PENNSYLVANIA ASSOCIATION FOR JUSTICE

WORKERS' COMPENSATION FOR BEGINNERS

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FOREWORD

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The Pennsylvania workers' compensation system represents a longstanding compromise between workers and employees. On the surface, workers' compensation appears to be a straightforward "no fault" system. Workers receive medical treatment and are compensated for lost wages if they are injured at their workplace. In return, WC is the "exclusive remedy" for injured workers and employers are protected from direct lawsuits from their employees. This is what was called the "grand bargain." However, the present WC system involves sometimes confusing administrative deadlines and medical requirements that can be frustrating to a seriously injured worker.

As you enter the litigation world of the Pennsylvania Workers' Compensation system it is important to remember an attorney must give their client more than just legal representation. You must also provide hope and guidance through what can be a challenging period for the injured worker. Imagine a person sitting at home dealing with constant pain, financial concerns about paying their bills, angry why their medication did not arrive in the mail, why the insurance company requires them to see an insurance company doctor every few months and fear they may be fired from their job even when they recover. You are the injured worker's lifeline to all their questions and problems.

As an attorney you need to appreciate how the workers compensation law evolved over the last century. In 2015 the Pa. Workers' Compensation Act (PWCA) celebrated its 100th anniversary. The PWCA was adopted on June 2, 1915. The law provided for payment of wage loss to the injured worker, the requirement the employer paid all the medical bills arising from the worker's injury, established the State Worker Insurance Fund (SWIF) and "encouraged" employers to carry workers' compensation insurance. It took over 50 years before WC insurance was made mandatory. Prior to the PWCA industrial accidents were usually borne by the injured worker or his family. The worker had to go through the tort system that placed a heavy burden of proof on the employee. At the same time, the employer was able to use three legal defenses that prevented a worker from receiving any compensation.

Since these defenses were extremely restrictive, they were more popularly called as the 'unholy trinity of defenses.' The defenses are:

1. Contributory Negligence — If the worker was responsible for their injury in any way, the employer was not held responsible.
2. The Fellow Servant Rule — According to this rule the employer was not held responsible for a worker's injury if the incident occurred due to the negligence of a co-worker or "fellow" employee.
3. Assumption of Risk — This defense was often used to show the injured worker was aware of a workplace hazard or risk associated with a particular job. If the employee voluntarily continued their employment under hazardous conditions the worker was deemed to have accepted the situation and assented to free the defendant of all obligations.

Throughout the decades, workers' compensation has evolved. The Occupational Disease Act became law in 1939 and significant changes were also made in the early 1970s. Unfortunately, the 1990s saw a disturbing trend where workers benefits were drastically reduced. In 1996 Act 57 became law. In Act 57 the WC system became weighted to the advantage of the employer and the insurance industry. The spirit of the law changed. An injured worker was required to see a company doctor for 90 days rather the previous 30-day period. It also gave employers the right to reduce an injured worker's WC benefits against their pension and social security retirement benefits. The most egregious change was the creation of the Impairment Rating Evaluation (IRE) process. This allowed employers to cut off wage loss benefits to severely injured and disabled workers after they received 500 weeks of benefits. Although the courts tried to address some of the inequities, Act 57 still cast a dark shadow on our workers' compensation system.

Since the start of the 21st century the insurance industry and major corporations have aggressively pursued a legislative agenda to weaken WC laws throughout the nation. Legislation that permits a company from opting out of their state's WC system or once again requiring a worker to overcome a negligence standard are becoming more frequent. These anti worker laws have not been introduced or adopted in Pennsylvania. However, we must be vigilant and not return to a system where an injured worker and your client can not access the workers' compensation safety net or find a remedy to their workplace injuries.

FEES AND ECONOMICS OF A WORKERS' COMPENSATION PRACTICE

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Overview. The practice of law in general is a mix of business and profession. That principle is true in our practice as workers' compensation law practitioners. We have to strike a balance and sometimes make difficult choices. But like stock picking, you have to choose your cases wisely as the cost of litigation is frontloaded and expensive, as described below. As a profession, you have a certain duty to zealously represent your client, and sometimes the value of the case does not justify the expense but you still have to be diligent.

Building your book of business. But how do you acquire a new client or case in today's environment? There are a variety of ways. Often, as a new attorney, you may be handed cases from the partners in your firm to gain experience, or through family, friends and where you worship or other associations. Often, clients remain loyal and refer family and friends if you treat them well. After you gain some level of expertise, you may receive referrals from other attorneys and pay a referral fee. And then there's advertising, which is generally more expensive. The old ways had everyone competing together by placing an ad in the Yellow Pages. Now you can create an app, have Facebook and other social media advertising, and even compete with the traditional TV, radio, billboards or public transit (which is very expensive). Unless you have deep pockets, it is better to start with relationship marketing and build your practice up before investing too heavily, as not only do you pay for the ads, but the expense of screening calls in additional staffing, office space and equipment, let alone the expense of a new case.

Attorney fees in a workers' compensation practice. What you can charge your clients in our practice is regulated. Sections 440 and 442 of the Pennsylvania Workers' Compensation Act provide the rules. In general, a contingent fee of 20% of your client's benefits is deemed reasonable per se. As in any area of the law, your fee agreement must be in writing, but we have the additional requirement that the agreement must be approved by a workers' compensation judge or the Workers' Compensation Appeal Board. The contingency is that you successfully prosecuted a claim for benefits and your client was granted an award, or you successfully overcame a request to suspend your client's benefits in a supersedeas hearing, a prelude to a petition to stop or

modify your client's benefits. In some circumstances you can charge an hourly rate, such as where the client is not receiving or going to receive a financial award. You can also ask the judge to award a 20% fee against the unpaid medical bills, but the fee agreement must show your client agreed, and your client needs to understand that he or she may be liable for the difference to the medical provider.

