MARSHALL DENNEHEY

WHAT'S HOT IN WORKERS' COMP

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Delaware Workers' Compensation

By Paul V. Tatlow, Esquire | 302.552.4035 | pvtatlow@mdwcg.com

Paul V. Tatlow

The Superior Court holds that the Board correctly ruled that the claimant was required to execute a Receipt which states that the work injury had resolved where this reflected the finding made in a prior Board decision.

Dawn Peer v. State of Delaware, (C.A. No. K20A-02-001 WLW-Decided Oct. 29, 2020)

This case came before the court on the claimant's appeal from the Board's decision which the claimant contended should be reversed since it contained errors of law. There were actually two Board decisions in this case that were intertwined. The first decision was issued October 9, 2019, and granted the claimant's petition. In this decision, it was found that on April 17, 2019, the claimant suffered a compensable work injury while driving a bus for the employer when she was involved in a rear-end collision and sustained injuries to her head, shoulder, neck and lower back. The claimant was awarded compensation for a closed period of temporary total disability from April 17, 2019 to June 25, 2019. Importantly, the Board's decision found that the injuries had resolved as of the latter date.

Subsequent to that decision, the employer sent the claimant an Agreement and Receipt of Compensation Paid reflecting the period of disability also stating: "Per Board Order of October 9, 2019, the Claimant's injuries resolved by June 25, 2019." On the advice of her counsel, the claimant signed the documents, but crossed out the language on the Receipt indicating that the injuries had resolved. The employer filed for a legal hearing before the Board, following which the Board issued the second decision dated January 15, 2020, affirming the initial decision by finding that the claimant's compensable injuries had resolved and directing the claimant to execute the legal documents in their original form.

The claimant's argument on appeal was that the purpose of a Receipt is merely to acknowledge the compensation benefits the employer has paid but that, if the claimant signs the Receipt with language stating the injury has resolved, it would effectively terminate her claim in the same manner as a commutation. The employer's counter argument was that the claimant's appeal was in essence an effort to appeal the Board's first decision of October 9, 2019, which found that the injury had resolved, but the time for taking an appeal had passed. The employer further argued that the "resolved" language in the Receipt simply reflected what the Board had found in its initial decision.

The Superior Court agreed with the employer's argument and proceeded to dismiss the claimant's appeal. In so doing, the court reasoned that the Board's initial decision, that the claimant's compensable injuries had resolved as of June 25, 2019, was based on the testimony of medical experts and surveillance evidence showing the claimant conducting herself in a manner inconsistent with someone continuing to suffer residual injuries. The court

reasoned that since the initial Board decision was clearly based on substantial evidence and contained no errors of law, the Board was correct in its second decision directing the claimant to execute the Receipt as prepared by the employer, including the "resolved" language.

This case illustrates that while in Delaware the typical Receipt of Compensation Paid does not include language stating that an injury has resolved, it is legally permissible where the parties either agree to it or, as in this case, where the Board has made such a determination.

Florida Workers' Compensation

By Linda W. Farrell, Esquire | 904.358.4224 | lwfarrell@mdwcg.com

Linda W. Farrell

The court finds that there was no competent or substantial evidence to support that the employer/carrier had only accepted the aggravation. Therefore, the employer/carrier waived the ability to deny compensability. As such, the apportionment defense also fails, and the full permanent impairment benefits were owed by the employer/carrier.

Joe Sullivan v. NuC02, LLC/Broadspire, No. 1D19-3275, First District Court of Appeal, Decision date: Dec. 9, 2020

The claimant appealed the Judge of Compensation Claims' order, which apportioned impairment benefits and future medical treatment. The claimant had injured his right shoulder in a compensable accident in August 2016. Following an MRI and one-time change request, Dr. Steen performed right shoulder surgery in February 2017. In January 2018, the claimant was placed at maximum medical improvement with an 18% permanent impairment rating. After conferencing with the employer/carrier's attorney, Dr. Steen indicated that the claimant's pre-existing condition was the major contributing cause of the need for any future medical care. The doctor also apportioned 60% to the pre-existing condition and 40% to the work accident. Thereafter, the employer/carrier de-authorized the doctor from providing further care and reduced the claimant's impairment benefits based on the apportionment per the doctor.

