OCTOBER 2011 CASE LAW UPDATES

GMS Mine Repair & Maintenance, Inc. and Chartis Claims, Inc. v. WCAB (Way), No. C.D. 2011 (Commw. Ct., 10/7/2011)

Issue: Whether an employer was entitled to reimbursement from the Supersedeas Fund for payments made to the claimant under an initial Order that deemed it to be the liable party, even though the employer was ultimately relieved of all liability and another employer was held to be responsible to pay claimant's benefits.

Answer: No. An employer who paid compensation to a claimant, but was ultimately relieved of liability because another employer was found to be liable, cannot recoup those payments from the Supersedeas Fund.

Analysis: The claimant initially pursued an occupational disease Claim Petition against GMS. GMS joined other companies into the litigation, alleging that claimant's work for those companies "may have caused" her injury. The WCJ granted to the Claim Petition against GMS only, finding that GMS never filed an Answer to the Claim Petition. GMS appealed and the WCAB, and its request for Supersedeas relief was denied. However, the WCAB eventually reversed the WCJ and also found that one of the joined defendants, R&R Mining, Inc., was actually the liable employer.

In light of the WCAB's Decision, GMS filed an Application for Supersedeas Fund Reimbursement through which it sought to recoup all of the payments made to and on the claimant's behalf after it was deemed the liable employer by the WCJ. The Fund/Commonwealth denied this Application, and the matter was assigned to a WCJ. The WCJ denied GMS's Supersedeas Petition on the basis that one of the key elements of Section 443 of the Act had not been met – namely, that there had not been a final outcome that "such compensation was not, in fact, payable."[1] GMS appealed and the WCAB affirmed. GMS further appealed to the Commonwealth Court.

The Commonwealth Court affirmed the decisions below, holding that there had never been a determination that the compensation paid to claimant was not, in fact, payable. Rather, the ultimate determination was simply that GMS was not responsible to pay claimant. However, it had been determined that claimant was, in fact, due compensation from R&R. Therefore, the Court held that GMS had a right of subrogation against R&R to recoup the monies it had previously paid the claimant, but could not recover these monies from the Supersedeas Fund.

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[1] The five requirements that must be met before an employer or insurer may obtain reimbursement from the Supersedeas Fund are: (1) Supersedeas must have been requested; (2) the Supersedeas request must have been denied; (3) the request must have been made in a proceeding under Section 413 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 was determined that such compensation was not, in fact, payable. Section 443 of the Act; Bureau of Workers' Compensation v. WCAB (Consolidated Freightways, Inc.), 876 A.2d 1069, 1071-72 (Pa. Commw. 2005).

Conclusion and Practical Advice: If an employer pays compensation based upon an initial finding that it was the responsible party for a claimant's injury, but it is ultimately held that *another employer* was actually responsible for the injury, the first employer cannot recoup those payments from the Supersedeas Fund, but must exercise its Section 319 right of subrogation against the other employer.

The employer that is initially held responsible for the claimant's injury and ordered to pay compensation but appeals to the WCAB should still request Supersedeas relief during the pendency of its Appeal, even if the ultimate outcome mirrors this case and Supersedeas Fund Reimbursement is not available. In the event that the WCAB grants its Supersedeas request made in connection with the Appeal, the employer will be relieved from paying benefits at that time.

Miller v. WCAB (Peoplease Corp., Arch Ins. Co. and Gallagher Bassett Svcs.), No. 204 C.D. 2011 (Commw. Ct., 10/11/2011)

Issue: Whether the employer presented unequivocal medical evidence to establish that the claimant had fully recovered from his work-related injury.

Answer: No. The opinions of the employer's medical witness were held to be equivocal on the issue of full recovery; therefore, they could not support employer's Termination Petition.

Analysis: Claimant sustained a work-related injury on December 29, 2007. The employer recognized claimant's injury via an NCP in the nature of a "cervical disc protrusion with radiculopathy." On June 22, 2009, the employer filed a Petition to Modify/Suspend/Terminate claimant's benefits.

The employer presented the testimony of claimant's treating orthopedic surgeon, Dr. Charles Wagener, in support of its case-in-chief. Dr. Wagener had performed surgery on January 24, 2008 to decompress the claimant's spinal cord and nerve roots at C5-6 and C6-7. Dr. Wagener opined that claimant's surgery had been successful because his pain had "largely resolved" and because a post-surgery MRI showed no impingement on the spinal cord. Even though claimant subsequently developed a frozen shoulder, Dr. Wagener found claimant to be fully recovered from his work injury, and capable of returning to work with no restrictions, as of June 5, 2009.

During the litigation, claimant stated that he still had symptoms and, in his opinion, chronic nerve damage related to his work injury. Claimant did not present any expert medical testimony in opposition to Dr. Wagener's opinions.

The WCJ credited Dr. Wagener's testimony as substantial, competent and uncontradicted, and granted the employer's Termination Petition (dismissing the Suspension and Modification Petitions as moot). Claimant appealed and the WCAB affirmed. Claimant further appealed to the Commonwealth Court.

