THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
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ATTORNEY FEE

- An attorney discharged prior to the time a settlement is reached is not entitled to an additional proportionate share of the contingent fee from the settlement proceeds based on the relative contributions of the two attorneys.

  This is because a client may discharge an attorney at any time, for any reason. Once the contractual relationship has been severed, any recovery must necessarily be based on the work performed pursuant to the contract up to that point. Where the contingency has not occurred, the fee has not been earned.

  Therefore, Attorney A, who successfully litigated an underlying Claim Petition, for which he was awarded a 20% contingent fee but was discharged prior to the date the claimant resolved his matter for a C&R following discharge of attorney A and retention of Attorney B, was not entitled to a quantum meruit attorney fee against the 20% contingent fee that Attorney B received chargeable to the proceeds of the C&R. This is despite the fact Attorney A was alleged to have commenced the initial resolution negotiations, without reaching a resolution, but was discharged 2-4 months prior to the C&R hearing.

Mayo v. WCAB (Goodman Distribution, Inc.), No. 683 C.D. 2014 (Decision by Judge Simpson, January 8, 2015) 1/15

IMPAIRMENT RATING EVALUATION

- An IRE physician must first determine that a claimant has reached MMI before calculating an impairment rating.

  The WCJ did not commit an error of law upon findings that an Impairment Rating Evaluation was valid based upon finding credible employer's medical experts opinion that the claimant had reached Maximum Medical Improvement (MMI) despite the fact that the employer's expert conceded that surgery upon the claimant's elbow was a reasonable surgical option but still opined that though the surgery had potential to improve Claimant's "pain" and "symptoms," the surgery would not cure Claimant, who would have permanent damage and remain impaired.

This is because whether a claimant has reached MMI is a matter of application of the Guides to the Evaluation of Permanent Impairment (Guides) to a claimant's medical condition. Thus, whether a claimant has reached MMI is an inherently medical determination, which, by necessity, must be the subject of medical testimony. Provided that the medical expert considers the appropriate factors required by the Guides when rendering a determination that a claimant has reached MMI, a WCJ may rely on the expert's determination that a claimant has reached MMI.

- The pertinent Section of the Guides at 2.5e provide that Maximum Medical Improvement (MMI) refers to a status where patients are as good as they are going to be from the medical and surgical treatment available to them. It can also be conceptualized as a date from which further recovery or deterioration is not anticipated, although over time (beyond 12 months) there may be some expected change.

  This Section further provides:

  MMI represents a point in time in the recovery process after an injury when further formal medical or surgical intervention cannot be expected to improve the underlying impairment. Therefore, ***MMI is not predicated on the elimination of symptoms and/or subjective complaints****. Also, MMI can be determined if recovery has reached the stage where symptoms can be expected to remain stable with the passage of time, or can be managed with palliative measures that do not alter the underlying impairment substantially, within medical probability. (emphasis added)*

  The Guides further provide that an individual is at MMI when his condition has become static or stable and that while further deterioration or recovery may occur at some point in the future, one would not expect a change in condition at any time in the immediate future.

Neff v. WCAB (Pennsylvania Game Commission), No. 130 C.D. 2014 (Decision by Judge Brobson, January 8, 2015) 1/15

FEE REVIEW/MEDICAL BILLS

- The Bureau's Medical Fee Review Section lacks jurisdiction in the first instance to determine whether an entity preferring a bill for medical services provided the medical services being billed.

  This does not mean that providers lack any recourse. Claimants can file a petition to establish Insurer's liability to Physical Therapy Institute, such as a Review or Penalty Petition.

  Should the billing entity be adjudicated the provider, it can re-bill Insurer and proceed to Fee Review if an issue arises involving amount or timeliness of

payment. Should either party believe that the other is effecting a fraud, it can pursue that claim in a legal action, such as a declaratory judgment action.

- This is because the Fee Review is designed to be a simple process with a very narrow scope limited to determining the relatively simple matters of amount or timeliness of payment for medical treatment. This would include disputes over the amount of payment where the medical fee has not been calculated in accordance with the compensation fee schedule or medical billing protocols.

