THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
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REASONED DECISION/ UNPUBLISHED DECISION CAPRICIOUS DISREGARD

- Section 422(a) of the Act requires a WCJ to issue a decision that permits an appellate court to exercise adequate appellate review. In order to satisfy this standard, a WCJ does not need to discuss every detail of the evidence in the record. Rather, Section 422(a) of the Act requires WCJs to issue reasoned decisions so that the Court does not have to "imagine" the reasons why a WCJ finds that the conflicting testimony of one witness was more credible than the testimony of another witness.

  A WCJ need not explain credibility determinations relating to a witness who testifies before the WCJ, Section 422(a) of the Act requires some explanation of credibility determinations by a WCJ with regard to conflicting deposition testimony in order to enable this Court to review a WCJ's decision. Under Section 422(a) of the Act, a WCJ must articulate the objective rationale underlying his credibility determinations where the testimony of such witnesses is conflicting. A WCJ may satisfy the reasoned decision requirement if he summarizes the witnesses testimony "and adequately explains his credibility determinations."

  Thus, while summaries of testimony alone would be insufficient to satisfy the reasoned decision requirement, where a WCJ summarizes testimony and also objectively explains his credibility determinations, the decision will satisfy the requirement. Further, other evidence in the record may provide the objective support necessary under Section 422(a) of the Act for adequate credibility determinations.

- A WCJ's observation of a witness's demeanor alone is sufficient to satisfy the reasoned decision requirement. Therefore, although the claimant testified both live and by deposition, since there was contextual overlap in the claimant live and deposition testimony the WCJ's credibility finding based upon demeanor was sufficient to satisfy the requirements of 422(a) of the Act.

  A WCJ may render a reasoned decision on the basis of summarized testimony if the reason given in addition to the cited testimony constitutes an objective basis explaining why a WCJ did not find a witness credible.

- Pursuant to Section 414 of the Commonwealth Court's Internal Operating Procedures, parties may cite an unreported panel decision of the Commonwealth

Court, issued after January 15, 2008, for its persuasive value, but not as binding precedent.

Amandeo v. WCAB (Conagra Foods) No. 889 C.D. 2011 (Decision by Judge Brobson, February 17, 2012) 3/12

INDEPENDENT CONTRACTOR/ JOINT LIABILITY

- Independent contractors cannot recover benefits under the Act, making employment status critical. Employment status is a critical threshold determination for liability. Claimant bears the burden to demonstrate an employer-employee relationship. The existence of an employer-employee relationship is a question of law based on the facts presented in each case.

  Neither the compensation authorities nor the courts should be solicitous to find contractorship rather than employment, and that inferences favoring the claim need make only stronger appeal to reason than those opposed.

- With regard to whether a claimant is an independent contractor, courts consider many factors: (1) control of manner the work is done; (2) responsibility for result only; (3) terms of agreement between the parties; (4) nature of the work/occupation; (5) skill required for performance; (6) whether one is engaged in a distinct occupation or business; (7) which party supplies the tools/equipment; (8) whether payment is by time or by the job; (9) whether work is part of the regular business of employer; and (10) the right to terminate employment. But none of these factors is dispositive.

  The key factor is whether the alleged employer had the right to control the work to be done, and the manner in which work is performed. Control in an employment relationship exists where the alleged employer: possesses the right to select the employee; the right and power to discharge the employee; the power to direct the manner of performance; and the power to control the employee. Payment of wages and payroll deductions are significant, as is provision of workers' compensation coverage. However, payment is not determinative.

  Truck drivers, who direct their own routes, come and go as they see fit, and control their transport as owner-operators are often deemed independent contractors.

  A company whose controls could solely be traced to the carrier's compliance with government regulations will not, in and of itself, create an employment relationship.

- An employee's signing of an agreement stating he was an independent contractor to obtain occupational insurance, is but one factor, and not determinative of the employer-employee relationship.

- The display of a logo on a truck does not creates an "irrebuttable presumption" of an employment relationship.

The decedent was not an independent contractor where decedent did not engage in an independent trade or profession and could not control his time or manner of work.

- While rare, the concept of joint liability is not foreign to the workers' compensation scheme. One crucial factor in determining joint liability in trucking cases is the existence of an agency relationship between the carrier and the owner-operator. Payment of a driver by a lessor based on number and value of deliveries is a significant factor to show the lessor was the employer.

  There was no joint liability in this matter where the indicia of control suggest the carrier, American, was Decedent's employer.

  Here the lessee was the employer because it selected and trained drivers, and ensured their compliance with its policies. The lessee's policies exceeded the government criteria for drivers, and it disqualified, or essentially terminated, drivers who do not meet its standards. The lessor had none of its own policies to enforce, and received no paperwork from Decedent showing the work he performed and how he performed it. The lessee received and maintained all employment paperwork, and ultimately determined Decedent's day-to-day schedule through its agent, the lessor.

  Additionally, the record reflected that Decedent did not perform work to further the interests of the lessor, except to the extent that lessor interests coincided with those of the lessee due to its agent status.

American Road Lines and Lexington Insurance Company v. WCAB (Royal) No. 2428 C.D. 2010 (Decision by Judge Simpson, February 23, 2012) 3/12

FEE REVIEW/ MEDICAL BENEFIT

- The regulations with respect to downcoding require an insurer to notify a provider in writing of the proposed changes and the reasons supporting the changes. Insurers also must give a provider 10 days to respond to the notice of proposed changes as well as the opportunity to discuss the proposed changes and offer support for the original coding decisions. The regulations further provide that an insurer's failure to strictly comply with these requirements will result in the Bureau's resolution of an application for fee review in favor of a provider.

The carrier was not entitled to the downcoded value of TMR treatments where it did not even attempt to downcode providers' bills until approximately two years after it issued explanations of benefits denying payment on the basis that the TMR treatment was research, experimental, or investigative services and after Providers filed Applications for Fee Review, the Bureau issued administrative decisions, Providers requested fee review hearings, and hearing notices were issued.

- Section 306(f.1)(3)(i) of the Act states that a medical provider shall "not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the…applicable fee schedule…or…any other Medicare reimbursement mechanism."

  Additionally, this section states that if the prevailing charge, fee schedule or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed eighty per centum of the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

  The regulations similarly state that 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.

  The insurer bears the burden before the Hearing Officer to establish by a preponderance of the evidence that it properly reimbursed the Provider.

  The insurer did not fulfill its burden where before the Hearing Officer where it offered no evidence as to the usual and customary charge by failing to cite or rely upon the Medicare regulations in its explanations of benefits reducing Providers' bills for the TMR. Instead, insurer downcoded Providers' bills without strictly complying with the procedures for such downcoding.

- Failure to pay medical bill within 30 days of receipt of the required bills and medical reports results in the accrual of interest on the unpaid balance at the rate of 10% per annum.

- Penalties are payable to the same person to whom compensation is payable, i.e., the claimant.

Liberty Mutual Insurance Company v. WCAB (Kepko, D.O., Lindenbaum, D.O. c/o East Coast TMR) No. 1182 C.D. 2011 (Decision by Judge McCullough, February 23, 2012) 3/12