The cost of litigating your case. As a general rule, you will spend a lot more than you will make on most cases until resolution (see "winning your case or settling," below.) This "investment" is the litigation cost required to prosecute the petitions you filed or defend the petitions filed against your client to stop his or her benefits. For example, your orthopedic expert can charge from $4,000 to $7,000 to testify, and you may pay $1,000 for the expert's opinion in a comprehensive report. Other expert's charges vary depending on the area of practice and level of experience, but know that you will have to invest heavily in the cases you believe in. You can avoid these heavy charges if your disability period is fewer than 52 weeks and you can proceed on reports, giving up an ongoing claim for benefits but avoiding a burdensome expense when the cost is not justified. The purpose of the expenditure is to secure the evidence to win your case before a judge by establishing that your client is injured as a result of a work injury (causation) and is disabled, defined as a loss of earning power, such as being unable to return to the time-of-injury job full duty, or even other offered jobs on a limited duty basis.

Winning your case or settling. If you manage to set up the case well, you can go to a mediation and attempt to settle your case for a lump sum, and if that fails, to go to final decision and successfully defend or prosecute your client's case. In either situation, you will be awarded your litigation expenses directly from the employer in addition to your fees. Your client will not, unless agreed upon otherwise, be obligated to pay your costs. You only have to be successful "in whole or in part" to be reimbursed your costs, and what is reimbursable is also defined in the Pennsylvania Workers' Compensation Act. In general, office expenses like copy costs and postage are not included, but the transcripts, reports, witness fees, records, etc. are. However, if you were unsuccessful, then your contingent fee agreement would reflect that you bear the loss of the litigation costs. It is very difficult to succeed in this business without settling your cases, as the lump sum 20% fees pay for your risks, but a 20% fee on your client's weekly checks do not, at least in the near term.

Conclusion. The experienced practitioner has learned over time how to determine whether to take the risk of a final decision over a final offer to settle, and unfortunately as a business, we must be mindful of the risks we take. Sometimes the client does not agree with your assessment to settle, and as a professional you are reasonably obligated to take on the risk of a decision. Thus, you must pick your cases wisely and learn early whether you can afford or justify taking on a new case to a decision.

THE INITIAL CLIENT INTERVIEW

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The importance of learning about your new client or prospective client at the start of the relationship cannot be understated. Later chapters will address many of the implications of the things you have learned about their case, but you must first find out the injured worker's story. At the same time, you are learning the information you will need to successfully advocate for them, you'll likely be fielding questions; they came to you for a reason and almost assuredly have pressing concerns. Are their medical bills going to be paid? Is the insurance company going to send them a check, and if so, when? Will the benefits they've been receiving end because the insurance company says they've fully recovered? They may also want to know about you and your story, and how you can help.

With that in mind, a client interview can never be looked at in a vacuum where you are simply asking a series of questions to gather information and get back to them in a month. It is a dynamic situation where you need to be prepared to hear what they have been living through. Even if certain information strikes you as unrelated to the workers' compensation case, your client is telling you about what is important to them. You will also likely need to field questions before you have enough information to properly advise them.

Being organized and well-prepared for the initial interview is crucial for everything that comes after in the life of your client's case. For starters, by gathering the baseline information at the outset, your next contact will likely be by providing answers, and not to gather more information you could have gathered at the beginning. Save yourself time, and demonstrate to your client that you were ready to take the reins the moment you left the initial meeting.

It should be noted that the timing of the initial interview will almost certainly affect your client's concerns and their focus on the meeting, as well as your own. If you client's injury just occurred, it is unlikely that they will have much information on the insurance company, or that they would have pursued any other legal actions related to the claim, such as a third-party suit. Perhaps your client was injured six years ago and they've been receiving benefits without issue, and cannot understand why you're asking questions about the

provider they were sent to for a few weeks right after they were injured. Additional chapters will provide better context on the importance of these details as the case progresses.

So what do you need to know as you start? A large part of the interview is going to focus on simple questions: who, what, when, where, why, and how, though not necessarily in that order.

Who: There are certain parties to every workers' compensation case. You obviously need the name, address, phone number, date of birth, and Social Security number of your client. If they have a spouse, parent, child or any other person who will be providing you information, get their contact information as well. Also, the name, phone number, and address of their employer, and their workers' compensation insurance carrier as well if possible. If the carrier is represented, the contact information for their attorney. Witnesses to injuries are important to identify as soon as possible, particularly in a disputed case.

The names and practices of your client's medical providers must be identified as well. If they have treated for injuries to the same body parts in the past, or there are related medical providers for conditions or treatments which impact the workers' compensation case, those providers should also be identified. Lastly, primary care physicians should also be identified.

Beyond just the above information, you need to dig a bit deeper to ensure that there are no relevant third parties in your client's case. Does your client have a second job or self-employment? Other sources of income after they were hurt, or have they returned to work? Who is their regular health insurer? Do they receive any government benefits such as Social Security, Medicare, Medicaid, unemployment compensation or cash assistance? Was a third party at fault for causing your client's injury?

What, When, Where: Before we being to address the injury itself, you need additional information about the claimant and their employer. What kind of work do they do? When did they start working for their employer? What was their job title and rate of pay? Was it full-time, part-time, seasonal, or intermittent? Did they receive overtime? Did they work regularly at any location(s)?

A great template for gathering information on the injury is the Claim Petition for Workers' Compensation Benefits, LIBC-362. What body parts were affected by the injury? How did the injury itself occur? When did the injury happen, and who did they tell? Did they provide notice verbally or in a written incident report? Where were they sent for treatment, and what kind of treatment has been provided? Have they been unable to work due to their doctor's restrictions, or working but earning less than their pre-injury wages?

