THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
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SUPERSEDEAS/SUBROGATION

- An employer is not entitled to Supersedeas Fund reimbursement for moneys paid to a claimant, following denial of its supersedeas request filed in conjunction with its appeal of the granting of a Claim Petition by the WCAB, where it was determined that another employer was responsible for those same payments to the claimant but it was still determined that those same moneys were due to the claimant for his occupational disease, albeit by a different employer.

  This is because the purpose of the supersedeas fund is to provide a means to protect an insurer who makes compensation payments ***to a claimant*** who ultimately is determined not to be entitled thereto. (Emphasis added).

  The employer's remedy was to pursue subrogation against the responsible employer under Section 319 of the Act, which provides impertinent part:

  Where the compensable injury is caused in whole or in part by the act or omission of a third party, the employer shall be subrogated to the right of the employe, his personal representative, his estate or his dependents, against such third party to the extent of the compensation payable under this article by the employer….

  It was immaterial that the employer ultimately found liable was no longer in business and did not carry workers' compensation insurance.

- The five requirements that must be met before an employer or insurer may obtain reimbursement from the Supersedeas Fund are as follows:

  1. A supersedeas must have been requested;
  2. The request for supersedeas must have been denied;
  3. The request must have been made in a proceeding under Section 413 of the Act or Section 430 of the Act;
  4. Payments were continued because of the order denying supersedeas; and
  5. In the final outcome of the proceedings, it is determined that such compensation was not, in fact, payable.

GMS Mine Repair & Maintenance, Inc. v. WCAB (Way) No. 92 C.D. 2011 (Decision by Judge Friedman, October 7, 2011) 11/11

MEDICAL TESTIMONY/TERMINATION

- An employer's expert need not say "magic words" in providing his opinion that a claimant's work injury is fully resolved such that he can return to work. However, medical testimony is equivocal if it is vague, leaves doubt, is less than positive or is based upon possibilities.

  The WCJ committed an error of law upon granting the employer's Petition for Termination where the claimant's treating physician, who testified on behalf of the employer and was the only medical witness to testified, offered equivocal testimony on the issue of whether the claimant was recovered where he:

  - Responded to the question whether the claimant's spinal cord following surgery had returned to its pre-existing state by answering "*It's hard to say… there can be some permanent damage*."-

    If there was any permanent damage to Claimant's spinal cord from the surgery that was done to address the work injury, then Claimant could not have been fully recovered from the work injury.

  - When asked whether he considered the surgery a success, he stated his belief that it was successful because Claimant has not "declined in function insofar as his ability to use his hands and/or his ability to walk with regard to the surgery itself."

    The medical witness deemed the surgery a success because it did not make Claimant's ability to function worse than before the surgery. Moreover, he never testified that the surgery relieved any numbness or tingling Claimant might have experienced in his extremities. Such testimony is not unequivocal that Claimant is fully recovered from his work injury.

  - With regard to Claimant's pain, he testified, "I think that his pain that he was having pre-operatively *nearly completely resolved for the most part*. That is his arm pain and to a large degree his—much of his neck symptoms."

    To say that Claimant's arm and neck pain "nearly completely resolved for the most part" is the same as saying the pain had not fully resolved.

  - With regard to an MRI he testified, it didn't "show any *significant pressure* on the spinal cord itself."

Such testimony demonstrates that there **was** some pressure on Claimant's spinal cord a year after the surgery, which is not unequivocal testimony that Claimant is fully recovered from his work injury.

- An employer seeking a termination of benefits bears the burden of proving either that the claimant's disability has ceased or that any current disability arises from a cause unrelated to the claimant's work injury. An employer meets this burden when its medical expert unequivocally testifies that "it is his opinion, within a reasonable degree of medical certainty, that the claimant is fully recovered, can return to work without restrictions and that there are no objective medical findings which either substantiate the claims of pain or connect them to the work injury." Further, an employer's burden of proof in a termination proceeding is considerable, and it never shifts to the claimant, whose disability is presumed to continue until proven otherwise.

Miller v. WCAB (Peoplease Corp.) No. 204 C.D. 2011 (Decision by Judge Friedman, October 11, 2011) 11/11

AVERAGE WEEKLY WAGE/ UNEMPLOYMENT COMPENSATION

- A claimant is not entitled to have the moneys received in Unemployment Compensation during the 52 weeks preceding his work injury included in his pre-injury average weekly wage calculation made pursuant to Sections 309(d).

  This is because the Act concerns itself with compensable work injuries and their effect upon earning capacity; a decline in a worker's earnings which results from business or economic forces is not the same as a decline in that worker's earnings due to a job-related impairment. The Workers' Compensation system operates to insure a worker against the economic effects of a workplace injury, not against the economic effects of variations in the business cycle. Thus, inclusion of unemployment compensation benefits paid out during a work layoff is not required in order to ensure an accurate measure of a worker's earnings history and earning capacity.