Although the Court acknowledged that a medical expert need not say the "magic words" of full recovery when issuing such an opinion, it noted that "medical testimony is equivocal if it is vague, leaves doubt, is less than positive or is based upon possibilities." In this case, Dr. Wagener was asked whether the surgery he had performed could have caused permanent damage to the claimant's spinal cord, and he responded by saying "it's hard to say…" and "there can be some permanent damage." The doctor also opined that claimant's pre-operative pain had "nearly completely resolved for the most part." In light of Dr. Wagener's *less-than-positive* answers, the Court held that his testimony was equivocal.

The Court reversed the WCAB's affirmation of the WCJ's granting of the Termination Petition. The Court also remanded the matter to the WCAB for further remand to the WCJ for findings of fact and conclusions of law on the Modification and Suspension Petitions.

Conclusion and Practical Advice: While a medical expert need not explicitly state that a claimant has "fully recovered" from the work injury, the substance of the expert's testimony

must unequivocally establish that the claimant has, in fact, fully recovered from the injury in order to support a Termination Petition.

If an expert's opinion is less than clear on the issue of full recovery to begin with, it would be reasonable for the employer's attorney to seek clarification from the expert on the issue of full recovery, preferably in writing. The attorney should make efforts to clearly establish this full recovery opinion before filing the Termination Petition, and certainly before deposing the expert and possibly soliciting equivocal testimony which would defeat the Termination Petition. Additionally, employer's attorney should not rely on the fact that the claimant does not present any medical evidence to contradict the employer's expert as the expert's opinions may not be sufficient in and of themselves.

Lenzi v. WCAB (Victor Paving), No. 741 C.D. 2011 (Commw. Ct., 10/13/2011)

Issue: Whether a claimant's receipt of unemployment compensation benefits during the 52-week period preceding an injury date should be included in the calculation of his average weekly wage.

Answer: No. Unemployment compensation benefits are not included as "wages" in the calculation of one's AWW.

Analysis: Claimant began working for the employer in June of 2006. He was injured on July 30, 2007. He filed a Claim Petition and the employer maintained a denial of the injury throughout the litigation. Both sides submitted calculations of claimant's pre-injury AWW. Claimant included the monies he had received in unemployment compensation benefits during the 52-week period preceding the work injury, whereas the employer excluded the unemployment compensation benefits from its calculations. The parties did not dispute that the "employment relationship" continued during this 52-week period, even during the time that claimant received unemployment compensation benefits when he was laid off from the employer for economic reasons.

The WCJ granted the Claim Petition and awarded claimant benefits at the rate of $157.49 per week based upon an AWW of $174.99. In doing so, the WCJ rejected claimant's calculations, and his argument that including the unemployment benefits would be a "truer measure" of his pre-injury earnings. Both parties appealed to the WCAB and the Board affirmed. Only claimant appealed to the Commonwealth Court.

In affirming the WCAB, the Commonwealth Court noted that there is no precedent for claimant's suggestion that his unemployment benefits be included in the AWW calculation. Although claimant cited to the concurring opinion in Reifsnyder v. WCAB (Dana Corp.), 883 A.2d 537 (Pa. 2005), which is certainly not precedential. The Court acknowledged that the "goal of the AWW is to 'create a reasonable picture of claimant's pre-injury earning experience for use as a projection of potential future wages and, correspondingly, earnings loss," and correctly noted that the methods for calculating one's AWW are set forth in Section 309 of the Act.

Under Section 309(d)[2], the calculation of one's AWW takes a look at the "total wages earned in the employ of the employer in each of the highest three of the last four consecutive periods of thirteen calendar weeks in the fifty-two weeks immediately preceding the injury and averaging the total amounts earned during these periods." The Court noted that "employ" is not limited to the actual days an employee performs work, but encompasses the period that an employment relationship is maintained between the parties. In Reifsnyder, the majority of our Supreme Court addressed a case very similar to the instant one – where the injured employee was subject to work-related layoffs for economic reasons during the 52-week look-back period – and nonetheless held that unemployment compensation benefits would not be included in the AWW calculation. The Supreme Court distinguished that situation from the situation in Colpetzer v. WCAB (Standard Steel), 870 A.2d 875 (Pa. 2005), where it was held that a

[2] Section 309(d) is to be used when wages are not fixed by the week, month or year as outlined in Sections 309(a-c).

claimant's receipt of workers' compensation benefits for a work-related injury during the 52-week preceding a different injury *would be included* in the calculation of his AWW for the subsequent injury.

The Commonwealth Court reiterated the prior holding in Reifsnyder to support its affirmation of the WCAB's decision in this case, and in doing so noted 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."

Conclusion and Practical Advice: Even if a claimant remains "employed" by an employer during the 52-week look-back period preceding a work-related injury (or a portion of that period), but was subject to economic layoffs during that time and received unemployment compensation benefits while laid off, those benefits are expressly excluded from the calculation of claimant's pre-injury AWW.

The workers' compensation practitioner should always review the AWW calculations performed by an employer, insurer or claimant in order to ensure that the figures are correct. In doing so, the practitioner should compare these calculations with the raw wage data from the employer. If there are weeks of "zero earnings" during the relevant look-back period, the practitioner should investigate the reason for this lack of earnings. If the lack of earnings is due to economic layoffs, then these "zero" weeks are simply added with the remaining earnings in their respective 13-week quarters, and the AWWs from the three highest quarters (or fewer if the claimant did not work for the employer that long) are averaged together to determine the final AWW.

