THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
DECEMBER 2012 AT A GLANCE
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PSYCHIATRIC CLAIM

- The WCJ did not commit an error of law upon applying the "physical-mental" analysis to the claimant's claim where the triggering event was physical in nature and the claimant subsequently developed Post Traumatic Stress Disorder, although he did not suffer a physical disability caused by the triggering event.

- To substantiate a physical/mental injury claim, the psychological injury must be the result of a triggering physical event and the injury must arise in the course of employment.

  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 injury continues during the life of the psychic disability. Rather, a claimant need only show that a physical stimulus resulted in a mental disability.

  Moreover, a claimant alleging a psychological injury stemming from a physical injury is not required to show abnormal working conditions.

  In this matter, Claimant suffered a significant physical stimulus in the form of the head-on collision causing the death of the other driver before Claimant's eyes, and disabling his loaded tractor-trailer causing it to descend an embankment. Claimant's intimate involvement in the fatal accident is sufficient to constitute a "physical stimulus" to support a compensation award.

- Psychological injuries fall into three categories:

  (1) Mental/Physical—where a psychological stimulus cause's physical injury- Where Psychological stimulus causes a purely physical injury proof of abnormal working conditions is not required.

  (2) Physical/Mental—where a physical stimulus causes a psychic injury the claimant alleging a psychological injury stemming from a physical injury is not required to show abnormal working conditions. A claimant is not required to prove he/she suffered a physical disability that caused a mental disability for which he or she may receive benefits

(3) Mental/Mental—where a psychological stimulus causes a psychic injury the claimant must establish by objective evidence that he suffered a psychological injury and that the injury was more than a subjective reaction to normal working conditions. Even if a claimant adequately identifies actual (not merely perceived or imagined) employment events which have precipitated psychiatric injury, the claimant must still prove the events to be abnormal before he can recover

These categories require different standards of proof, the last being the most rigorous, requiring proof of abnormal working conditions.

New Enterprise Stone & Lime Co., Inc., and PMA Management V. WCAB (Kalmanowicz), No. 1492 C.D. 2012 (Decision by Judge Covey, December 6, 2012) 12/12

INTEREST/ LOSS OF USE

- Although the filing of the petition constituted notice to Employer that Claimant was seeking loss of use benefits, it did not establish Claimant's right to compensation. Therefore, only when Claimant had evidence that he had a permanent, loss of use of left arm and legs was compensation due and resulting interest due.
- The statutory interest on the unpaid specific loss benefits began to accrue on the dates claimant's medical expert testified that all of Claimant's work-related injuries had resolved into specific losses of her left arm and legs . Until that time, payment of the specific loss benefits was not due and payable.

- A claimant is permitted to receive specific loss benefits for the work injury for which he or she is receiving total disability benefits only when total disability has revolved into a specific loss. Consequently, specific loss benefit payment may not begin until after payment of total disability payments ends. Section 306(d) of the Act

- Court notes in dicta that interest on a claimant's disfigurement benefits began to accrue on the date that the WCJ viewed the claimant's scars for the second time at the hearing.

Jacqueline Fields v. WCAB (City of Philadelphia), No. 1432 C.D. 2011(By Judge Leadbetter, April 30, 2012) 12/12

AVERAGE WEEKLY WAGE

- The WCJ did not commit an error of law by applying Section 309(d) to the claimant's wage calculation rather than to Section 309(d) where the Claimant, who suffered a compensable injury on September 12, 2006, admitted that he had an ongoing employment relationship with Employer for five years prior to the

work incident and although he had worked for a different employer between December 2005 and March 2006, the WCJ found employer's testimony credible he was unaware that Claimant had ever severed ties with Employer and the Claimant did not provide any evidence that he had been terminated and reapplied for employment with employer as a new hire.

- Section 309(d) and subsections (d.1) and (d.2) address work/employment histories – *i.e.,* employees who have been employed for at least four consecutive periods of thirteen calendar weeks.

  Subsections (d.1) and (d.2) address progressively shorter employment relationships: (d.1) governs employees employed for at least one, but less than three consecutive periods of thirteen calendar weeks; while (d.2) addresses cases of recent hires, i.e., employees who worked less than a single complete period of thirteen calendar weeks at the time they suffered a work injury.