Relative to the defense of major contributing cause, the claimant raised waiver under the 120-day rule.

Following each parties IMEs, the judge appointed an Expert Medical Advisor (EMA) and afforded those opinions as presumptively correct. Based on the EMA's opinion, the judge ordered that the employer/carrier to pay 70% of the impairment benefits based on the 18% permanent impairment rating. The judge also awarded authorization of Dr. Steen, but only to provide palliative care for the aggravation to the shoulder.

The First District Court of Appeal reversed the judge, finding that there was no competent substantial evidence to support that the employer/carrier had only accepted the aggravation. Therefore, the employer/carrier had waived the ability to deny compensability. As such, the apportionment defense also failed, and the court indicated that the full permanent impairment benefits were owed by the employer/carrier.

The employer/carrier cross appealed the judge's acceptance of Dr. Steen's 18% permanent impairment rating over the EMA doctor's opinion of 12%. The court indicated that because the employer/carrier had listed the impairment rating as 18% on the pre-trial stipulation, there was not enough information to show that they expressly disputed the total permanent impairment rating.

The employer/carrier also argued that the judge erred by awarding continued care with Dr. Steen because they have the right to control the selection of the treating physicians. The court pointed out that the employer/carrier did select and authorize that doctor based on the claimant's one-time change request. The court then turned to the issue of whether the employer/carrier had properly de-authorized Dr. Steen in April 2018. They noted that, as a general rule, a unilateral de-authorization of an authorized treating physician is not permitted. The statute and case law provide only a few exceptions to this general rule. The employer/carrier contended that their de-authorization was valid because the doctor had opined that the work injury was no longer the major contributing cause of the need for medical care. However, the employer/carrier did not prevail on that issue, so their argument failed.

The court reversed the judge's order apportioning the claims for indemnity and medical benefits, affirmed the issues on cross-appeal and remanded for entry of an order consistent with the opinion.

New Jersey Workers' Compensation

By Dario J. Badalamenti, Esquire | 973.618.4122 | djbadalamenti@mdwcg.com

Dario J. Badalamenti

The Appellate Division affirms a Judge of Compensation's dismissal of petitioner's occupational exposure claims as being time-barred based on an assessment of the credibility of petitioner's own testimony and petitioner's reliance on the "net opinion" of his medical expert.

Bender v. Twnp. of North Bergen, DOCKET NO. A-4564-18T3 (Appellate Division, Decided Dec. 24, 2020)

This Appellate Division decision addresses proof issues as to the statue of limitations in the context of occupational exposure claims. Under N.J.S.A. 34:15-34, an injured worker must file a petition for compensable occupational exposure within two years of the date on which he discovers the nature of the disability and its relationship to his employment. Here, the Judge of Compensation's factual findings and credibility determinations led to a conclusion that the injured worker's claims for occupational exposure were time-barred as he failed to comply with the appropriate statute of limitations.

The petitioner had been employed as a police officer with the respondent from 1979 until his retirement in 2004. On October 4, 2007, he filed claims with the Division of Workers' Compensation, alleging occupational orthopedic and psychiatric disability. At trial, the petitioner testified about his exposure to various gruesome assignments and trauma during his years as a police officer. He further testified that in 2002, he began experiencing negative psychiatric issues as a result of this exposure. He alleged that the stress led him to retire. Despite suffering from what he perceived to be an occupationally-related psychological condition, he did not report his condition nor file a claim until five years later.

As to his orthopedic injuries, the petitioner testified that he did not realize until 2007 that his orthopedic injuries, which necessitated surgery to his neck, back, right knee and left shoulder, resulted from "numerous falls, motor vehicle accidents, lifting stretchers" and fights during his tenure as a police officer. Rather, he contended that these injuries were progressive and did not manifest themselves until less than two years before filing his claim petition in 2007.

At the conclusion of trial, the Judge of Compensation found that the petitioner's claims were time barred as they had not been filed within two years of the petitioner having had knowledge of the nature of his orthopedic and psychiatric disabilities and their relation to his employment. The judge dismissed the claims, and the petitioner appealed.