Following the injury, what other doctors have they seen? Have they been sent for any examinations by the insurance company directly?

Have they been placed under restrictions, and have they been accommodated by the employer?

Have they ever suffered injuries to or receive treatment for the affected body part(s) in the past? If so, when, what happened, and with whom did they treat?

Why: Do not assume you know why your client came to you. It could be very easy to take in your client's story and miss the question that brought them to you in the first place. Indeed, as lawyers, we are trained to issue-spot and look for the problems, and that's a large reason people come to see us! Your client may have just answered every question you've thrown at them, but before you start down the path of explaining what you can do for them, be direct and ask them what brought them to see you. You may be surprised at what they tell you; perhaps it is not one of the half-dozen issues you spotted while gathering the information, but is what gives them the most difficulty in the claim. Don't assume — find out what brought them there.

How: What's next? After you've taken in all the information from you client, are you prepared with all the information for everything that might come next in the case? Almost assuredly not. Your next steps are going to be to gather more information. Perhaps your client will be able to provide records in their possession if they have not already done so, but there are additional documents you will need permission from your client to request.

The Pennsylvania Bureau of Workers' Compensation keeps records on file for reported claims. In order to properly address your client's case, you will need the "Bureau documents" on file, so no

initial client interview should be concluded without having your client sign an authorization for the release of those documents. Likewise, your client's health information is private, but you must be able to review their records, so HIPAA compliant authorizations signed by your client to release their records must also be obtained.

Once you've gathered the information you need, ensure that you effectively communicate to your client what your next steps will be, so they know what to expect. If you've just peppered them for an hour with questions and they don't know why, they may not be feeling any better off than before they talked to you!

Sample Interview Checklist:

Client Name:

Address:

Phone Number:

Email Address:

Date of Birth:

Social Security Number:

Employer Name:

Address:

Phone Number:

Job Title/duties/physical capacities required:

Date of Hire:

Rate of Pay:

Schedule:

Concurrent employment at time of injury:

Insurer Name:

Claim Number:

Adjuster:

Address:

Phone Number:

Fax Number:

Email Address:

Date of Injury/Date of Last Exposure:

Description of Injury/Body parts affected:

Mechanism of Injury:

Location of Injury:

Witnesses:

Notice of injury provided on _____ to:

Lost time after injury:

Third-party involvement?

Medical Treatment:

Practice Name:

Treating Doctor:

Date treatment began:

Still treating:

Diagnosis/diagnoses:

Treatment provided:

Treatment recommended:

Restrictions:

Current Case Status:

Has Client received Notice of Compensation Payable or Denial?

Are wage loss benefits being paid for partial or total disability?

Are all medical benefits being paid by the insurer?

Working now?

With whom?

In what capacity?

If not, last date worked?

Prior injuries/medical condition related to work-injury?

Prior work-injuries?

Receiving other benefits?

Unemployment:

Sickness & Accident:

Short-Term Disability:

Long-Term Disability:

Pension:

DHS Cash Assistance:

Social Security Retirement:

Social Security Disability:

Medicare:

Medicaid:

Health Insurance:

Third-Party Case/Representation?

Initial File Documents:

Representation Agreement:

Medical Authorization(s):

Bureau of Workers' Compensation Authorization:

Client Concerns:

THE EXCLUSIVE REMEDY DOCTRINE UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT

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The Pennsylvania Workers' Compensation Act was enacted in 1915. It was a part of a historic compromise, a "quid pro quo," that established a remedial and humanitarian process for providing payment of wage loss compensation and medical expenses in a no-fault system to injured workers in exchange for workers giving up their common law rights to action at law seeking potentially larger and unpredictable jury awards from the employer. The purpose of the Act was to protect and make whole the injured worker in an expeditious no-fault system addressing "the evil … of uncompensated work injuries." (*Keller v. Old Lycoming Twp.,* 428 A.2d 357 (Pa. Super 1981); See also *Colpetzer v. WCAB*, 802 A.2d 1233 (Pa. Cmwlth. 2002); *City of Erie v. Annunziata*, 799 A.2d 946 (Pa. Cmwlth. 2002); *Taylor v. Ewing*, 166 Pa. Super. 21, 70 A.2d 456 (1950).

Litigation has since focused on what "injuries" fall within the "exclusivity clause" of the Workers' Compensation Act (herein, "the Act") which provides that:

> *(a) The liability of an employer under this act shall be exclusive and in place of all other liability or such employees, his legal representative, husband or wife, parents, dependents, next of kin or anyone entitled to damages in any action at law or otherwise on account of any injury or death as defined in Section 301(c)(1) and (2), or occupational disease as defined in section 108;*
>
> *(b) In the event injury or death to an employee is caused by a third party, then such employee, his legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to receive damages by reason thereof, may bring their action at law against such third party, but the employer, his insurance carrier, their servants and agents, employees, representatives acting on their behalf or at their request shall not be liable to a third party for damages,*

contribution, or indemnity in any action at law, or otherwise, unless liability for such damages, contributions or indemnity shall be expressly provided for in a written contract entered into by the party alleged to be liable prior to the date of the occurrence which gave rise to the action. (77 P.S. Section 481(a))

The exclusivity provision is specifically authorized by a 1915 amendment to the Pennsylvania Constitution, which presently provides:

The General Assembly may enact laws requiring the payment by employers, or employers and employees jointly, of reasonable compensation for injuries to employees arising in the course of their employment, and for occupational diseases of employees, whether or not such injuries or diseases result in death, and regardless of fault of employer or employee, and fixing the basis of ascertainment of such compensation and the maximum and minimum limits thereof, and providing special or general remedies for the collection thereof; but in no other cases shall the General Assembly limit the amount to be recovered for injuries resulting in death, or for injuries to persons or property, and in case of death from such injuries, the right of action shall survive, and the General Assembly shall prescribe for whose benefit such actions shall be prosecuted. No act shall prescribe any limitations of time within which suits may be brought against corporations for injuries to persons or property, or for other causes different from those fixed by general laws regulating actions against natural persons, and such acts now existing are avoided. (Pa. Const. Art. 3, Sec. 18, Amended Nov. 2, 2015, Renumbered from Art. 3 Sec. 21, May 16, 1967.)