If the practitioner discovers that the weeks of "zero" earnings resulted from a different AWW for which s/he was paid compensation, then, under Colpetzer, the amount of the TTD paid for each of the weeks the claimant was out of work shall be included as "earnings" during those periods.

Dept. of Public Welfare/Norristown State Hospital v. WCAB (Roberts), No. 1677 C.D. 2010 (Commw. Ct., 10/14/2011 – previously unreported, 6/21/2011)

Issue: Whether claimant had voluntarily removed himself from the workforce by accepting a voluntary retirement pension and receiving a Social Security Disability pension.

Answer: Yes. The employer established, based upon a totality of the circumstances, that the claimant had removed himself from the workforce, thereby entitling it to a suspension of claimant's benefits.

Analysis: Claimant suffered a total of three injuries with the employer, the third on September 3, 1998. Claimant did not return to work at any time following the third injury. The employer sent claimant for an IME on June 5, 2003, at which time the IME physician found claimant to be capable of returning to full-time, sedentary duty work. The employer sent the claimant a Notice of Ability to Return to Work and pursued a Labor Market Survey. The employer subsequently filed a Modification Petition based upon the Labor Market Survey. The employer also filed a Suspension Petition on the basis that claimant had voluntarily withdrawn from his labor market.

The employer presented testimony from the IME physician and the vocational expert in support of the Modification Petition. Claimant testified that he took a retirement pension from the employer after he had stopped working following the third work injury (he was entitled to this pension based upon having more than 20 years of service at that time). Shortly thereafter, claimant began receiving a Social Security Disability pension as well. Claimant also testified that he felt unable to work due to ongoing pain.

The WCJ credited the opinions of the employer's medical expert over those of the claimant's expert, and found that claimant was capable of working in a sedentary duty capacity. However, the WCJ found that claimant did not voluntarily withdraw himself from the workforce, but rather that his choice to take a retirement pension was an economic decision; therefore, the WCJ dismissed the employer's Suspension Petition.

The WCJ also dismissed the employer's Modification Petition on the basis that it had failed to establish that there was no work available for the claimant *anywhere* within the Department of Public Welfare. In fact, the WCJ stated that "it is inconceivable that somewhere within the Department of Public Welfare, no position exists within Claimant's abilities."

The WCJ awarded unreasonable contest fees against the employer as well. Employer appealed and the WCAB affirmed the WCJ's holding that claimant had not voluntarily withdrawn from the workforce. However, the WCAB held that the WCJ erred in taking judicial notice that there were available positions within the employer and remanded the matter for the presentation of evidence in this regard.

On remand, the WCJ did not take new evidence regarding the availability of work with the employer. Rather, the WCJ simply evaluated the opinions and findings of the vocational expert but held them to be less credible than claimant's "own opinion concerning his inability to return to a full-time position in the workforce." Accordingly, the WCJ once again denied the

employer's Modification Petition. However, he modified his earlier award of unreasonable contest attorney's fees by cutting them in half on the basis that the employer *had* presented a reasonable contest of the Modification Petition.

In terms of the Suspension Petition, the WCJ held that he was without jurisdiction to reconsider his initial decision because that decision had been affirmed by the WCAB.

The employer appealed again (#2) and the WCAB affirmed the WCJ's decision with respect to the Modification Petition because the WCJ's decision was based upon his finding that the employer's failure to establish that any of the jobs identified in the Labor Market Survey were actually available to the claimant. The WCAB once again rejected the employer's arguments regarding the Suspension Petition. The WCAB also affirmed the WCJ's modification of the award of unreasonable contest attorney's fees. The employer appealed to the Commonwealth Court.

First, the Court reversed the WCAB's affirmation of the WCJ's denial of the Suspension Petition. In doing so, the Court found that the employer's evidence did establish, based upon a totality of the circumstances, that claimant had voluntarily withdrawn from the workforce. The Court noted that an employer who can show that the claimant has voluntarily withdrawn himself from the workforce, but is otherwise found capable of working in some capacity, need not present any evidence of actual job availability (either by specific referrals or through a Labor Market Survey). The burden on the employer is to establish a voluntarily withdrawal from the workforce based upon a *totality of the circumstances.* If an employer satisfies this initial burden, then the burden shifts to the claimant to show that he is still seeking employment after retirement OR that he was forced to withdraw from the workforce due to his work-related injury.

In this case, the Court pointed to the following evidence in support of a voluntary withdrawal from the workforce by claimant: (1) claimant had not worked since his third work injury occurred; (2) soon after he stopped working, he applied for and received a retirement pension and a Social Security Disability pension; (3) he was deemed capable of working in a full-time, sedentary duty capacity; and (4) despite having received the Notice of Ability to Return to Work which notified him of his obligation to look for work, he had not attempted to even look for work because he felt incapable of working at all. The Court also found that claimant did not rebut the employer's evidence of a voluntary withdrawal from the workforce. Additionally, the Court reversed the WCJ's award of unreasonable contest fees as the employer ultimately prevailed on the Suspension Petition.

In light of the Court's decision regarding the Suspension Petition, it did not address the issues pertaining to the employer's Modification Petition as they were deemed moot.

