February 2012 Case Law Summaries

City of Pittsburgh and UPMC Benefit Management Services, Inc. v. W.C.A.B. (Marinack), No. 100 C.D. 2011, Submitted January 6, 2012

Background: Claimant sustained an injury while working as a firefighter. The city of Pittsburgh filed a petition to suspend claimant's disability benefits based upon the allegation that he had removed himself from the workforce.

The WCJ found that the city sustained its burden because it showed that claimant was able to perform "some level of work" and had retired from his position with the city, according to the opinion. As such, the WCJ found that the burden shifted to claimant to show that either he was forced out of the workforce by his work injury or was seeking work in good faith. The WCJ found that claimant failed to sustain his burden and suspended his benefits.

The WCAB reversed the suspension of benefits because it determined that claimant did not retire, but, rather, was fired, rendering him ineligible for any pension. As the WCAB found that claimant did not withdraw from the workforce, the WCAB held that it was the city's burden to prove that he had an earning capacity, which it did not do, according to the opinion.

Holding: The Commonwealth Court held that the city's evidence did not prove an intent to withdraw from the workforce, especially because claimant denied any intention to withdraw from the workforce and his intent was "undisputed," according to the opinion. Moreover, as the city had the burden to show that it assisted claimant in returning to the workforce but did not present any evidence of this, the court held that the city did not sustain its burden for a suspension of benefits based upon a voluntary withdrawal from the workforce, which would have resulted in the burden shifting to claimant to prove otherwise.

The Commonwealth Court summarized the different presumptions that can be drawn from a claimant's application and receipt of a pension depending on the type

of pension. There is no presumption that a claimant collecting a disability pension has withdrawn from the workforce and, as such, the employer must show that a claimant receiving a disability pension does not intend to return to work. When a claimant becomes eligible for a retirement pension as a result of age and/or years of service, it can be presumed that the claimant has withdrawn from the workforce.

In support of its argument that the "totality of the circumstances" revealed that claimant voluntarily withdrew himself from the workforce, the city of Pittsburgh cited to the following undisputed facts: 1) claimant's job as a firefighter was not eliminated; 2) he did not show that he wanted to return to work for the city; 3) he applied for a disability pension; 4) he did not advise the city of the work he could do given his medical restrictions; 5) he did not show that he made a sincere effort to return to the workplace; and 6) he applied for two jobs only after the city filed its suspension petition. Applying the totality of the circumstances test announced in *City of Pittsburgh and UPMC Benefit Management Services Inc. v. WCAB (Robinson)*, the court disagreed with the city that these facts demonstrated that claimant had withdrawn from the workforce before he was fired.

The Commonwealth Court further stated that claimant's failure to look for another job did not satisfy the "totality of circumstances" requirement because it has been established that a claimant's failure to look for work becomes relevant only after an employer proves that the claimant intended to withdraw from the workforce, according to the opinion. The court further stated that claimant's lack of effort to look for a job did not prove an intention to withdraw from the workforce.

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

Background: Claimant worked for Conagra Foods as a "utility worker." Claimant filed his claim petition in March 2009, averring a work-related injury on or about December 1, 2006, that

allegedly occurred when he dropped the end of a skid on himself.

The WCJ conducted hearings and accepted deposition testimony from claimant as well as medical evidence.

The WCJ determined that claimant's testimony was not credible regarding the alleged work incident. The WCJ found the testimony of Employer's expert to be credible and found the testimony of claimant's expert not credible. The WCJ therefore concluded that claimant had failed to satisfy the burden to prove that he sustained a work-related injury on or as a result of the alleged December 2006 work incident.

Claimant petitioned for a review of an order of the WCAB. The Board affirmed the decision of a WCJ, denying claimant's claim Petition.

Claimant appealed challenging the WCJ's credibility determinations as being "unsubstantial." The Board affirmed the WCJ's decision, concluding that claimant's arguments related more to the weight of the evidence rather than to the question of whether substantial evidence supported the WCJ's findings of fact.