The Appellate Division affirmed the Judge of Compensation's decision that the petition claiming psychiatric occupational disease was not filed within two years of the date on which the petitioner knew the nature of his disability and its relation to his employment. However, the Appellate Division was unable to determine from a reading of the decision whether, or on what basis, the Judge of Compensation decided the compensability of the occupational orthopedic claim. Accordingly, the Appellate Division remanded as to the dismissal of the orthopedic claim, instructing the judge to make a finding as to whether the petitioner filed his claim regarding his orthopedic injuries within the appropriate statute of limitations.

In setting forth the reasons why he concluded the petitioner had not timely filed his orthopedic claim petition, the Judge of Compensation cited the credibility of the petitioner's testimony and the opinion of his medical expert, Dr. Floyd Krengel. According to the judge, Dr. Krengel's opinion that the petitioner's orthopedic injuries were causally related to occupational exposure was a "net opinion" with no support in factual evidence. *See Jimenez v. GNOC, Corp.*, 286 N.J.Super. 533, 540 (App. Div. 1996); *see also Townsend v. Pierre*, 221 N.J. 36, 54 (2015). Furthermore, the judge concluded that, had the petitioner's orthopedic disability been as severe as he testified and were it, in fact, related to his occupational injuries, then "one would clearly expect some manifestation arising during the work exposure or within two years of the work exposure." Accordingly, the judge again dismissed the petitioner's orthopedic claim as time barred. The petitioner appealed a second time.

In affirming the dismissal of the petitioner's occupational orthopedic claim, the Appellate Division concluded that the Judge of Compensation's findings were wholly consistent with the trial record. As the Appellate Division reasoned:

> [Dr. Kengel's] report was based on the doctor's review of . . . a 2012 cervical MRI stud[y] and a single physical examination in June 2013 only. The examination did not include petitioner's shoulder or knee, and offered no explanation for the doctor's conclusion that petitioner's back injuries—both cervical and lumbar—were causally related to "occupational exposure." The doctor's failure to relate the injuries to specific incidents and to give the "why[s] and wherefore[s]" of his mere conclusion, rendered it a net opinion.

With regard to the credibility of the petitioner's testimony, the Appellate Division concluded:

> Here, petitioner challenges the judge's fact-finding in the first instance; namely, whether petitioner was aware he had a compensable claim and yet did not file a claim petition within the two-year statute of limitations. Those findings required credibility determinations[.] Despite the urging of petitioner on this score, we conclude that our independent review of the judge's factual findings and credibility determinations based on the trial proofs is unwarranted. Even were we to conclude otherwise . . . the judge's conclusions are . . . entirely consistent with the trial record.

Given its review of the record and in consideration of its standard of review, the Appellate Division indicated that it could discern no error in the Judge of Compensation's holding that the petitioner failed to file a timely claim related to his occupational disability.

As this decision demonstrates, unlike an accident, the precise onset of an occupational disease may be difficult to ascertain. As a result, N.J.S.A. 34:15-34 and the courts have recognized that the period for filing an occupational claim does not run until two years after the date the worker knows the nature of his occupational disability and its relationship to his employment. For statute of limitation purposes, knowledge of the nature of the disability connotes a knowledge of the most notable characteristics of the disease sufficient to give rise to an understanding of its extent and seriousness. An employer asserting a statute of limitations defense to an occupational exposure claim must establish that the injured worker had knowledge of the nature of the disability, its relation to his employment and the compensability of the injuries alleged. As in this case, these issues will require factual findings and credibility determinations on the part of the court.

News

Angela DeMary (Mount Laurel, NJ) was a featured speaker in the Camden County Bar Association CLE program, "Practicing Workers' Compensation Law Remotely and COVID-19 Type Cases." The webinar was held on January 27 and focused on the process of managing a workers' compensation claim; what is an essential worker and who is considered a first responder; and recent legal and legislative updates based on the Governor's Orders. The usage of DocuSign and remote forms as well as Zoom settlements and trials were also discussed.

Pennsylvania Workers' Compensation

By Francis X. Wickersham, Esquire | 610.354.8263 | fxwickersham@mdwcg.com


Francis X. Wickersham

The Commonwealth Court holds that if the 120th day for notice of a work injury falls on a weekend or holiday, notice is extended to the next business day, pursuant to the statutory construction act.