  The holding is also consistent with the fact that the Workers' Compensation system operates to insure a worker against the economic effects of a workplace injury, not against the economic effects of variations in the business cycle

- The goal of AWW calculation is to "create a reasonable picture of claimant's pre-injury earning experience for use as a projection of potential future wages and, correspondingly, earning loss and the calculation is designed with one focus on the economic reality of a claimant's recent pre-injury earning experience. Section 309 of the Act sets forth the methodology for calculating an employee's AWW.

- Section 309(d) applies to situations where the claimant has been employed by the employer for at least one year preceding the work injury.

  The term "employ" as used in Section 309 is not limited to the actual number of days an employee performs work, but encompasses the period of time that an employment relationship is maintained between the parties. Therefore, Section 309(d) applied to a claimant who received periods of Unemployment Compensation during the 52 weeks preceding his work injury because he maintained his employment relationship with the employer during the period he was receiving unemployment compensation.

Lenzi v. WCAB (Victor Paving) No. 741 C.D. 2011 (Decision by Judge Kelley, October 13, 2011) 11/11

MEDICAL BILLS/ PENALTY/ UTILIZATION REVIEW/LITIGATION BY REPORT/ EVIDENCE

- The WCJ did not commit an error where the WCJ assessed a 50% penalty against the employer where it was found the employer unilaterally refused to pay $140,876.00 in payments for TMR and failed to avail itself to the remedy of filing a Request for a Utilization Review.

- Under Section 435(d) (i) of the Act, the WCJ is empowered to assess a penalty of up to 50 percent for violations of the Act involving "unreasonable or excessive delays." Here, the WCJ found that the delay resulting from Employer's refusal to pay Claimant's medical bills for TMR was unreasonable and excessive, and opted in his discretion to assess a 50 percent penalty. The WCJ acted as permitted by the Act and was not required to consider any other factors in assessing the penalty.

- In a penalty petition proceeding, the claimant has the burden of proving that a violation of the Act occurred.

- An employer is obligated to pay for reasonable medical expenses that are causally related to the work injury. Under Section 306(f.1) (5) of the Act, the employer must pay the claimant's medical bills within 30 days of receiving them, unless the employer disputes the reasonableness and necessity of the treatment. If the employer believes that the treatment is not reasonable and necessary, it must submit the bills for a Utilization Review or face the possibility of a penalty.

- If an employer questions the reasonableness and necessity of medical treatment, the employer can submit the bills for a Utilization Review. The Utilization Review process is the sole means for determining if treatment is reasonable and necessary. Unless bills have gone through utilization review, the WCJ has no jurisdiction to rule on their reasonableness and necessity

- If an employer refuses to pay bills because it believes they are not causally related to the work injury, the employer runs the risk of being assessed a penalty if the WCJ determines that they are, in fact, causally related.

- Section 127.467 of the Medical Cost Containment Regulations requires that utilization reviewers "shall apply *generally accepted treatment protocols* as appropriate to the individual case before them." 34 Pa. Code §127.467 (emphasis added). Thus, whether a particular treatment is generally accepted in the medical community is a matter to be determined through Utilization Review, not in a penalty proceeding. Employer was required to file a Utilization Review to address its objections to the treatment where Employer, not Claimant, bears the burden of proof.

- The codes and costs assigned to medical procedures must be decided in accordance with the fee review established in Section 306(f.1)(5) of the Act, The Bureau of Workers' Compensation, not workers' compensation judges, oversees fee reviews. Therefore, the Claimant did not have to show that the cost of his TMR treatments was reasonable to make out his case for penalties.

- The Claimant was not required to present medical testimony and was properly permitted to litigate his Penalty Petition by submission of medical reports. This is because Section 422(c) of the Act allows the use of medical reports in any litigation involving 52 weeks or less of disability. Section 422(c) applies where the issue is one of disability, *i.e.*, earnings loss. When, as here, the litigation involved medical expenses, medical reports were admissible regardless of the duration of the disability.

CVA, Inc. and State Workers' Insurance Fund v. WCAB (Riley), No. 2658 C.D. (Decision by Judge Leavitt, October 14, 2011) 11/11

ILLEGAL IMMIGRANT/ EVIDENCE/ ADVERSE INFERENCE

- A party's failure to testify can support an inference that whatever testimony he could have given would have been unfavorable to him. The inference to be drawn from a party's failure to testify *serves to corroborate the evidence produced by the opposing party*. Also, the failure to testify to facts within one's presumed knowledge permits an inference that can erase the equivocal nature of other evidence relating to a disputed fact. However *a party cannot satisfy its burden of proof in a civil cause solely through reliance on the defendant's failure to testify*.

  The inference created when a party refuses to testify is not considered evidence established by the party with the burden of proof, and therefore does not count in calculating whether a party has met its burden in introducing substantial evidence. Rather, the inference is directed to the credibility of the evidence presented by the party with the burden.

The reason that an adverse inference cannot serve as substantial evidence to support a finding of fact is because an adverse inference does not constitute evidence.

