THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
APRIL 2018 AT A GLANCE

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SUBROGATION/ HEART AND LUNG ACT/ MOTOR VEHICLE FINANCIAL RESPONSIBILITY LAW

- The employer, who was the self-inured Commonwealth of Pennsylvania, was not entitled to subrogation for the period in which Claimant was eligible for both Heart and Lung and WC benefits since the injury resulted ***from a motor vehicle accident.***

  Although the Heart and Lung Act does not contain a subrogation provision such as Section 319 it has been interpreted as providing employers with subrogation rights. However, if the compensable injury is the result of a motor vehicle accident, the Motor Vehicle Financial Responsibility Law (MVFRL) is implicated and its effect on an employer's subrogation rights must be considered. The MVFRL has been interpreted to exclude Heart and Lung benefits from Subrogation.

- The Employer would be entitled to subrogation from the date the receipt of Heart and Lung benefits ended he began receiving workers' compensation benefits and into the future

- The employer, who was the self-inured Commonwealth of Pennsylvania, was also not entitled to subrogation against the medical bills paid during the period the claimant was receiving Heart and Lung benefits. This is because the Heart and Lung Act provides payment of both wage loss and medical benefits and Act 44 makes no distinction between wage loss or medical benefits – thus neither were subject to subrogation.
  The Employer would be entitled to subrogation from the date he began receiving workers' compensation benefits and into the future

- Certain public employees who are injured performing their work duties and are temporarily unable to perform those duties are entitled, due to their positions with a public employer, to the payment of their full salaries as a result of their "serving the public in essential, high-risk professions."

  In these circumstances, both WC and Heart and Lung benefits are paid concurrently, but any WC payments the employee receives are required to be turned over to the public employer. Self-insured employers may issue an NCP to acknowledge the work injury but

the unilateral issuance of an NCP by an employer does not transform Heart and Lung benefits into WC; they are separate

Commonwealth of Pennsylvania v. WCAB (Piree), No. 995 C.D. 2017 (Decision by Judge Cohn, April 4, 2018) 4/18

MEDICAL BILLS/ FEE REVIEW

- Section 127.105 of the Medical Cost Containment Regulations governs payments to chiropractors and provides:

  (e) Payment shall be made for an office visit provided on the same day as another procedure ***only when the office visit represents a significant and separately identifiable service performed in addition to the other procedure.*** *The office visit shall be billed under the proper level HCPCS [Medicare coding system] codes 99201--99215, and shall require the use of the procedure code modifier "-25" (indicating a Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure).*

  This means that a Provider, who in this matter was a chiropractor, was only entitled to payment for office visits if the office visit examinations constituted "***a significant and separately identifiable service***" beyond the other procedures that he performed on those dates.

  An examination involving no new medical condition, change in medical condition, or other circumstances that require an examination and assessment above and beyond the usual examination and evaluation for the treatment performed on the same date does not constitute "a significant and separately identifiable service" for which a chiropractor may be paid under Section 127.105(e).

  The language permitting payment for office visits "only when the office visit represents a significant and separately identifiable service performed in addition to the other procedure," 34 Pa. Code § 127.105(e) shows a clear intent to make payment for same-day examinations the exception, not the rule.

- While the question of what constitutes "a significant and separately identifiable service" is an issue of law, whether Provider is entitled to payment for the office visits also involves issues of fact concerning the examinations, Claimant's medical condition, and Provider's treatments. Such factual determinations are for the fee review hearing officer to make as the finder of fact, and are not the province of the Commonwealth Court.

Accordingly, this matter was remanded back to the Bureau of Workers' Compensation Fee Review Hearing Office for a determination as to whether the examinations for which Provider sought payment of office visit charges were conducted because of a new medical condition, change in medical condition, or other special circumstances that required an examination and assessment above and beyond the usual examination and evaluation for the treatment that Provider performed on those dates.