  The structure of the statute strongly indicates that subsection (d.2) was not intended to apply to employees, such as Claimant here, with long-term employment relationship with their employer, who happens to have been subject to layoffs. Both (d) and (d.1) include look-back periods encompassing the preceding fifty-two weeks, in search of "completed" thirteen-week periods; in contrast, subsection (d.2) has no such long-term focus, and indeed, it provides for a prospective calculation of potential earnings.

  By its terms, (d.2) contemplates persons for whom there is little work history with the employer upon which to calculate the AWW. Viewing the interrelationship of these subsections, and it is unlikely that the General Assembly intended (d.2) to supplant (d) or (d.1) anytime a long-term employment relationship happens to involve periods with a "work" cessation. Instead, subsection (d.2) was intended for instances that it plainly covers; i.e., those instances of work injuries to recently-hired employees for whom there was, by definition, no accurate measure of AWW other than taking the existing hourly wage and projecting forward on the basis of the hours of work expected under the employment agreement.

Robert Janson v. WCAB (EM Force, Inc.), No. 2257 C.D. 2011 (Decision by Judge Pellegrini) 12/12

COURSE AND SCOPE

- The court has analyzed course of employment cases in two ways, depending on whether the claimant is a traveling employee or a stationary employee.

  Factors relevant to the determination of whether an employee is a traveling or stationary employee include: whether the claimant's job duties involve travel,

whether the claimant works on the employer's premises or whether the claimant has no fixed place of work.

Each case is determined on a case-by-case basis

The WCJ did not commit an error of law by finding the claimant was a stationary employee where the claimant testified that traveled to visit customers but also testified that he had an office at Employer's place of business, and that he was a supervisor who was required to spend time in the office on a regular basis as part of his job duties. The JWCJ's decision was also supported by his finding that the employee testified credibly that Claimant did not travel every day to service accounts because Claimant's job duties included working in the office to place orders, contact customers by telephone, and prepare equipment. Therefore, Claimant had a fixed place of employment and he was primarily required to work on Employer's premises.

- Whether an employee is acting within the course and scope of his employment at the time of his injury or death is a question of law and is reviewable de novo

- The general rule is that an employer is not liable to the employee for compensation for injuries received off the employer's premises while the employee is traveling to or from work. Generally, the "going and coming rule" holds that an injury or death sustained by an employee traveling to or from a place of employment does not occur in the course of employment; thus, it is not compensable under the Act.

- However, such an injury or death will be considered to have been sustained in the course of employment and thus is compensable under the Act if one of the following exceptions applies:

    1) Claimant's employment contract includes transportation to and from work;
    2) Claimant has no fixed place of work;
    3) Claimant is on a special mission for employer; or
    4) Special circumstances are such that claimant was furthering the business of the employer.

With respect to whether an employee's contract did, in fact, provide transportation to and from work, a reviewing court must look at the totality of the circumstances.

Claimant bears the burden of proving that one of the foregoing exceptions to the "going and coming" rule applies.

The fact that claimant was driving a company vehicle did not mean that his contract of employment included transportation to and from work where the plain language of a Use of Company Vehicle" memorandum provided to the claimant

showed that Claimant's travel to and from work in the company car was not considered business usage.

- For an assignment to constitute a special mission, it cannot be part of the employee's regular duties. Therefore, the Claimant's contention that he was performing a duty that was a common part of his job before driving home mandates the conclusion that Claimant was not on a special mission for Employer.

- The contract between Claimant and Employer that agreed in 2004 that Claimant was not a traveling employee and that Claimant's work day ended when he left the last customer's store or left the workplace did not violate public policy.

  This is because Employers and employees are free to enter into employment contracts which outline an employee's terms of employment. Although the contract provisions may appear to affect an employee's entitlement to WC benefits if the employee is injured, the Act, and the Courts' interpretation thereof, provides protections to employees who are injured in the course and scope of employment

Steckel v WCAB (Have-A-Vend, Inc.), No. 2011 C.D. 2011 Judge Jubelirer (June 7, 2012) 12/12

UTILIZATION REVIEW

- The WCJ's decision, upon denying claimant's Petition to Review a UR Determination, was supported by substantial evidence where the found that Fentanyl lozenges, despite the palliative nature of the treatment, was not reasonable or necessary where the WCJ determined the highly addictive nature of the Fentanyl lozenges as evidenced by Claimant's increased use of the medication rendered it unreasonable and unnecessary where an alternative treatment plan could be implemented.