Claimant raised the following issues: 1) whether the WCJ's manner of rendering factual findings based on summation of testimony and without identification of objective factors in support of his credibility determinations fails to satisfy the reasoned-decision requirement of Section 422(a) of the Act; 2) whether the WCJ's factual findings concerning the occurrence of a work-related injury are not supported by substantial evidence and are inconsistent with the record as a whole; and 3) whether the WCJ erred as a matter of law in concluding that claimant failed to provide competent and credible evidence to satisfy his burden of proof.

Holding:

In rendering its decision, the Commonwealth Court explained that 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.

The court further held that 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.

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

Background: This case involves potential joint employers in the trucking industry, and addresses whether the WCAB erred in reversing a WCJ opinion and order finding an owner-operator and motor carrier jointly liable for the work-related injuries and death of their truck driver, Federick Royal, (Decedent) under the Act.

Decedent worked as a truck driver for Ayerplace Enterprises, LLC, an owner-operator of a tractor, and American Road Lines, Inc., a motor carrier licensed under federal law.

Decedent, while attempting to repair an air leak in one of the air brake lines on a trailed owned by American Road Lines, was run over by the rear drive wheels of the tractor, suffering serious injuries, ultimately leading to his death. At the time of the accident, Ayerplace owned its tractor through a lease-purchase agreement with Patriarch Leasing, a company affiliated with American. Before his death, claimant filed claim petitions against both American and Ayerplace.

Ayerplace is the owner-operator of a single tractor leased to exclusively to American. With regard to the relationship between American and Ayerplace, the WCJ found that Michael DeLuca, the sole employee and shareholder of Ayerplace, and thus Ayerplace itself, had a contract with American as an owner-operator/driver, and subsequently began to serve as a dispatcher for American.
With regard to payment, the WCJ found that decedent received checks from Ayerplace, from which Ayerplace made payroll deductions and deductions for occupational insurance. American deducted fuel charges and costs of insuring drivers from payments to Ayerplace. American paid Ayerplace a lump sum for decedent's trips, from which Ayerplace paid decedent.

With regard to supervision and control, the WCJ found responsibility belonged to both American and Ayerplace.

Thus, the WCJ found American and Ayerplace jointly liable as joint employers since decedent furthered the interests of both Ayerplace and American at the time of injury.

The WCAB revered the WCJ's order as to joint employment and liability, holding joint and several liability is not consistent with the Act. The Board determined that American was decedent's direct employer and that Ayerplace directed decedent only as an agent of American. Thus, the Board reversed the grant of the claim and fatal claim petitions against Ayerplace, holding American solely liable.

Holding: The Commonwealth Court affirmed the result on alternate grounds.

In rendering its decision the court noted that independent contractors cannot recover benefits under the Act, making employment status critical. The court further explained that 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.

The court explained that 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.
Instead, the court held that 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.

Moreover, 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 court further noted that the display of a logo on a truck does not create an "irrebuttable presumption" of an employment relationship. Thus, 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.

The court further explained that 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. Thus, the court held that 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. Therefore, the Commonwealth Court affirmed the decision below.

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

Background: In a decision and order dated May 27, 2011, the Hearing Officer affirmed the administrative decision of the Bureau that Providers were entitled to no fees/payment reimbursement with respect to the applications for fee review numbers 237088 and 250483. However, the Hearing Officer reversed the Bureau's administrative decision concluding that Providers were entitled to $38.76 with respect to applications for fee review numbers 21926, 225688, 226584 and 253421, and awarded Providers a combined total of $16,143.77 plus interest.

Liberty Mutual Insurance Company petitioned for a review of the decision of a fee review hearing officer involving six consolidated fee review petitions, all relating to therapeutic magnetic resonance treatment (TMR) provided by Dr. Joseph Kepko and Dr. Jeffrey Lindenbaum.

Holding: The Commonwealth Court affirmed the decision below.

The court explained that 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.

Moreover, the court noted that 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.

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

Accordingly, 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.