgement of that notice on both occasions.

4. Strive for an injury-free workplace. Premium discounts may be available to employers who have not had a compensable lost-time injury during the preceding 2 years.

5. Apply for exclusion of certain executive officers. Executive officers who have ownership interest in a subchapter S corporation (at least 5% ownership interest) or at least a 5% ownership interest in a subchapter C corporation, or who serve voluntarily in a non-profit corporation, may apply for exclusion from coverage. Application for exclusion must be made with the carrier or, if self-insured, with the Bureau.

6. Report suspected workers' compensation fraud. Fraud contributes to the cost of doing business for *all* employers, not just the immediate victim of the fraudulent activity. Fraud committed by employers or medical providers should be reported to the PA Insurance Fraud Prevention Authority at 1-888-565-IFPA. Individuals who are fraudulently collecting workers' compensation benefits should be reported by sending written correspondence to the Compliance Section of the Bureau of Workers' Compensation.

Make a New Year's resolution to follow through on at least one of the above suggestions over the next twelve months. If you do, maybe next year you'll be able to strike one item from your list before sending it off to Santa Claus.

For more information regarding any of these suggestions or any other cost cutting measures, please contact us at: wc@trc-law.com

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.