Conclusion and Practical Advice: While an employer that seeks to suspend a claimant's benefits on the theory that he has voluntarily withdrawn from the workforce need not actually show evidence of available jobs (as this element is not required once the employer satisfies the burden of establishing a voluntary withdrawal), it is reasonable that the employer should either offer an available job or identify jobs within the claimant's Labor Market as an alternate grounds for suspending or modifying the claimant's benefits.

CVA, Inc. and State Workers' Insurance Fund v. WCAB (Riley), No. 2658 C.D. 2010 (Commw. Ct., 10/14/2011)

Issue: Whether the employer violated the Act by unilaterally refusing to pay the claimant's medical bills, even though there was no dispute that a work-related injury had been accepted, at least from a medical standpoint.

Answer: Yes. The employer violated the Act by failing to pay for claimant's medical bills when the bills were for treatment related to the accepted work injury, and the employer had not pursued avenues to challenge the reasonableness and necessity or the cost of these bills via Utilization Review, Fee Review, or a Petition to Review Medical Treatment.

Analysis: Claimant was injured while working for the employer on October 18, 2007. Even though no Bureau documents were ever issued, the employer acknowledged that it had recognized a work-related left knee injury. Claimant filed a Penalty Petition alleging that the employer had failed to pay his medical bills from Bristol Family Practice and Medical Center (provider).

At the only hearing before the WCJ, the parties were instructed to submit their respective evidence and Briefs within three months. Claimant submitted the HCFA billing statements from the provider (for numerous Therapeutic Magnetic Resonance (TMR) treatments between May of 2008 and June of 2009), the corresponding medical reports for these bills, and denial letters that had been sent to the provider by the employer. Some of the denial letters indicated that the bills were denied because the "documentation does not support charges as billed." Other denial letters indicated that "it has been determined that the current medical treatment is not causally related to the original accepted work injury." Beginning February 19, 2009, the employer began downcoding many of the bills and paid a lesser amount for each treatment. The claimant did not seek a penalty on the downcoded bills.

The employer objected to the claimant's evidentiary submissions as hearsay, but the WCJ overruled this objection. Otherwise, the employer presented no evidence in opposition to the Penalty Petition and did not submit a Brief to the WCJ.

The WCJ accepted claimant's evidence as credible and found that it established that the treatment at issue was for claimant's left knee, that the bills had been submitted on the proper forms, and that they had been denied by the employer. The WCJ found that the employer had, without explanation, refused to pay a number of the provider's bills, with the total outstanding balance equaling $140,876.00. Because the employer had not filed a Utilization Review Request, nor had it sought an IME or a records review, the WCJ found that the employer had acted unreasonably in denying payment of these bills in violation of the Act. Accordingly, the WCJ ordered the employer to pay a fifty percent (50%) penalty on the unpaid bills and also assessed an award of quantum meruit attorney's fees against the employer.

The employer appealed and the WCAB affirmed. The employer then appealed to the Commonwealth Court which affirmed the decisions below.

The Court noted that, under Section 306(f.1)(5) of the Act, an employer must pay the claimant's medical bills within thirty (30) days of receiving them, unless the employer disputes the reasonableness and necessity of the treatment, at which point it should refer the bills for Utilization Review or risk the imposition of a penalty. If the employer denies payment of the bills on the basis that they are not related to the recognized work injury, it also faces a penalty situation if the WCJ ultimately determines that the treatment at issue is causally related to the work injury.

The Court rejected the employer's assertion that claimant's evidence contained inadmissible hearsay. The Court held that Section 422(c) of the Act provides for the submission of medical reports in any litigation involving fifty-two weeks or less of disability, and further held that this Section of the Act applied to the instant case because the litigation merely involved the issue of medical expenses and did not involve the length of claimant's disability, even though the claimant had been disabled by the work injury for more than fifty-two weeks. Accordingly, the Court held that claimant was not required to present medical testimony about the bills and treatment at issue and could simply submit medical reports under Section 422(c).

The Court also rejected the employer's argument that claimant's evidence failed to establish a causal relationship between the recognized work injury and the TMR treatments because the treatment was neither reasonable nor necessary as it is not "generally accepted" in the medical community, but, rather, is a novel medical procedure. The Court noted that the issues of "reasonableness and necessity" and "general acceptance in the medical community" are not relevant in determining whether a treatment is causally related to the work injury. Moreover, the Court noted that the WCJ had no jurisdiction to evaluate the reasonableness or necessity of the treatment because the employer had not reviewed any of the bills for Utilization Review.

Similarly, the Court rejected the employer's assertion that the costs of the treatment were excessive, presumably another basis for its argument of unreasonableness. The Court noted that the Bureau of Workers' Compensation, not WCJs, is charged with overseeing fee disputes under Section 306(f.1)(5) of the Act. Nonetheless, the provider in this case never pursued an Application for Fee Review for the unpaid medical bills.

The Court also rejected the employer's second argument that its due process rights were violated because it was denied the opportunity to confront and cross-examine witnesses. The Court noted that the employer had been provided with an opportunity to submit evidence and a Brief, but chose not to submit anything to the WCJ.