The Pennsylvania Occupational Disease Act was enacted in 1939. Acts 223 and 337 of 1972, amending the Act, brought occupational diseases into the general injury provisions of the Act for all purposes by redefining "injury" to include occupational diseases. This expansion applied only to disability or death

resulting from exposure that occurs after exposure to the occupational hazard after June 30, 1973. (Section 301(c)(2), 77 P.S. §411(2). See *Pawlosky v. WCAB (Latrobe Brewing Co.),* 525 A.2d 1204 (Pa. 1987) (a job-related aggravation of a pre-existing disease is not precluded from being an "injury" under the Act merely because that disease is not "occupational disease."))

When initially enacted in 1915, the Pennsylvania Workers' Compensation Act was an "elective" or "opt-out" system by implied contract between the employer and employee. (*Miller v. Reading Co.*, 140 A. 618 (Pa. 1928) ("He can reject its provisions if deemed wise, and is bound only if he fails to signify an intention to preserve the legal right of action existing as between master and servant. The Act, carrying with it a presumption of acceptance…")) In 1974, this was changed to a mandatory system. (See *Bible v. Dept. of Labor and Industry*, 696 A.2d 1149 (Pa. 1997)) The 1974 amendments changed the title to "Liability and Compensation" and deleted major provisions of the sections of the law that set forth the manner in which coverage was accepted or rejected.

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Note: The original document written by Mr. Michael Foley is a wonderful and importantly thorough dissertation that unfortunately was too voluminous to include in its entirety in this particular PAJ publication. For the readers' convenience, we included the first section of Mr. Foley's work and encourage readers who wish to see the document in its entirety to request it by contacting Mr. Foley at mikef@foleylawfirm.com.

RECOVERABLE DAMAGES: WAGE LOSS BENEFITS AND MEDICAL BENEFITS

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Under the Workers' Compensation Act, wage loss and compensation for medical bills are the primary benefits provided to injured workers. Additionally, the specific loss of body parts, vision, and hearing are recoverable under Section 306, 77 P.S. §513 of the Act, and included in specific loss is compensation for work-related disfigurement to an injured worker's face and neck. All these various benefits are calculated according to specific schedules and formulas issued by the Bureau of Workers' Compensation.

Specifically, indemnity benefits are statutorily calculated by using the wages that an injured worker earned during the 52-week period immediately preceding the date of injury. The annual wages are then broken down into four 13-week periods, which are averaged. Using a Workers' Compensation Rate Schedule, which the Bureau issues each January, an injured worker's weekly compensation rate is set at 66 2/3 percent if the wages are average, 90 percent if wages are low, or are capped at a maximum compensation rate if the wages are high.

While these are generally strict formulas, case law has established exceptions for when the standard calculation does not provide an accurate representation of a claimant's actual earnings. If, for example, an injured worker had a concurrent job at the time of the injury, then these wages are to be included in the compensable average weekly wage. Notably, concurrent wages do not include self-employment and employees must be out of work for more than seven days.

Wage loss benefits are presently not taxable and are theoretically available indefinitely, although there are numerous grounds to limit or terminate them by initiating litigation before a workers' compensation judge.

Partial disability benefits are available when an injured worker has returned to work at reduced wages, or if a judge has ruled that the injured worker has earning power or could perform an offered job within restrictions. Partial disability payments are calculated at 2/3 of the difference between the pre-injury and post-injury wage or earning power. Importantly, partial disability benefits are only payable for 500 weeks.

Medical benefits are compensable for any reasonable, necessary, and related medical care that was provided to treat the work-related injury or disease. However, the reimbursement for these services is subject to the repricing provisions. Medical providers are required to accept the scheduled reimbursement as payment in full and cannot balance the bill.

In addition, initial medical treatment is subject to limitations. If an employer establishes a valid panel of six medical providers, by following a strict set of criteria as set forth in the bureau regulations, an injured worker constructively must treat with those designated doctors for the first 90 days because an insurer can refuse to reimburse bills for treatment for non-panel physicians. If a claimant needs to see a medical specialist who is not on the panel, treatment outside of the panel is allowed.

All bills for medical treatment must be submitted to the insurance carrier on forms as prescribed by the Bureau regulations to trigger the obligation to pay. If an insurer decides to dispute the reasonableness and necessity of specific treatment, it has 30 days to file a utilization review.

If the treatment is determined by the reviewing organization not reasonable nor necessary, neither the insurer nor the injured worker can be held responsible for the medical bills. Notably, a utilization review determination is appealable, and a workers' compensation judge will determine if the treatment is reasonable and necessary with a *de novo* review.

TIME LIMITATIONS AND DEADLINES

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Time Limitations and Deadlines can be broken down into two separate but interconnecting topics. I will discuss both in this chapter.

Original Claim Time Limitations

A) **Notice of Injury or Death**

Section 311 of the Act, 77 P. S. Section 631, requires that notice be given by an injured employee to their employer of their injury within 120 days of the injury. See also, *Katz v. Evening Bulletin,* 403 A.2d 518 (PA. 1979).

