

**THE MONTH IN PENNSYLVANIA WORKERS' COMPENSATION:
JUNE 2011 AT A GLANCE
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VOCATIONAL

- Whether the employer is required to provide a description of the job being offered to the claimant within his or her restrictions depends upon whether the employer is offering the claimant a pre-injury position or a different position that fits within claimant's restrictions.

Where the employer is providing referral to jobs that the claimant has not been previously employed in, the employer must provide information related to the job duties and the classification so that the claimant can make an informed decision regarding whether the position offered is within his or her capabilities.

Where the employer is offering claimant a light duty position that the claimant has previously performed, no job position or job duties must be specified. The employer need not specify the job position or duties since the claimant can reasonably assume that he or she is being offered the same position that he or she previously worked, and thus, is familiar with requirements of that position.

Therefore, the WCJ did not commit an error of law by granting the employer's Petition For Suspension/Modification where the employer's job notification letter merely advised the claimant that his "activities at work will be modified to accommodate the restrictions" of his doctor, which were enclosed, but did not give a specific description of the job being offered because the claimant was being offered his pre-injury job - meaning the letter contained sufficient information to enable the claimant to make an informed decision about whether the proposed position was within his capabilities.

Vaughn v. WCAB (Carrara Steel Erectors) No. 1790 C.B. 2010 (decision by Judge Butler, March 11, 2011). 7/11

CREDIT

- The offset provided for pension benefits is only appropriate to the extent that the pension is funded by the employer directly liable for payment of compensation. The Bureau Regulations provide that the offset is dollar-for-dollar and is applicable to both defined benefit and defined contribution plans.

A Defined Benefit Plan is a pension plan in which the benefit level is established at the commencement of the plan and actuarial calculations determine the varying contributions necessary to fund the benefit at an employee's retirement.

A defined benefit plan is funded collectively with the employer's contributions pooled in a common trust fund from which all participants receive their benefits. The employee receives a said amount based on factors known only at retirement, such as length of employment and retirement age.

A Defined Contribution Plan is a pension plan which provides for an individual account for each participant for benefits based solely upon the amount of accumulated contributions and earnings in the participant's account.

- An employer using a defined benefit plan need not show the actual contributions made to a specific account in order to obtain a pension benefit offset but can rely upon expert actuarial testimony to meet its evidentiary burden.

Horner v. WCAB (Liquor Control Board) No.2155 C.D. 2010 (Decision by Judge McCullough, June 14, 2011). 7/11

MEDICAL BILL/FEE REVIEW/EVIDENCE

- The Hearing Officer, upon ruling on Provider's Fee Review Petition, did not commit an error of law by reversing the Bureau by finding that the carrier did not improperly down code the provider's bills for VAX-D treatment where the carrier downcoded the bills from "miscellaneous physical therapy" to "mechanical traction."

This is because the carrier is permitted to downcode a provider's billing codes pursuant to Section 306(f.1)(3)(viii), which allows an insurer to change, or "downcode," a provider's billing codes if the change is consistent with Medicare guidelines and the insurer has sufficient information to make the change after consulting with the provider.

It is also required that the carrier comply with regulation 127.207, which provides that the provider is to be given notification in writing of the proposed changes, the facts in support of those changes and the ***provider is to be given 10 days to respond to the notice of the proposed changes.***

In this matter, the provider did not respond to the changes within 10 days of receiving notification of those changes.

- It is the carrier's burden to have written evidence of the date notice was sent to the provider.

- The ten day letter sent by the carrier advising the Provider its invoice was being downcoded was admissible into evidence before the Hearing Officer adjudicating the Provider's Fee Review Petition despite the fact it was unsigned and the carrier's witness testified that she did not personally draft or mail the letter. The letter was not rendered inadmissible on hearsay grounds because a fee review proceeding is not bound by the strict rules of evidence.

Nevertheless, the copies of the 10 day letters produced by the insurer fell within Pennsylvania's hearsay exception for business records Pa.R.E. 803(6).

Accordingly, the insurer was not required to produce the person who drafted the letters or the custodian of the letters at the time the entries were made, nor was the insurer's qualifying witness required to have personal knowledge of the content of the records. Instead, since the documents were generated in the regular course of business there was no reason to doubt their trustworthiness.

- The fee review hearing at the hearing officer level, which follows the Bureau level, it is a *de novo* hearing and the Bureau's investigation is no longer relevant.

The party aggrieved by the Bureau's resolution of a medical fee review may request a *de novo* proceeding before the Hearing Officer. During a hearing review hearing, the insurer bears a burden of proving by preponderance of the evidence that it acted properly in down coding or reimbursing the provider.

A hearing officer is a fact finder and the Court will not be weighing evidence or substitute its credibility determinations for those of the Hearing Officer.

Scott H. Jaeger, M.D. v. Bureau Workers' Compensation Fee Review Hearing Office (American Casualty of Reading) c/o. CNA, (No. 2205 C.D. 2010) (decision by Judge Leavitt, June 22, 2011). 7/11

REINSTATEMENT/MEDICAL TESTIMONY

- A claimant who filed a Petition for Reinstatement after his compensation was suspended by virtue of a Stipulation wherein the claimant agreed that he was now disabled due to a non-work related injury meaning his earning power was impacted by both a work injury and a non-work related injury, had the burden to prove that there had been a change of physical condition or circumstances since the last proceeding addressing the nature and extent of disability.

The claimant was required to show that the non-work related injury was no longer disabling and that the work related injuries were now causing the loss of earning power.

- The claimant did not fulfill his burden of proof in support of his Petition for Reinstatement where in prior litigation the claimant stipulated that after he returned to his pre-injury job in October 2004 he missed no time from work because of his work injury and that he left work in December 2004 for reasons unrelated to his work injury, which means the claimant would have continued to perform his pre-injury job without restrictions but for his non-work related problems. The claimant had to show that the reason for the suspension of his benefits in December 2004 no longer existed in order to reinstate his total disability benefits.
- Where a claimant's earning power is affected by both a work injury and a non-work injury, the claimant seeking reinstatement must prove that "there has been a change of physical condition or circumstance since the last legal proceeding addressing the nature and extent of the disability.
- The claimant's medical expert's testimony did not support his Petition for Reinstatement where the doctor's opinions were based upon the incorrect information that the claimant was disabled by his work injury because he had earlier attempted to return to his regular job but could not do it and this testimony directly contradicted the claimant's own signed stipulation of facts.
- A claimant upon filing a Petition for Reinstatement was bound by the facts established by the stipulation and was required to show that *something changed in his condition or circumstances* after the WCJ's decision adopting the stipulation.
- A claimant seeking a reinstatement of suspended benefits must prove that the reason for the suspension no longer exists. In general, the claimant has burden of proving that:
 1. His earning power, or disability, is once again adversely affected by his work injury, and
 2. That the new disability is related to the original injury.

Upper Darby Township v. WCAB (Nicastro), No. 1285 2010 (decision by Judge Leavitt, March 17, 2011). 7/11