Holy Redeemer Health Systems v. WCAB (Figueroa); No. 372 C.D. 2020; filed Dec. 31, 2020; President Judge Leavitt

On July 25, 2015, the claimant, an emergency room nurse, began experiencing significant pain in her leg, which increased over the course of her shift. By the end of her shift, the claimant could not walk. She called off the following day and saw her doctor, who took her out of work. On November 23, 2015, the claimant notified her employer that she sustained an injury on July 25, 2015. Initially, the employer issued a Notice of Temporary Compensation Payable (NTCP), but then issued a Notice of Compensation Denial (NCD) and a Notice Stopping Temporary Compensation Payable (NSTCP). The claimant then filed a claim petition.

Although the Workers' Compensation Judge found that the claimant did sustain a work injury, the judge also found that the claimant's November 23, 2015, notice to her employer was one day late under § 311 of the Act and denied the claim petition.

The claimant appealed to the Workers' Compensation Appeal Board, which reversed. According to the Board, the 120th day after the claimant's work injury was November 22, 2015, a Sunday. Because § 311 of the Act was silent as to whether notice must be given to an employer on a Sunday, the Board looked at the Statutory Construction Act of 1972, which states that whenever the last day of any such period shall fall on Saturday or Sunday, or any day made a legal holiday, such day shall be omitted from the computation. Thus, the Board held that the claimant was required to provide notice by Monday, November 23, 2015, and in fact did so. The case was remanded to the Workers' Compensation Judge for a calculation of the compensation to be awarded to the claimant.

Following the judge's decision on the remand, the employer appealed to the Board, which again held that the claimant's notice of her work injury was timely. The employer then appealed to the Commonwealth Court.

The court noted that the Act requires an employee to give notice of an injury to the employer within 120 days of the injury's occurrence, but is silent on how to calculate the 120-day time period. The court rejected the employer's argument that the Statutory Construction Act did not apply to § 311 since the Statutory Construction Act essentially states that it applies to all statutes. The court also rejected the employer's position that the calculation of 120 days for notice under § 311 was dependent on whether the employer operates over the weekend. The court considered this to be a hyper-technical reading of § 311 that directly contradicted the legislature's directive in the Statutory Construction Act of 1972. The court dismissed the employer's appeal.

An award of specific loss benefits payable to the claimant that became part of her estate after her death from non-work-related causes are subject to the employer's subrogation lien upon the proceedings of a third party settlement for the claimant's work injuries.

Richard G. Kinzler, Trustee of a Trust for the Benefit of Kyra Kinzler v. WCAB (Association for Vascular Access and Twin City Fire Insurance Company); No. 165 C.D. 2020; filed Jan. 6, 2021; Judge Fizzano Cannon

The claimant was at a work-related restaurant event when she fell from a high stool and landed on her back. The employer acknowledged the injury by issuing a Notice of Compensation Payable and made benefits payments to the claimant. Later, she filed a review petition to expand the description of the injury and filed a civil complaint against the restaurant. The civil lawsuit resulted in a settlement of $4,375,000.

The parties then completed a Third Party Settlement Agreement, which entitled the employer to a net lien amount from the civil settlement and 41% of ongoing weekly payments to satisfy its obligation to reimburse its pro-rata

share of the claimant's fees and expenses until the subrogation interest was exhausted. The claimant set up a special needs trust for the third party settlement funds for herself during her lifetime and named her brother as trustee and her daughter as the beneficiary after her death. The claimant's condition worsened, and ultimately, her lower right leg below the knee was amputated. The claimant filed a petition seeking specific loss benefits for the loss of the leg, but she died the following day. The Workers' Compensation Judge granted the petition and awarded 350 weeks of specific loss benefits under § 306(c)(5) of the Act, but reduced the amount of those benefits pursuant to the employer's subrogation rights and interests. The trustee appealed to the Appeal Board, which affirmed the judge.