Where the employee is exposed to continuing multiple traumas, the injury does not take place until the last exposure or trauma occurs, usually the last day of work. *City of Philadelphia v.WCAB (Williams),* 851 A.2d 838 (PA. 2004).

In certain circumstances the time for giving notice of an injury does not begin to run until the employee knows, or by the exercise of reasonable care should know, of the existence of the injury and its possible relationship to his or her employment. 77 P. S. Section 631 (2nd sentence). The determination of whether or not this "discovery rule" applies in any particular case is very fact sensitive. For example, it has been held that notice must be given within 120 days of date of injury, not the date that a diagnosis is established, *Bolitch v. WCAB (Volkswagen of America, Inc.)* 572 A.2d 39 (PA. Cmwlth 1990), and on the other hand, that notice provided more than 120 days after onset of disease but before a medical opinion of causation was timely. *Bullen Cos. v. WCAB (Hausmann),* 960 A.2d 488 (PA. Cmwlth 2008).

Where an injury is aggravated daily, each day constitutes a new injury, and notice is timely if given within 120 days from the last day of work. *Zuro Industries v. WCAB (Bottoni),* 755 A.2d 108 (PA. Cmwlth. 2000).

B) **Proof of Notice**

Details relating to the form and manner of giving notice sent to whom notice shall be given are specified in Sections 312 and 313 of the Act, 77 P. S. Sections 632 and 633. The employee has the burden of proving the employer's actual receipt of notice. See also, *Kocher's IGA v. WCAB (Dietrich),* 729 A.2d 145 (PA. Cmwlth. 1999).

Whether the notice given is considered adequate is based on the totality of the circumstances. Notice does not necessarily have to be given in a single communication. *Centex Corporation v. WCAB (Morack),* 23 A.3d 528 (PA. 2011). Morack does not require an exact diagnosis for notice to be considered adequate, rather only a reasonably precise description of the injury is required.

No notice of injury is necessary if the employer has actual knowledge of the occurrence of the injury. 77 P. S. Section 631. See also, *Sheetz v. WCAB (Firestone Tire & Rubber Co.),* 522 A.2d. 146 (PA. Cmwlth. 1987).

Where more than one injury is sustained as a result of one accident, the employee may not be required to give the employer separate notice of each injury. *Crown Servs., Inc. v. WCAB (Beck),* 682 A.2d 1333 (PA. Cmwlth.1996). N.B. There is some case law to the effect that separate notice of each injury must be given but these in general are older cases.

C) **Statute of Limitations**

The Statute of Limitations for Workers' Compensation claims can be found at Section 315 of the Act, 77 P. S. Section 602. The Statute of Limitations requires that a Claim Petition be filed within three years of the date of injury. As with the notice provisions discussed above, there is some flexibility with the Statute of Limitations. *E.G., Zimmennan v. WCAB (Pennsylvania Power & Lightcap Co.),* 597 A.2d 1272 (PA. Cmwlth. 1991) held that the date of disability, not the date of trauma governs the commencement of the Statute of Limitations.

When medical evidence establishes that ongoing work activities aggravated an injury, the last day of work or the last day on which aggravation occurred is the date of injury for Statute of Limitations purposes. *Armitage v. WCAB (Gurtle Chemicals),* 842 A.2d 516 (PA. Cmwlth. 2004).

The payment of Medical Benefits without the payment of Indemnity Benefits does not toll the three-year Statute of limitations. See *Viw1nco v. WCAB (Homer),* 656 A.2d 566 (PA. Cmwlth. 1995). Where a Medical-Only NCP is issued, a Claim Petition seeking IndemnityBenefits must be filed within three years of the date of injury. *Sloane v. WCAB (Children's Hospital of Philadelphia),* 124 A.3d 778 (PA. Cmwlth. 2015).

D) **Reinstatement of Benefits**

A Petition for Reinstatement of Benefits must be filed within three years of the date of the last payment of lndemnity Benefits. Section 413 of the Act, 77 P.S. Section 772.

E) **Death Claims**

Section 315 of the Act, 77 P.S. Section 602 requires the filing of a Claim Petition within three years after the date of death. See also *Zafran v. WCAB (Empire Kosher Poultry, Inc.)* 713 A.2d 698 (PA. Cmwlth. 1998). Further, the death must have occurred within 300 weeks after the date of injury. See Section 301(c)(1) of the Act, 77 P.S. Section 411 (1).

N.B. death caused by an Occupational Disease is compensable only when the disability occurs within 300 weeks of the last date of employment in an occupation or industry to which the employee was exposed to hazards of such disease. See Section 301 (c) (2) of the Act, 77 P.S.411 (2).

F) **Specific Loss Claims**

The date of injury for Statute of Limitations purposes is the date the employee is notified by a physician of the loss of use of the member or faculty for all practical intents and purposes and that the injury is job-related in nature. *Roadway Express, Inc. v. WCAB (Siekierka),* 708 A.2d 132 (PA. Cmwlth 1998).

The three-year Statute of Limitations contained in Section 315 of the Act, 77 P.S. Section 602 applies to Specific Loss Claims.

One last plug, this article is meant to be an outline only of the various time limitations and deadlines contained in the Pennsylvania Workers' Compensation Act. To be kept really up-to-date on these matters, please join the Workers' Compensation Listserv of the Pennsylvania Association for

Justice.