Finally, the Court rejected the employer's argument that the 50% fee was excessive and disproportionate, finding that it had failed to preserve this argument before the WCAB below. Nonetheless, the Court noted that the WCJ is empowered with ordering a penalty of up to 50% for violations of the Act involving "unreasonable or excessive delays." The Court agreed with the WCJ's finding that the employer's refusal to pay the bills at issue was unreasonable and excessive.

Conclusion and Practical Advice: The Court was clearly perturbed by the employer's persistent and unreasonable denial of the bills in this case, noting that the employer could have

pursued Utilization Review or even a Petition to Review Medical Treatment to challenge the reasonableness and necessity of the treatment and the excessive costs associated with the treatment.

The Court did not take issue with the fact that the employer had downcoded a number of the bills beginning in February of 2009. In fact, the Court noted that, had the employer "simply downcoded all of the bills, there would have been nothing on which to assess a penalty."

Clearly, the employer here allowed a significant amount of bills to accrue without taking any action to challenge the appropriateness of the bills and/or the treatment at issue. In doing so, the employer exposed itself to a penalty in excess of $70,000.00.

The workers' compensation practitioner should advise his or her clients to deny the bills and pursue Utilization Review if the treatment is thought to be neither reasonable nor necessary. If the client disagrees with the costs of treatment, it should attempt to downcode the bills by following the procedures set forth most recently in Jaeger v. Bureau of Workers' Compensation Fee Review Hearing Office (American Casualty of Reading c/o CNA), 24 A.3d 1097 (Pa. Commw. 2011). The provider can then challenge the downcoding if it so chooses. Finally, if the client disputes that the treatment is for the work injury at all, then it should file a Petition to Review Medical Treatment/Billing and litigate the issue before the WCJ. In summary, the client should make *some effort* to challenge the treatment at issue rather than simply allowing the bills to accumulate as was done in this case. Although the client may not completely shield itself from the imposition of penalties by taking the above action, it is certainly worthwhile to take a proactive approach to the billing dispute rather than taking the position that the employer did in the instant case.

Kennett Square Specialties and PMA Management Corp. v. WCAB (Cruz), No. 636 C.D. 2011 (Commw. Ct., 10/19/2011)

Issue: Whether a claimant's benefits can be suspended on the basis that he is an undocumented alien when he has failed to answer any questions about his immigration status and the WCJ has drawn an adverse inference against this refusal to answer such questions.

Answer: No. Unless there is independent evidence in the record to establish that the claimant is an undocumented alien, it is not sufficient for the WCJ to suspend the claimant's benefits based solely on an adverse inference drawn against him for failing to answer questions about his immigration status.

Analysis: The employer initially recognized a work-related injury of July 19, 2008 via an NTCP issued on August 8, 2008. On September 8, 2008, the employer issued a Notice Stopping Temporary Compensation and also an NCD. The claimant filed a Claim Petition the next day wherein he alleged a low back injury. The employer filed an Answer denying the allegations of the Claim Petition.

During a hearing before the WCJ, the claimant refused to answer any questions on cross-examination regarding his citizenship/immigration status. The medical experts for each side agreed that claimant had sustained a lumbar disc herniation at L5-S1 with radiculopathy and could not return to work for the employer as a truck driver, but both experts felt that claimant was otherwise capable of working in a modified duty capacity.

The WCJ granted claimant's Claim Petition, finding that he had sustained a work-related low back injury on July 19, 2008. In doing so, the WCJ ordered the employer to pay claimant's reasonable and necessary medical expenses for treatment related to the work injury. However, the WCJ suspended claimant's benefits effective July 19, 2008 on the basis that claimant was an undocumented alien worker. The WCJ explained that he had drawn an adverse inference from claimant's refusal to answer any questions about his immigration status.

Claimant appealed and the WCAB reversed the WCJ's suspension, citing a lack of substantial evidence in the record to support the WCJ's finding that claimant was an undocumented alien worker. The employer appealed to the Commonwealth Court which affirmed the WCAB.

The Court noted that an undocumented alien worker's status alone does not render him ineligible for receiving disability benefits under the Workers' Compensation Act. However, if there is evidence that the worker is capable of working in *some* capacity (even modified duty), the employer is entitled to a suspension of the worker's indemnity benefits by reason of the worker's undocumented alien status, and need not show any evidence of job availability under Kachinski.

There was no dispute between the parties' medical experts that claimant was capable of working in some capacity, albeit not in his pre-injury position. However, the employer did not present any independent evidence of the claimant's immigration status. Therefore, the only

information on this issue in the record was the claimant's failure to answer questions posed by employer's counsel, from which the WCJ drew an adverse inference.

The Court concluded that an adverse inference does not constitute evidence. Rather, it has been held by our appellate courts that an adverse inference drawn from a party's failure to testify can serve to corroborate the evidence produced by the opposing party, but is insufficient, in and of itself, to satisfy the opposing party's burden of proof.

In one of its footnotes, the Court addressed the employer's argument that it had no way in which to demonstrate claimant's immigration status after he failed to answer questions in this regard. Specifically, the Court noted that 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 the I-9 form.