On appeal to the Commonwealth Court, the trustee argued that the specific loss benefits awarded by the Workers' Compensation Judge were payable for the original, full temporary total disability rate, not the subrogation rate. According to the court, the issue hinged on whether there was "equatability" between the claimant's pending specific loss benefits and her third party recovery funds. If so, the employer's subrogation interests would be retained. The court pointed out that where, after a claimant's death, surviving children become eligible for fatal claim benefits in their own right, rather than derivatively, the equatability that supports an employer's right to post-mortem subrogation is broken.

The court rejected the trustee's argument that any equatability ended with the claimant's death because, although she was eligible for specific loss benefits, she was unable to personally receive those benefits. The court also dismissed the trustee's argument that in instances such as this one, specific loss benefits become analogous to fatal claim survivor benefits and are, therefore, not subject to subrogation. The court pointed out that under § 306(g) of the Act, when a claimant dies of a cause not related to her work injury, any specific loss benefits to which she was already entitled, but did not collect, are heritable and, thus, subject to subrogation. The court affirmed the Workers' Compensation Judge and the Appeal Board and dismissed the trustee's appeal.

Fee Reviews

Workers' compensation is becoming increasingly sophisticated in Pennsylvania, and our practice group is dedicated to supporting our clients in all areas of the law that affect workers' compensation claims. In particular, fee review filings have accelerated recently, and our practice group is very familiar with the legal issues associated with the fee review process and its interplay with active workers' compensation litigation. By becoming involved at the onset of a fee review filing, we are better positioned to defend the interests of employers/carriers.

Medical providers use fee reviews to challenge the timeliness or amount of medical payments made by employers/carriers. Providers are given two opportunities to file a timely application for fee review: (1) within 90 days of their original billing date, or (2) within 30 days after they are provided with notice of a dispute, whichever is later. The fee review process presupposes that liability has been established. Thus, providers' allegations are accepted at face value during the initial stages. As an unfortunate consequence, employers/carriers may face unjust initial determinations. Disputing a fee review determination requires a de novo appeal, which must be filed within 30 days of the date of the determination. Our attorneys have extensive experience navigating the issues that then arise during fee review hearings, and we provide excellent guidance based on our thorough understanding of CPT codes and types of treatment. Our goal is to handle each case in an efficient and cost-effective manner.

For more information on fee review matters, please contact:

Jennifer Timmeney Callahan, Esquire
570.496.4607 | jtcallahan@mdwcg.com

Daniel W. Deitrick, Esquire
412.803.1181 | dwdeitrick@mdwcg.com

Robin M. Romano, Esquire
215.575.2705 | rmromano@mdwcg.com

Outcomes

Judd Woytek (Allentown, PA) was successful in receiving a decision denying a penalty petition. The claim had settled by Compromise & Release. The claimant had undergone three surgeries to her wrist while litigating her review petition to expand the accepted injury. As part of the C&R, the claimant agreed that the carrier would not be responsible for any medical bills related to her second and third wrist surgeries. The carrier agreed to pay her $5,000 to cover her out-of-pocket expenses related to those surgeries. Her private health insurance carrier later retracted payments it had made for her follow-up care and physical therapy post-surgery. The claimant then filed a penalty petition against the workers' compensation carrier when it refused to pay the bills on which the private insurance carrier had retracted payment. The judge denied and dismissed the penalty petition, finding that the claimant had negotiated away her right to seek payment from the workers' compensation carrier with regard to any bills related to the subsequent wrist surgeries as she had accepted $5,000 in exchange and was bound by the C&R. The workers' compensation carrier had no obligation to pay the bills.

Judd also received a decision denying a reinstatement petition in a claim where the claimant, who was working under restrictions, sought reinstatement of temporary total disability for a closed period of time when he was laid off due to Governor Wolf's Order issued in March 2020 directing that all non-life-sustaining businesses close. The judge agreed with our position that the claimant's loss in earnings was unrelated to the work injury and was due solely to the Governor's Order. The reinstatement petition was denied and dismissed.