A REVIEW OF SELECTED FORMS FOR PA WORKERS' COMPENSATION

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The Pennsylvania Workers' Compensation Act is administered by the Department of Labor, Bureau of Workers' Compensation. It is an administrative practice. The process is governed by the Workers Compensation Automation and Integration System (WCAIS). There are a host of standardized forms – produced for WCAIS by the Bureau of Workers' Compensation – that govern the payment, suspension, termination, and settlement of indemnity and medical benefits. Every practitioner should become well acquainted with WCAIS and the following forms used, extensively, in the practice:

- **Notice of Compensation Payable (NCP)** – LIBC 495: Arguably the most important document in workers' compensation claims, the NCP is the document filed by the employer to formally accept a workers' compensation injury. The NCP must be filed with the Bureau by the employer within 21 days of being notified of the work injury. The document outlines (1) the date of injury; (2) body parts involved; (3) a narrative description of the injury/diagnosis, and; (4) whether the claim is being accepted for:
    - Payment of medical benefits *only* ("medical only NCP") where there is brief or no lost time from work, or;
    - Payment of both indemnity (lost wages) and medical benefits.

  If benefits are payable, the document outlines the Average Weekly Wage (AWW) and Temporary Total Disability (TTD) amounts. Practitioners are advised to scrutinize the document, paying particular attention to the description of injury to ensure that all body parts are included and sufficiently identified. The NCP may need to be amended at a later time to add additional body parts and/or diagnoses.
- **Notice of Denial (NCD)** – LIBC 496: If an employer decides to deny a claim for workers' compensation benefits, a notice of denial must be provided to the Bureau within 21 days of being notified of the injury. Practitioners are advised to scrutinize the blocks checked and the reasons

specified for denying benefits. Inaccurate or insufficient reasoning may constitute a basis for an unreasonable contest and an award of attorney fees.

- **Temporary Notice of Compensation Payable (TNCP)** – LIBC 501: This unique feature of the workers' compensation process allows an employer to temporarily accept an injured workers' claim — for up to 90 days — while it continues to investigate the existence and extent of the work injury. The NTCP *automatically converts* to a Notice of Compensation payable at the end of the 90-day period, unless the employer files separate documents to fully deny or partially deny (shift from "indemnity and medical" to "medical only") the claim.
- **Notice Stopping Temporary Compensation** (NSTC) - LIBC 502: Where an employer decides to deny the claim within the 90-day period after issuance of the TNCP, it must issue an NSTC to effectuate a stoppage of benefits, along with a separate Notice of Denial.
- **Claim Petition** – LIBC 362: If the employer denies, or ignores, the claim of an injured worker, a Claim Petition must be filed within three (3) years of the work injury. Likewise, where the claim of an injured worker has been accepted by the employer as "medical only," but the claim later evolves to include lost wages, the injured worker must file a Claim Petition to expand the accepted claim to include payment of indemnity benefits. Practitioners should broadly define the body parts and diagnoses involved, and include psychological sequelae. Once filed, the employer must file an answer to the Claim Petition within 20 days of its assignment to a workers' compensation judge or risk payment of benefits, by default, based on well-pleaded facts in the Claim Petition — at least through the date the Answer was to be filed ("*Yellow Freight*" theory).
- **Notice of Claim Against Uninsured Employer/Claim Petition for Benefits from the Uninsured Employers Guaranty Fund (UEGF) –** LIBC 550/551**:** Although workers' compensation insurance is mandatory in Pennsylvania, not everyone follows the rules. Where an employer does not secure workers' compensation insurance, the injured worker can pursue indemnity and medical benefits through the Uninsured Employer Guaranty Fund (UEGF). The injured worker *must* start by filing the Notice of Claim Against Uninsured Employer with the Workers' Compensation Office of Adjudication

in Harrisburg. Caution: The notice of claim *must* be filed with 45 days of when the injured worker becomes aware that there was no workers' compensation insurance policy (or self- insured status) on the date of injury. (Otherwise, benefits do not start until the notice is filed). Following a 21-day waiting period, the injured worker may then file a claim petition against the UEGF. The UEGF assumes the defense of the Claim Petition.

- **Statement of Wages (SOW)** – LIBC 494C: Drafted by the employer, the SOW provides the injured worked with a delineation of wages earned in each of the four quarters prior to the work injury. There are multiple formulas for computing the Average Weekly Wage (AWW) and Total Temporary Disability (TTD) rate. Practitioners are advised to scrutinize the SOW, as miscalculations and omissions frequently occur (i.e, failure to add in year-end bonus payments, wages from concurrent employment, payments from sickness and accident, or to exclude incomplete quarters)
- **Petition to Review Compensation Benefits** – LIBC 378: This Petition may be used to (1) expand the description of injury to include additional body parts/diagnoses; (2) request review of disfigurement (scarring) of the head, face or neck to calculate specific loss benefits; (3) request an increase of the Average Weekly Wage (AWW)/Temporary Total Disability (TTD) rate; or (4) request review of prospective medical treatment.
- **Petition for Suspension or Modification of Benefits** – LIBC 378: Where an injured worker returns to full or partial employment, the employer may file a petition to modify (if post injury-earnings are lower than the AWW) or fully suspend (if post injury earnings are equal to or greater than the AWW) payment of indemnity benefits. The employer may also use this Petition to request modification or suspension of indemnity benefits where: (1) an injured worker has been released by a physician to some level of work and is refusing a modified-duty job offer; (2) a vocational evaluation has determined that work is generally available and is being refused by the injured worker; (3) the injured worker has voluntarily withdrawn from the labor market (i.e. retired, not seeing work); (4) the injured worker is contemporaneously receiving other benefits (unemployment compensation, Social Security retirement, sickness and accident benefits, pension benefits) or has received a recovery in a third-party/civil action;

or (5) is refusing reasonable medical treatment that would increase earning capacity. Injured workers should file an answer (LIBC 377) to the Petition and will need to produce evidence rebutting the employer's contentions.

