THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
APRIL 2013 AT A GLANCE
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CREDIT/ NOTICE OF SUSPENSION/ RETIREMENT/WAIVER/ PETITION TO REVIEW/LITIGATION COSTS

- A WCJ has the authority to suspend a claimant's benefits in the absence of a formal petition where doing so would not prejudice the claimant. A claimant is not prejudiced where she is put on notice that a suspension or termination is possible and she is given the opportunity to defend against it.

  The Claimant was placed on notice that her retirement would be an alleged issue subject to a suspension, though a formal Petition for Suspension was not filed where, the WCJ's interlocutory order also granted Employer a credit against Claimant's weekly indemnity benefits for the Social Security old age benefits and retirement pension benefits, which put Claimant and her attorney on notice that her application for and receipt of Social Security old age benefits and retirement pension benefits would be at issue in the ensuing WCJ's proceeding.

  Moreover, the parties fully litigated the issue of whether Claimant voluntary retired from the workforce.

- An employer need not prove the availability of suitable work when the employer establishes, under the totality of the circumstances, that the claimant has voluntarily retired from the workforce. The mere possibility that a retired worker may, upon some future time, seek employment does not transform a voluntary retirement from the labor market into a continuing compensable disability.

- A claimant must have the opportunity to contest the amount of a credit claimed by her employer and to have a hearing where there is a disagreement on the amount. Although the Board's regulation, at 34 Pa. Code §123.4, allows the employer to take the credit unilaterally it requires that notice be given to the claimant so that she can challenge the amount and basis for the credit.

  Where the Employer took an offset pursuant to the WCJ's decision, and not unilaterally, it was not required to provide Claimant with prior notice of that offset.

- The WCJ was required to reduce the Claimant's award by the amount of her unemployment compensation benefits regardless of whether the employer had requested the offset because the mandate of Section 204(a) cannot be waived by an employer.

- Where no reasonable nexus or obvious relationship exists between the injury described in an NCP and a subsequently claimed physical condition, the claimant must still bear the burden of establishing the work-relatedness of a condition before an employer will bear the burden of disproving any continuing disability related to that subsequently alleged condition.

- An employer may automatically suspend benefits when a claimant fails to return the completed LIBC-760, and where a party alleges non-receipt of a notice, that party bears the burden of proof.

  Any notice or copy shall be deemed served on the date when mailed, properly stamped and addressed, and shall be presumed to have reached the party to be served; but any party may show by competent evidence that any notice or copy was not received. Claimant could only rebut the presumption that she received the notice by introducing competent evidence demonstrating otherwise.

- Costs for a nurse to attend an IME are not recoverable as "witness" costs. While costs incurred in obtaining testimony from a witness are recoverable, "there is no authority for awarding as costs time spent by a witness observing and preparing to testify to facts."

- It is well established that an issue is waived unless it is preserved at every stage of the proceeding. The strict doctrine of waiver applies to a workers' compensation proceeding. Because the issue of whether the costs were reimbursable for the nurse to attend the IME was not raised by Employer before the WCJ, it is deemed waived.

Fitchett v. WCAB (School District of Philadelphia), No. 1713 C.D. 2011 (Decision by Judge Simpson, April 8, 2013) 4/13

EVIDENCE/ DRUG TEST/SUSPENSION/NOTICE OF ABILITY TO RETURN TO WORK/APPEAL

- The issuance of a Notice of Ability to Return to Work (LIBC-757) was not required where claimant, notwithstanding the occurrence of a work injury, was terminated due to failure of a drug test.

  This is because Section 306(b)(3) of the Act is limited to modifications based on medical evidence received by the employer. Compliance with Section 306(b)(3) - Issuance of LIBC-757-is a threshold burden an employer must satisfy to obtain a

modification or suspension of a claimant's benefits. However, Section 306(b)(3) is expressly limited to modifications sought upon the receipt of medical evidence.

- The WCJ did not err in suspending the Claimant's compensation where Claimant's loss of earnings resulted from his discharge for cause resulting from his violation of Employer's substance abuse policy. This is because if the Claimant's loss of earnings is the result of the work injury, he is entitled to disability benefits; if not, benefits must be suspended.

- A violation of an employer's substance abuse policy constitutes cause for a discharge.

- Substantial evidence supported the finding that the Claimant failed Employer's drug test, though the drug test was not entered into evidence, where the WCJ credited employers testimony: 1) that Claimant told her that his drug test would be positive while they were driving to the emergency room on the day of the accident; 2) testified that Employer's medical facility sent her a report that Claimant's drug test had been positive; and 3) Claimant testified that he had used drugs "three days . . . before the accident" and that he "wouldn't dispute that the drug test was positive.

- Failure to raise an issue before the Board results in waiver of the issue upon Commonwealth Courts review.

Brewer V. WCAB ((E2 Payroll & Staffing Solutions), No. 337 C.D. 2012 (Decision by Judge Leavitt, February 13, 2013) 4/13

MEDICAL BILL/ FEE REVIEW

- Pursuant to the clear language of the Regulations before downcoding, an Insurer must comply with the requirements of 34 Pa. Code §127.207. Otherwise, pursuant to subsection (d) of this Regulation, the Fee Review will be decided in favor of the provider.

- The Regulation 127.207, which was in question, provides in pertinent part:

> (a) Changes to a provider's codes by an insurer may be made if the following conditions are met:
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> (1) The provider has been notified in writing of the proposed changes and the reasons in support of the changes.
>
> (2) The provider has been given an opportunity to discuss the proposed changes and support the original coding decisions.
>
> (3) The insurer has sufficient information to make the changes.
>
> (4) The changes are consistent with Medicare guidelines, the act and this subchapter.

(d) *If an insurer changes a provider's codes without strict compliance with subsections (a)-(c), the Bureau will resolve an application for fee review filed under §127.252* (relating to application for fee review—filing and service) in favor of the provider under §127.254 (relating to downcoding disputes).

Therefore, the Hearing Officer erroneously dismissed sixty-one consolidated fee Review Applications filed by Providers with the Bureau's Fee Review Hearing Office based upon its rational that the two decisions of another hearing officer had collateral estoppel effect with regard to Providers' Fee Review Applications where the same treatment and downcoding were at issue. This is because it was improper for the hearing officer to consider the application of the doctrine of collateral estoppel before considering first whether Insurer complied with the requirements of Section 127.207.

If a Hearing Officer concludes that Insurer did comply with 34 Pa. Code §127.207, the hearing officer then may consider whether collateral estoppel precludes consideration of the merits of a Providers' challenge to the downcoding at issue.

Brian Walsh, D.O., et al.(c/o East Coast TMR et. al) v. Bureau of Workers' Compensation :Fee Review Hearing Office :(Traveler's Insurance Co.), No. 851 C.D. 2012 (Decision by Judge Brobson, April 22, 2013.) 4/13