Conclusion and Practical Advice: The workers' compensation practitioner should always ask the claimant about his or her immigration status. If the claimant refuses to answer these questions, as was the situation in this case, the practitioner should obtain documentation from the employer regarding claimant's Social Security Number, Green Card status, etc. Even if the employer has documentation which indicates that the claimant presented a Social Security card at the time of hire, the practitioner should recommend that further investigation be taken to confirm whether the Social Security Number is actually valid and/or associated with this claimant, as there have been cases where the workers purchased fraudulent Social Security cards which they presented to their employers to make it appear that they were U.S. citizens.

__City of Philadelphia v. WCAB (Kriebel)__, **No. 49 EAP 2010 (Supreme Ct., 10/19/2011)**

Issue: Whether the employer was able to overcome the rebuttable presumption of disease causation as set forth in Section 108(m.1) of the Act when the employer's medical expert based his opinion upon a lone notation of drug use in the decedent's medical records from more than thirty years earlier that was otherwise unsubstantiated by any of the other medical records available to both experts.

Answer: No. The employer's medical evidence was insufficient to rebut the presumption of disease causation because the expert's opinion was based a single record which indicated that the decedent had a history of drug use and had contracted Hepatitis B in 1969, which the expert relied upon in order to opine that (1) the decedent had contracted Hepatitis B as a result of his drug use, which most likely involved sharing contaminated needles, and (2) that he most likely contracted Hepatitis C (the disease at issue in this matter) via the same means.

Analysis: The decedent worked as a firefighter for the employer from 1974 until 2003. He was diagnosed with Hepatitis C in 1997. On October 25, 2004, the decedent died from liver disease caused by Hepatitis C. The decedent's wife (appellant) filed a Claim Petition, and later a Fatal Claim Petition, through which she alleged that the decedent had contracted Hepatitis C as a result of his employment with the employer. Appellant relied upon the rebuttable presumption, set forth in Section 108(m.1) of the Act, that professional and volunteer firefighters with Hepatitis C contracted it in the course of their employment.

Appellant presented factual testimony from one of the decedent's fellow firefighters. This witness testified that the decedent had been exposed to the blood of victims throughout his employment as a firefighter for the employer. The witness also testified that he had observed the decedent with torn gloves and blood on his hands, and further explained that the employer had no specific procedures following exposure to blood other than to "just wash [it] off."

Appellant also presented medical testimony from Dr. Victor Navarro who began treating the decedent in 2002. Dr. Navarro opined that the decedent had most likely contracted Hepatitis C while working as a firefighter, and that this condition developed into cirrhosis of the liver, which ultimately caused hepatocellular carcinoma, a form of liver cancer, that caused the decedent's death.

The employer presented medical testimony from Dr. Stephen Gluckman who agreed that the decedent suffered from Hepatitis C which led to cirrhosis, cancer and, ultimately, death. However, Dr. Gluckman disagreed that the decedent had contracted Hepatitis C as a result of his work as a firefighter. Rather, Dr. Gluckman opined that the decedent had contracted this condition as a result of drug use, and he based this conclusion upon a medical record from 1971 which indicated that the decedent had contracted "serum hepatitis from drug usage" in 1969. Although Dr. Gluckman admitted that "serum" Hepatitis now referred to as Hepatitis B, he explained that this condition is often transmitted through needle-related drug use, which is a common manner of transmitting Hepatitis C as well. Dr. Gluckman also pointed to the fact that the complications from Hepatitis C (i.e. cirrhosis) typically manifest approximately thirty years after the initial exposure to the disease, which he felt was consistent with the decedent's drug use in 1969. Additionally, Dr. Gluckman testified that he saw nothing

in the decedent's medical records to suggest that the blood he had been exposed to as a firefighter had ever penetrated his skin.

The WCJ credited Dr. Gluckman's testimony over that of Dr. Navarro and denied appellant's Fatal Claim Petition. Appellant appealed and the WCAB reversed on the basis that Dr. Gluckman had "impermissibly 'parroted' the opinion of another expert and failed to offer an assessment based on his own expertise and judgment," and had also "impermissibly assumed … that decedent used needle-based drugs when there was no evidence of record to substantiate the finding." The employer appealed to the Commonwealth Court which reversed, finding that Dr. Gluckman's testimony "constituted substantial, competent evidence to rebut the statutory presumption." Appellant appealed to the Supreme Court, which ultimately reversed the Commonwealth Court and reinstated the decision of the WCAB.

The Supreme Court noted that, once a claimant establishes that he suffers from an enumerated occupational disease, he is entitled to the presumption that the disease arose during the course of his employment, at which point the burden shifts to the employer to rebut the presumption with substantial, competent evidence. In order to qualify as substantial, competent evidence, the medical expert must base his opinion upon fact which are supported by the evidence of record, and cannot rely on facts that are assumed or are unproven.

The Court held that Dr. Gluckman's opinions did not qualify as substantial, competent evidence because they were based upon a series of assumptions that lack a factual predicate. Specifically, Dr. Gluckman relied upon "the lone notation in the 1971 medical record" which documented "serum hepatitis from drug usage" in order to *reason* that the decedent's drug use was intravenous, that he shared needles and had used a contaminated needle which led him to contract Hepatitis B, and that he contemporaneously contracted Hepatitis C by using a contaminated needle. The Court noted that there was no was "absolutely no evidence in the subsequent thirty years of medical records to corroborate the finding that Decedent was an intravenous drug user." Therefore, the Court held that Dr. Gluckman's opinions constituted "nothing but conjecture and speculation" which renders them incompetent and insufficient to rebut the statutory presumption.