- **Petition for Reinstatement of Benefits** – LIBC 378: Where the injured worker's benefits have been modified or fully suspended, and the circumstances supporting a modification/suspension no longer exist (i.e., injured worker experiences a decrease in earning power due to the work injury, no longer receiving UC), reinstatement of full or partial indemnity benefits may be requested using this form.
- **Petition to Terminate Benefits** – LIBC 378: Where the employer has obtained a medical opinion that the injured worker has fully recovered from the work injury, the employer may file a Petition to Terminate its obligation to the employee. Injured workers should file an answer (LIBC 377) to the Petition and be prepared to produce medical evidence of ongoing impairment. The practitioner is cautioned to procure such medical evidence for the first hearing where the Workers' Compensation Judge (WCJ) will issue an order (supersedeas), preliminarily, to continue or stop indemnity.
- **Compromise and Release Agreement (C&R)** – LIBC 755: Workers' compensation settlements require a compromise and release agreement (C&R). The C&R is a comprehensive document created to memorialize all settlement terms. The C&R, traditionally drafted by the employer, and supplemented by counsel for the injured worker, must be signed by all parties and presented to the Workers' Compensation Judge (WCJ) for review and approval, at a hearing. The injured worker is questioned regarding complete knowledge and understanding of the terms of settlement. The WCJ will approve if satisfied that the injured worker has a full understanding of the terms of settlement.
- **Utilization Review Request (UR)/Petition for Review of Utilization Review Determination** – LIBC 601/601: The UR is utilized by employers, and less often by injured workers, to request an independent assessment of whether medical treatment already incurred (retroactive UR) or prescribed (prospective UR) is *reasonable and necessary* for the work injury. Following submission of the UR request, a Bureau-designated reviewer issues a report approving or denying the reasonableness and necessity. In

either scenario, both parties are entitled to request review of the UR determination via a Petition for Review of UR Determination.

- **Agreement for Compensation for Disability or Permanent Injury / Supplemental Agreement for Permanent Injury or Death (Supp Agreement)** – LIBC 336/377: This form is utilized to determine the rate of compensation payable to a widow/widower and eligible dependents upon the work related death of an employee. It is also filed to reflect a termination of the eligibility of the widow (co-habitating/meretricious relationship) or dependents (if not under a disability, reaching age 18 or 23)
- **Third Party Settlement Agreement** – LIBC 380: When an injured worker receives a third-party recovery for injuries that arose out of the work injury, the employer may be entitled to repayment of past indemnity/medical benefits paid on behalf of the injured worker, and credit out of future indemnity (only) benefits payable to the employee. The Bureau has created a step-by-step form to calculate repayment/future credit, to include assessment of employer's share of third-party fees and costs.

WCAIS AND THE MANAGEMENT OF WORKERS' COMPENSATION CLAIMS

In 2013, the Pennsylvania Bureau of Workers' Compensation took a giant leap into the digital world with the introduction of its proprietary Workers' Compensation Automation and Integration System (WCAIS). This statewide claim management system provides all users real-time, 24/7 access to workers' compensation claims, including:

- Immediate access to claim documents filed with the Bureau of Workers' Compensation;
- Filing and answering petitions;
- Requesting subpoenas;
- Corresponding with the Workers' Compensation Judge and associated staff, including postponement requests;
- Confidential submission of position statements ahead of mediation;
- Submitting briefs.

Additionally, WCAIS has expanded the functionality to include filings at the Workers' Compensation Appeal Board (WCAB).

WCAIS is organized by claims, which are further divided into individual "disputes" relative to pending petitions. WCAIS has friendly "search by name" function that allows for quick access to any client's file.

New practitioners are advised to immediately sign up for WCAIS and familiarize themselves with the intricacies of the system. Thankfully, the Bureau of Workers' compensation has compiled a robust step-by-step guide – everything from signing up to advanced user forms and videos – on their website:

WCAIS - Attorney Comprehensive Survival Guide

Questions Repository, Process Guides, and Previously Recorded Trainings

PROCEDURES BEFORE WCJS

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As in every area of law, it is important to know the basic rules of engagement. In the Workers' Compensation arena, rules governing the trial of workers' compensation cases are contained in The Special Rules of Administrative Practice and Procedure, 34 Pa Code Section 131.1. The Rules establish general guidelines and time limitations practitioners need to be aware of. Though evidentiary rules and procedural formalities are typically not as strict as in other practice areas, failure to follow the judges' Rules can result in significant sanctions including the preclusion of evidence, dismissal of the action, and imposition of penalties. For example, a WCJ has the power to sanction an insurance carrier or employer for failing to respond to a claim promptly by treating facts well pleaded in the petition as admitted. Remember to read the rules and know them.

The main thrust of the Rules of Practice is administrative efficiency, and Workers' Compensation Judges are required to pay close attention to the length of time a matter remains pending. Different judges have different opinions on how to handle a matter most efficiently; however, the Rules allow WCJ's to waive or modify requirements. For this reason, the way a workers' compensation case runs can differ greatly depending upon the judge. In practice, procedures vary tremendously from region to region and judge to judge. Some judges use a "one-day trial" procedure, for example, and others conduct serial hearings. Some expert testimony to occur by deposition while others prefer to hear all witnesses live. Knowing the WCJ's expectations beforehand can be crucial to success.

It is a good practice to discuss the presiding judge with more experienced lawyers available to you. The Department of Labor and Industry required each Workers' Compensation Judge to complete a questionnaire outlining individual hearing preferences. The questionnaire includes the following: First Events (first hearing or pre-trial conference), Supersedeas Procedures, Hearings, Witnesses, Exhibits, Compromise and Release Agreements, Stipulations Resolving Disputes, Briefs, Post-Hearing Submissions, Mediations, and Special Requests. This resource is particularly useful for new attorneys or attorneys handling a case in front of a judge for the first time.