Therefore, the WCJ's drawing of an adverse inference resulting from the claimant's refusal to answer whether he was a naturalized citizen or an undocumented worker, by invoking his privilege against self-incrimination under the Fifth Amendment to the United States Constitution, could not be the sole support of a finding that the Claimant was an undocumented alien that resulted in the suspension of claimant's compensation.

- A claimant's status as an undocumented alien worker does not preclude him from receiving disability benefits under the Act. Nevertheless, where it is shown that the claimant is capable of performing some work, albeit in a modified duty capacity, the employer is entitled to a suspension of benefits by reason of the claimant's undocumented status. In such a situation, the employer is not required to show job availability as required under Kachinski because it is presumed that an undocumented alien cannot work in this country, the rationale behind this rule is that the claimant's loss of earning power is caused by his immigration status, not his work-related injury, and, therefore, it would be an exercise in futility to require the employer to show available work.

- A claimant's immigration status is relevant only to determining whether an employer is entitled to a suspension, not to whether the claimant's claim petition should be granted. Although Claimant's claim petition was the only formal petition pending before the WCJ, the WCJ correctly treated Employer's response to Claimant's claim petition as a request for suspension.

  As it is the employer's burden in every instance to prove its entitlement to a suspension, the burden is on Employer to demonstrate Claimant's undocumented status, even in the context of a Claim Petition.

- Commonwealth Court rejected employer's contention that an employer is not in a position to demonstrate a claimant's immigration status. For instance, the federal Immigration Reform and Control Act (IRCA) requires employers, at the time of hire, to verify the identity and employment authorization of employees, which must be documented by the completion of an I-9 form. *See* 8 U.S.C. § 1324a. In *Reinforced Earth Co. v. Workers' Comp. Appeal Bd. (Astudillo)*, 570 Pa. 464, 476, 810 A.2d 99, 106 (2002)., the employer was able to establish the claimant's status as an undocumented alien worker by showing that the claimant failed to present to the employer the information the IRCA required in order to demonstrate that he was authorized to work in this country.

Kennett Square Specialties v. WCAB (Cruz) No. 636 C.D. 2011 (Decision by Judge Brobson, October 19, 2011) 11/11

MEDICAL RECORD/ FEE REVIEW

- Pursuant to Section 306(f.1) of the Act, a provider may file a fee review application within 30 days following notification of disputed treatment if more than 90 days elapsed from the original billing date for the treatment subject to the fee dispute, whichever is later.

  Providers Fee Review Application was not untimely where In May 2009, it submitted a detailed bill on the proper forms to Employer, in November 2009 the employer sent provider an EOB, which explained why it paid the reduced amount for Claimant's inpatient hospital care and three days after receiving Employer's EOB but more than 90 days after Provider submitted its bill to Employer Provider filed a Fee Review Application challenging the amount of payment.

  This is because Employer's November 2009 EOB, which explained why it paid the reduced amount for Claimant's inpatient hospital care, qualified as notification of disputed treatment. Therefore, Provider had 30 days from Employer's EOB to file a Fee Review Application. It did so well within this period.

- An employer must pay 100% of a Provider's fee, irrespective of the Fee Schedule if the claimant's injury and Providers services confirm to the trauma center exemption in Section 306(f.1)(10) of the Act and Section 127.128 of the Workers' Compensation Medical Cost Containment regulations, which provide, in pertinent part:

  > *(a) Acute care provided in a trauma center or a burn facility is exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges if the following apply:*
  >
  > *(1)The patient has an immediately life-threatening injury or urgent injury.*
  >
  > *(2) Services are provided in an acute care facility…*
  >
  > *(d) The determination of whether a patient's initial and presenting condition meets the definition of a life-threatening or urgent injury shall be based upon the information available at the time of the initial assessment of the patient. A decision by ambulance personnel that an injury is life threatening or urgent shall be presumptive of the reasonableness and necessity of the transport to a trauma center or burn facility, unless there is clear evidence of violation of the ACS triage guidelines.*

- The decision by EMS personnel that an injury is immediately life threatening or urgent, absent a clear violation of the ACS guidelines, is presumptive of the

If the patient is initially transported to the trauma center in accordance with the ACS triage guidelines, payment for transportation to the trauma center and payments for the full course of acute care services by all trauma center personnel, and all individuals authorized to provide patient care in the trauma center shall be at the provider's usual and customary charge for the treatment and services rendered.

Therefore, the Hearing Officer's determination that Claimant's work injuries were immediately life-threatening or urgent for purposes of the trauma center exemption in Section 306(f.1)(10) of the Act did not constitute an error where the Hearing Officer determined Claimant's injuries met the criteria in Step Four of the ACS triage guidelines for EMS transport to a trauma center and found Claimant's advanced age, his complaints to EMS of severe back pain after falling on ice, EMS' contact with medical command, and EMS' judgment, collectively warranted transfer to a trauma center.

Roman Catholic Diocese of Allentown v. WCAB (Lehigh Valley Health Network) No. 2711 C.D. 2010 (Decision by Judge Simpson, October 28, 2011) 11/11