Judd was again successful in receiving a decision denying a widow's claim for Federal Black Lung benefits. The deceased miner worked in underground coal mining for 11 years. His lifetime claim for benefits was denied after numerous claim filings and appeals. The widow then sought survivor's benefits based upon the opinion of her medical expert, who opined that the miner's death was hastened by coal workers' pneumoconiosis. The judge rejected the widow's expert in favor of our expert, who testified that the miner's death was not caused or hastened by pneumoconiosis. The widow requested reconsideration and attempted to submit additional evidence (an additional medical report and 12 medical journal articles) that she had not submitted during the litigation of the widow's claim. The judge again rejected the claim on reconsideration and found that, even if the employer's medical expert testimony were rejected, the testimony of the widow's medical expert was insufficient to sustain her burden of proving by a preponderance of the evidence that the miner's death was caused by or hastened by pneumoconiosis. The judge also agreed with our argument that the additional evidence submitted in conjunction with the request for reconsideration was impermissible and should be stricken from the record.

Tony Natale (Philadelphia, PA) was successful in dismissing the employer and insurer from a fatal claim as a result of COVID-19 infection. The claimant-widower filed the claim on behalf of his deceased wife, alleging she contracted COVID-19 while working in the capacity of a caretaker for a sick client. Tony argued that the correct employer for workers' compensation purposes was the claimant's client, not the named employer. The Workers' Compensation Judge agreed and dismissed the named employer and insurer as party defendants.

Tony also successfully defended a Philadelphia-based university in litigation surrounding both a claim and reinstatement petitions. The claimant sustained a non-disabling injury in the form of right thumb CMC joint arthritis from her repetitive job duties. After several years of employment, she alleged that her work injury forced her out of the labor market, and she requested disability benefits. The Workers' Compensation Judge accepted as credible, by preponderance of the medical evidence, that the claimant did not suffer a work-related disability of any kind. A big part of the rationale for this determination was Tony's cross examination of the claimant's medical expert, which exposed that the claimant's disability may have been due to a variety of non-work-related conditions to the left hand and upper extremity.

Tony also successfully defended a Delaware County machine shop before the Workers' Compensation Appeal Board with reference to the claimant's appeal from a Workers' Compensation Judge's decision denying work-related disability arising from an alleged head injury and a full recovery conclusion of law. Tony was able to have the appeal quashed

Outcomes (cont.)

based on its untimely filing. The Board also adjudged the appeal on the merits (which is unusual) and further found that the appeal lacked merit on all grounds.

Ashley Eldridge (Philadelphia, PA) was successful in defending a claim petition for an alleged spine injury on behalf of a construction company. The claimant was employed as a construction worker for the employer, and a week after being hired, he was allegedly injured while using a jackhammer. He filed a claim petition for multilevel disc injuries in the lumbar spine. Ashley presented the medical testimony of an orthopedic expert who explained how the injury was soft tissue in nature and had resolved as of an independent medical examination. While there was significant, multilevel disc bulges and herniations, which the opposing expert attempted to ascribe as work-related, the judge agreed these findings to be degenerative rather than acute. This conclusion was further supported by an ongoing factual investigation, which uncovered 17 prior low back injuries, the majority of which were denied by the claimant. Ultimately, the judge accepted the defense's evidence over that of the claimant and granted the full relief requested by the employer.

Michele Punturi (Philadelphia) successfully prosecuted a termination petition and defended the claimant's petition to review to expand the nature of the accepted injury on behalf of a well-known hospital. The injury was accepted as a right distal bicep strain, which included a partial tear resulting in surgery. The claimant asserted the injury should be expanded to also include right carpal tunnel, right elbow sprain and trigger fingers. A detailed cross-examination of the claimant established the complaints referable to right carpal and trigger fingers began six months after the injury, which was corroborated by the claimant's treating physician's records. The IME expert, a board-certified orthopedic surgeon with specialized training in hand surgery, had the opportunity to perform a comprehensive physical examination and review the diagnostic studies, post- and pre-injury medical records and the claimant's family physician's records. These records revealed non-work-related carpal tunnel risk factor conditions, including obesity, post-menopausal, non-insulin dependent diabetes and testing for hypothyroidism. It was further argued that the claimant's medical expert did not have expertise in the surgery involved in the case and failed to review the claimant's testimony and diagnostic films. Ultimately, the judge found the defense medical expert to be competent, credible and persuasive. This case highlights the importance of a defense expert having the opportunity to review all medical records, diagnostic films, claimant's testimony and claimant's expert's testimony to develop a timeline for claimant's complaints consistent with the medical evidence.