Conclusion and Practical Advice: An employer seeking to rebut a statutory presumption of occupational disease must present substantial, competent medical evidence which is based upon facts that are supported by the remaining evidence of record. If the employer's expert relies upon facts not in evidence, or renders conclusions based upon faulty assumptions, the expert's opinion will not be competent evidence and, therefore, cannot overcome the rebuttable presumption.

Habib v. WCAB (John Roth Paving Pavemasters), No. 2612 C.D. 2010 (Commw. Ct., 10/20/2011 – previously unreported, 8/12/2011)

Issue: Whether the employer established that claimant had violated a positive work order in performing the conduct that caused his injury, thereby rendering him ineligible for benefits under the Act.

Answer: Yes. The employer established its affirmative defense that claimant violated a positive work order by presenting evidence that claimant was instructed by a supervisor to stop his behavior immediately prior to engaging in that behavior a second time which caused his work injury, and that this behavior was not connected to the claimant's work duties.

Analysis: Claimant worked as a laborer for the employer. On May 23, 2008, the claimant and his fellow crew members were awaiting delivery of another truckload of asphalt when someone found a bowling ball next to the parking lot where they were working. "After a round of shot-put, a challenge arose to see if anyone could break the bowling ball with a sledge hammer." Claimant struck the bowling ball with the sledge hammer, cracking the bowling ball. Claimant's foreman reportedly told claimant to "knock it off" or "stop" and that he would not take him to the hospital if he got hurt. Nonetheless, claimant struck the bowling ball with the sledge hammer a second time, and this time a piece time of the bowling ball broke off and struck claimant in the eye. Claimant suffered a laceration, and ultimately, a total loss of his right eye.

Claimant filed a Claim Petition against the employer. The WCJ granted the Claim Petition, rejecting the employer's position that the claimant had violated a positive work order by striking the bowling ball a second time after his foreman instructed him to stop. The WCJ acknowledged the foreman's order to the claimant, but found that "it was not made sufficiently in advance to be considered a positive work order under the law." The employer appealed and the WCAB reversed, finding that the WCJ had erred in its legal conclusion regarding the issue of a positive work order violation. Claimant appealed to the Commonwealth Court which affirmed the WCAB.

The Court rejected claimant's arguments that the WCAB had exceeded its authority on appeal by failing to give the proper weight to the facts and credibility determinations of the WCJ. The Court held that the WCAB did not dispute any of the WCJ's factual findings or credibility determinations. The Court held that the WCAB merely corrected the WCJ's error of law, which is precisely within its scope of review.

The Court noted that, once a claimant proves all of the necessary elements to support an award of compensation, the burden shifts to the employer to prove, in defense, that the claimant was in violation of a positive work order when the claimant was injured. The elements of this defense are as follows: (1) the injury was, in fact, caused by the violation of the order or rule; (2) the employee actually knew of the order or rule; and (3) the order or rule implicated an activity not connected with the employee's work duties. The Court further noted that this defense is essentially a claim that the injury sustained by the claimant was not an injury which arose in the course of employment.

The Court agreed with the WCAB that the facts as accepted by the WCJ established that claimant was specifically told not to strike the bowling ball again (#2), that it was not part of claimant's work duties to break bowling balls with a sledge hammer (#3), and that he sustained an injury to his right eye after striking the ball a second time and causing a part of the ball to break off and cut his eye (#1). Therefore, the employer had successfully satisfied the elements of its defense, and established that claimant's injury was not compensable under the Act.

Conclusion and Practical Advice: Even though there was no dispute as to how claimant's injury occurred or the extent to which his eye had been damaged, the employer was nonetheless able to successfully defend against the Claim Petition on the basis that the claimant had violated a positive work order.

It is interesting that the WCJ rejected this defense on the basis that the positive work order had not been made sufficiently in advance of the injury-causing conduct. It is not clear from this opinion as to whether the WCJ elaborated on his position, and whether s/he felt that a certain amount of time would need to elapse between the communication of the order and the violating behavior. However, the Court obviously did not agree with the WCJ and did not set forth any specific timeframes needed to successfully establish positive work order violation defense. To the contrary, the Court's holding in this case should be helpful in similar cases where a claimant is already engaging in the violating behavior, is then told to stop this behavior by the supervisor, but continues to do so and is ultimately injured. It would seem that, as long as the employer is able to present credible evidence that the directive was actually communicated to the claimant before s/he engaged in the final behavior that caused the injury, the employer should be able to successfully defend a Claim Petition for benefits.

<u>Roman Catholic Diocese of Allentown v. Bureau of Workers' Compensation, Fee Review Hearing Office (Lehigh Valley Health Network)</u>, No. 2711 C.D. 2010 (Commw. Ct. 10/28/2011)

Issue: Whether the Bureau and Fee Review Hearing Office properly determined claimant's treatment by the Provider (Hospital) to be "trauma" care, and thus exempt from the medical fee caps in the cost containment provisions of the Act.