Sedgwick Claims Management v. Bureau of Workers' Compensation, Fee Review Hearing Office (Piszel and Bucks County Pain Center), No. 1033 C.D. 2017 (Decision by Judge Colins, April 11, 2018) 4/18

OCCUPATIONAL DISEASE/ STATUTE OF LIMITATIONS/ STATUTE OF REPOSE

- Section 301(c) (2), which pre-existed and was essentially unchanged by the passage of Act 46, requires some significant, objective manifestation of the occupational disease within 300 weeks of the last date of exposure at work for claim to proceed.

  If there is a claim for disability or death the disability or death must occur within the 300-weeks after the last date of employment in an occupation or industry to which he was exposed to hazards of such disease.

  Although the statutory language of 301(c)(2) does not explicitly address medical benefits this status would apply to a medical only claim where the illness requiring the treatment occurred within 300 weeks of the last date of exposure at work.

  Therefore the claimant's right to proceed was not extinguished by the 300 week statute of repose in Section 301(c) (2) where his cancer was diagnosed, and he underwent significant surgery and follow-up treatment within the 300-week period and he incurred some medical bills within the 300-week period.

- Where Claimant's bladder cancer occurred within 300 weeks of his last exposure to a work hazard in December 2003, he was entitled to medical benefits, regardless of any disability, if he could prove he sustained an occupational disease under the catchall provision in Section 108(n) of the Act.

- Where Claimant alleged he sustained an occupational disease under Section 108(n) within 300 weeks of his last exposure to the hazards of the disease, and where he filed his Claim Petition within 600 weeks (11.5 years) of his alleged last direct exposure to carcinogens in December 2003, Claimant was entitled also assert a firefighter's cancer claim for medical benefits under Sections 108(r) and 301(f) of the Act.

  It will be recalled that Act 46 created a new time limitation which applies only to firefighter cancer claims. Instead of the 300 weeks that applies to all other occupational diseases, a claim filed under new Section 108(r (defining cancer suffered by a

firefighter), may be made within 600 weeks after the last date of exposure to the hazards of the disease.

However, because Claimant failed to file a claim petition within the first 300 weeks after his last date of exposure to the hazards of the disease, he was not entitled to the presumption of compensability in Section 301(f) of the Act.

This holding was consistent with the courts prior holding in Fargo v. Workers' Compensation Appeal Board (City of Philadelphia), 148 A.3d 514, 520 (Pa. Cmwlth.), appeal denied, 168 A.3d 514 (Pa. 2016) that held:

> *Section 301(f) sets forth a two-tiered limitations period for Section 108(r) claims distinct from the time limit in Section 301(c)(2). First, a claimant must file the claim within 300 weeks of the last date of work with exposure to a known Group 1 carcinogen; if the claimant fails to do so, he is not foreclosed from bringing a claim by Section 301(f), but he loses the presumptions of Section 301(e) [7] and 301(f). However, if the claimant does not file the claim until more than 600 weeks of last exposure, the claimant is foreclosed from bringing that claim in its entirety.*

- Where claimant filed his Claim Petition more than 3 years following his last date of exposure but within 600 weeks after the last date of exposure to the hazards of the disease he still had to show that his Claim Petition was timely consistent with the 3 year statute of limitations set forth by Section 315 of the Act.

  Section 315 contains a discovery rule that applies to occupational diseases and this rule provides that the three-year period in which an employee must file a claim petition under section 315 commences at the time the employee knows through pertinent medical diagnosis that he was totally disabled and that it is the result of a work-related disease.

  In the matter the claimant claimed it was not until March 2013 that he first learned from a doctor that his bladder cancer was causally related to his fire service exposures and therefore this matter was remanded for a determination whether his medical-only claim petition was timely since it was filed in March 2013.

- The discovery rule of Section 315 applied to the 3 year statute of limitations in occupational disease cases but does not apply to the 300 week statute of repose.

Caffey v. WCAB (City of Philadelphia), No 1268 C.D. 2017 (Decision by Judge Simpson, April 12, 2018) 4/18