  The Fee Review process presupposes that liability has been established. In cases in which liability for a particular treatment is at issue, the claimant, not the medical provider, must pursue compensation before a WCJ in the regular course. Accordingly, a Fee Review proceeding is not undertaken to determine liability for a particular treatment

Physical Therapy Institute, Inc. v WCAB (Selective Insurance Company of SC), No. 71 C.D. 2014 (Decision by Judge Leavitt, January 16, 2015) 1/15

LOSS OF USE/WAIVER/APPEAL

- Pursuant to Section 306(c) (23), a claimant who suffers a bilateral loss of arms, feet, legs or eyes may file a petition with the Board to elect to receive specific loss benefits instead of the default presumption of total disability benefits.

  The determination as to whether to alter the presumption of total disability benefits is left to the discretion of the Board and the Board is to be guided solely by whether the default presumption of total disability or an election of the specific loss benefits provides the "optimum benefit available to a claimant" and that the benefits the claimant elects fall "within the statutory scheme."

  The WCAB did not commit an error by not allowing the claimant, who argued he was entitled to receive specific loss benefits to both legs concurrently, to elect specific loss benefits to both legs following a compensable back injury in place of total disability benefits.

  This is because the Act does not envision concurrent receipt of specific loss benefits resulting from the same injury but instead requires that multiple specific loss benefit awards related to one work incident be paid consecutively with aggregated terms and the specific loss benefit rate set according to Section 306(a). Thus Claimant at most would be entitled to elect two specific loss benefit awards for the loss of use of his legs with the 410 week terms for each award, or a total of 820 weeks, aggregated payable at the total disability weekly compensation rate.

  Here the Claimant did not identify in his petitions or present any evidence at the hearing before the WCJ that there existed any other economic rationale that would give the Board reason to depart from the Section 306(c) (23) presumption that

total disability benefits are the optimum benefit for an individual, such as Claimant, who suffers bilateral losses. Accordingly, the Board did not commit an error by determining that Section 306(c) (23) created a presumption in favor of total disability, and determined the claimant would remain on total disability consistent with its role, which is confined to determining whether another provision would prove more beneficial to Claimant.

- A claimant would not be entitled to concurrent receipt concurrent specific loss and total disability awards that exceed the maximum weekly compensation payable under the Act where Claimant's injuries arose out of a single work accident.

- Though it is true that a claimant may be entitled to receive both specific loss and disability benefits in cases where the specific loss results in a disability to a separate and distinct part of the body arising from the same workplace incident but that does not normally follow from the specific loss, Section 306(d) of the Act explicitly prohibits these benefits from being paid concurrently but instead provides that the total or partial disability period runs first and the specific loss benefits do not begin to be paid until after the disability payments end

- The Commonwealth Court may not consider an issue on appeal unless it is preserved at every stage of the proceeding below. The courts permit a litigant to make new arguments on appeal in support of a preserved issue but do not permit a party to advance an entirely new and different theory of relief for the first time on appeal.

  The claimant did not waive an issue on appeal where the confusion engendered below regarding the exact nature of Claimant's argument was the result of Claimant's imprecise and inconsistent draftsmanship rather than an attempt to change course and offer a completely new theory of relief on appeal.

- While an appeal may be dismissed or quashed when a defect in a brief is "substantial," the Commonwealth Court may ignore even "egregious violations" of the Rules of Appellate Procedure if these defects do not preclude meaningful appellate review. In fact, the Pa. Supreme Court has cautioned that the "extreme action of dismissal should be imposed by an appellate court sparingly, and clearly would be inappropriate when there has been substantial compliance with the rules and when the moving party has suffered no prejudice.

  The Commonwealth declined to quash the claimant's appeal although it failed to include a short conclusion stating the precise relief sought in his brief as required by Rule of Appellate Procedure 2111(a)(9) where the last several paragraphs of Claimant's brief make clear what he sought from his appeal.

  Therefore, Claimant's only dereliction of the Rules of Appellate Procedure was his failure to include a separately denominated conclusion section in his brief. The

court concluded that this failure did not prejudice Employer and does not preclude the Court's meaningful review of Claimant's appeal.

Arnold v. WCAB (Lacour Painting, Inc.), No. 565 C.D. 2014 (Decision by Judge Colins, January 28, 2015)1/15