  Furthermore, upon determining the reasonableness and necessity of a prescribed medication, it is appropriate for a UR Reviewer to consider the risk to the patient. In the other words, a UR reviewer may consider whether it is reasonable and necessary for a provider to expose a patient to the level of risk presented by a medication.

- The claimant bears no burden of proof in the UR process. Id. Rather, the employer bears the burden of proof throughout the entire UR proceeding to show the disputed treatment is not reasonable and necessary.

  In addition, the weight and credibility of the UR report, as with any other evidence, is for the fact-finder

Bedford Somerset MHMR v. WCAB (Turner) No. 1997 C.D. 2011 (Decision by Judge Simpson, June 6, 2012) 12/12

FEE REVIEW

- The Hearing Office did not commit an error of law, upon granting providers Fee Review where the invoice for VAX-D treatments did not include a recognized Medicare code where there is no recognized cod for VAX-D treatments, though the code used S9090 code is widely used for VAX-D treatments.

  This is because Section 127.102 of Title 34 of the Pennsylvania Code contemplates the situation where a Medicare code does not exist by stating:

  > *If a Medicare payment mechanism does not exist for a particular treatment*, accommodation, product or service, *the amount of the payment made to a health care provider shall be either 80% of the usual and customary charge* for that treatment, accommodation, product or service in the geographic area where rendered, *or the actual charge*, whichever is lower.

  This means that is the Medicare Payment Mechanism does not exist for a treatment, the provider will still be paid.

  The insurer's remedy is to: pay the lower of 80% of the usual and customary charge or the actual charge; or (2) Down code to an approved code.

- Section 306(f.1)(1)(i) of the Act, 77 P.S. §531(1)(i), requires employers to pay for medical services rendered to workers' compensation claimants. Medical service providers must use standardized claim forms and use the codes in the Department's Fee Schedule. These codes are developed nationally by the Health Care Financing Administration and statewide by local Medicare carriers.

  Generally, a provider cannot be paid more than 113% of the Medicare reimbursement rate for a particular treatment.34 Pa. Code §127.101(a). Where there is no Medicare code for the treatment provided, the provider will be reimbursed 80% of the usual and customary charge for the treatment or the actual fee charged, whichever is lower. 34 Pa. Code §127.102.

  The employer may "downcode" the provider's billing code where the change is consistent with Medicare guidelines and the insurer has sufficient information to make the change after consulting with the provider.

  Legion Insurance Company :c/o Inservco v. Bureau of Workers' Compensation :

Fee Review Hearing Office (Ferrara) No. 828 C.D. 2011 (Judge Leavitt, January 10, 2012) 12/12

PENALTY/ MEDICAL BILL

- The employer violated the Act where it only calculated interest where it did not pay interest past the closed period of disability because Claimant was fully employed at that time.

  This is because Section 406.1(a) of the Act provides that interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum. Thus, the interest will accumulate, or continue to grow, on all unpaid compensation at a rate of ten percent until such compensation is paid.

  The purpose of Section 406.1(a) of the Act is to compensate a claimant for the loss of the use of the money during the time the payment was delayed. There is no limitation in the Act if the Claimant returns to work or is no longer disabled.

  The Employer's error in calculating the interest and the fact that Claimant returned to work were irrelevant in determining the interest due Claimant for the loss of use of the money he was owed.

- The employer violated the Act by failing to timely pay the subrogation liens of a non-occupational medical carrier premised upon its argument that pursuant to Section 306(f.1)(2) of the Act, it was entitled to receive medical bills and records verifying medical charges for treatment of an injured worker before it must pay for the treatment.

  This is because Section 306(f.1)(2) does not apply only applies to providers and not insurers requesting subrogation of payments made on behalf of a claimant.

  Rather, Section 319 of the Act relates to the subrogation rights of the third-party health insurers and they are not required to resubmit any bills after an award of compensation..

Cleveland Brothers and its third party administrator, PMA v. WCAB (Hazlett) No. 68 C.D. 2012 (Decision by Judge Friedman, August 24, 2012) 12/12