Answer: Yes. Claimant's care by the Provider was appropriately deemed "trauma" care because it was treatment for immediately life-threatening or urgent injuries; therefore, the employer was responsible to pay for this treatment at 100% of the billed amount.

Analysis: Section 127.128 of the Workers' Compensation Medical Cost Containment (MCC) regulations holds that "acute care provided in a trauma center or burn facility is exempt from the medical fee caps, and shall be paid based on 100% of usual and customary charges" if, amongst other prerequisites, the patient has an immediately life-threatening or urgent injury, and the services are provided in a level I or II trauma center that is accredited by the Pennsylvania Trauma Systems Foundation. Also exempt from the fee cap provisions are services provided in the transport of patients to trauma centers. Moreover, the Regulations also state that "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 [American College of Surgeons] triage guidelines."

In this case, the claimant was a 72-year-old priest who slipped and fell on an icy sidewalk in January of 2009. He was not discovered until five minutes later, and an EMS ambulance arrived ten minutes after this initial discovery. At the scene, claimant complained of severe back pain and reported that he had struck his head (but did not lose consciousness). He also told the EMS unit that he had a history of a fused cervical spine.

The EMS unit contacted the Provider's medical command center and transported the claimant to the Provider's hospital. Upon arrival at the hospital, Provider's physicians determined that claimant's injuries included two unstable spinal fractures. Accordingly, claimant was admitted as a trauma patient and placed in the Trauma-Neuro ICU. He underwent spinal surgery two days later, and remained a "trauma patient" until he was discharged. Provider/hospital was, at all time, an accredited level I trauma center.

In May of 2009, Provider submitted a bill for all of the relevant treatment totaling $406,338.79. In November of 2009, the employer issued an Explanation of Benefits (EOB), approving payment of the Provider's services under the Workers' Compensation fee schedule. This fee schedule adjustment reduced the Provider's bill to $142,196.00, which the employer paid.

Three days after receiving this EOB, the Provider filed a fee review application. The Bureau held that the treatment qualified as trauma care and should have been paid at 100%. As

such, the Bureau directed the employer to pay the remaining balance of $264,142.79, plus interest. Employer appealed and requested a fee review hearing.

The Fee Review Hearing Officer heard testimony from (1) the employer's fee auditor/reviewer and assets recovery specialist, (2) the Provider's physician, and (3) the Provider's director of patient financial services. The employer was precluded from presenting testimony from its medical expert because it did not identify this witness in the required pre-trial submissions, and waited until the date of the hearing to request that the witness be allowed to testify by phone, even though this was contrary to the Hearing Officer's written rules for the presentation of witnesses. The Hearing Officer affirmed the Bureau's determination, and the employer appealed.

On appeal to the Commonwealth Court, the employer raised three arguments: (1) the Hearing Officer erred in failing to dismiss the Provider's fee review application as untimely; (2) the Hearing Officer erred in failing to reverse the Bureau's decision because the evidence failed to establish that the claimant's injuries were "immediately life-threatening" or "urgent;" and (3) the Hearing Officer violated the employer's constitutional right of due process by precluding the testimony of its medical expert. The Court ultimately affirmed the decisions below.

Regarding the employer's first argument, the Court noted that, per Section 306(f.1)(5) of the Act, a provider may file an application for fee review "no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment." The Court held that the Provider clearly filed its fee review application within 30 days of receiving notification of disputed treatment (i.e. the EOB indicating that the treatment would only be paid at a re-priced amount). Therefore, the Court rejected this argument outright.

In terms of the employer's second argument, the Court held that there was substantial, competent evidence of record to support a finding that the claimant's injuries were immediately life-threatening or urgent, pointing to the claimant's advanced age (72 years old) and his complaints of severe back pain. Additionally, the Court gave deference to the efforts and judgment of the EMS unit, and noted that the EMS' determination of "immediately life-threatening or urgent" is presumed to be reasonable and necessary absent any clear evidence of a violation of the ACS guidelines, which the Court did not find in this case. Furthermore, the Court noted that the ACS guidelines even state that spinal fractures are considered life-threatening or urgent because they can lead to paralysis. Based upon these findings, the Court held that the decisions of the Bureau and Hearing Officer were supported by the substantial, competent evidence of record.

Finally, the Court rejected the employer's argument that it was denied due process when the Hearing Officer precluded the testimony of its expert. The Court noted that the right to present witnesses is not absolute, and held that the employer in this case failed to follow the proper steps set forth by the Hearing Officer in advance of the hearing.

Conclusion and Practical Advice: The Court appears to have given great weight and deference to the assessment of the EMS personnel and Provider's personnel who initially evaluated the claimant and deemed him a "trauma patient." Although the facts of this case

(based upon the evidence presented) appear clear that the claimant's condition was life-threatening or urgent, one might wonder if the decision would have been different had the employer been allowed to present its medical expert's testimony.

Unfortunately for the employer here, it failed to follow the established protocol for identifying and presenting witnesses. To avoid a similar outcome in a case where the Hearing Officer or Judge requires pre-trial forms, defense counsel should attempt to identify all potential witnesses at the outset of the case, or as the need for such witnesses develops, and should not assume that a witness will be allowed to testify if the first mention of such witness is made at the time of the actual hearing.