A link to the DLI website is here: https://www.dli.pa.gov/Individuals/Workers-Compensation/wcoa/judge/Pages/Individual-WCOA-Judges'-Questionnaire-(Practice--Procedure).aspx

Once a practitioner understands the governing Rules of Practice and WCJ's expectations and the WCJ's individual procedure, a practitioner must be prepared for each stage of the proceeding. Specifically, a lawyer must understand who the moving party is, the nature of the petition, and the nature and focus of the hearing at hand. The moving party (i.e., an employee in a Claim Petition and the Employer/Insurer in a termination petition) must be able to prove his or her case in chief. To represent an injured worker, a claimant's lawyer must present prima facia medical evidence supporting the claim, and medical evidence should be gathered before filing a petition. Under the rules, there should be an exchange of all available documentation at or before the first hearing. The responding party has a similar obligation to disclose relevant documentation within 45 days of the first hearing. At the first hearing, a trial schedule will be discussed and established by the WCJ, generally including specific deadlines for evidence, dates of future hearings, and a date for a mediation conference.

Typically, a first hearing is focused on the injured worker's testimony, including direct and cross-examination. By the time of the hearing, the claimant should be thoroughly prepared to testify about the injury and medical treatment facts. Documentary or photographic evidence addressed by any witness should be submitted to WCAIS, the Bureau's electronic filing system, before presentation, and all evidence should be disclosed to opposing counsel beforehand. There should be no surprises.

By rule, the scheduling of mediation must be addressed by the WCJ, and this usually occurs at the first hearing. Ideally, mediation occurs when each party has sufficient information to place a value on the case. For example, in the setting of a claim petition, the timing of mediation often depends on the occurrence of an IME, clarifying medical issues to be decided. Other issues addressed at the first hearing can include the testimony of lay witnesses, typically presented at subsequent hearings. If necessary, medical witnesses usually are taken by deposition after mediation.

When practicing before a Workers' Compensation Judge, the most important thing a lawyer can do is be prepared. Knowing the rules, knowing the judge, knowing the case, knowing your role, understanding the

evidence, and understanding what your client needs you to do are the building blocks to becoming a successful workers' compensation lawyer.

FATAL CLAIMS

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In order to bring a claim for workers' compensation benefits under the Pennsylvania Workers' Compensation Act, an injured worker must prove that an injury was sustained within the course and scope of employment and caused a resulting loss of earning power.

In a fatal claim proceeding, the surviving family member has the burden of proving that the decedent sustained an injury in the course and scope of employment and that the decedent's death was causally related to the work-related injury. Additionally, when an injured worker dies as a result of medical treatment received for a work-related injury, the law considers the death as having been caused by the work-related injury.

As with all claim petitions, the elements of a fatal claim must be established by substantial evidence. As a practical tip, in any fatal claim proceeding, it is critical to start with the testimony of the dependent, which is often the widow or widower. Basic fundamental aspects of that are a death certificate, marriage certificate, and a funeral bill.

As a practical tip, from practicing in the area of workers' compensation for 35 years and trying thousands of cases, the rarest type of case is a fatal claim petition under the Pennsylvania Workers' Compensation Act. And thankfully so. Of the 50 to 100 cases that I've tried in fatal claim petitions, the fact patterns and the consequences have run the gauntlet. In fact, often in many cases, especially suicide cases, we have to go back to the other interesting part of the Workers' Compensation Act, and that is often mental injuries and whether or not they fall into a strictly mental/mental case to show abnormal working conditions, physical/mental where a physical/mental case is often what we have to address.

There are a lot of nuances to fatal claim petitions and often on the claimant's side; although someone has clearly died on the job, there must be a showing of dependency. The starting point of any fatal claim petitions then is to make sure that you look at Section 307, which states as follows:

In case of death, compensation shall be computed on the following basis and distributed to the following persons: Provided, that in no case shall the wages of the deceased be taken to be less than 50 percent of the statewide average weekly wage for purposes of this section:

(1) If there be no widow nor widower entitled to compensation, compensation shall be paid to the guardian of the child or children; or, if there be no guardian, to such other persons as may be designated by the Board as hereinafter provided as follows:

a. If there be one child, 32 percent of wages of deceased, but not in excess of the statewide average weekly wage.

b. If there be two children, 42 percent of wages of deceased, but not in excess of the statewide average weekly wage.

c. If there be three children, 52 percent of wages of deceased, but not in excess of the statewide average weekly wage.

d. If there be four children, 62 percent of wages of deceased, but not in excess of the statewide average weekly wage.

e. If there be five children, 64 percent of wages of deceased, but not in excess of the statewide average weekly wage.

f. If there be six or more children, 66 and 2/3 percent wages of deceased, but not in excess of the statewide average weekly wage.

The amounts payable under (b), (c), (d), (e), and (f) of clause (1) of this section shall be divided equally among the children if those children are with different guardians.

(2) To the widow or widower, if there be no children, 51 percent of wages, but not in excess of the statewide average weekly wage.

(3) To the widow or widower who is the guardian of all of the deceased's children, payment shall be as follows:

a. If there is one child, sixty per centum of wages, but not in excess of the Statewide average weekly wage.

b. If there are two or more children, 66 and 2/3 percent of wages, but not in excess of the statewide average weekly wage.

(4) If there is a widow or widower who is not the guardian of all of the deceased's children, the widow or widower and to the respective guardians as follows:

a. If there is one child, a total of 60 percent of wages, but not in excess of the statewide average weekly wage, to be divided equally between the widow or widower and the child.

b. If there are two or more children, a total of 66 and 2/3 percent of wages, but not in excess of the statewide average weekly wage, to be divided as follows: 33 and 1/3 percent to the widow or widower and the remainder to be divided equally among the children.

(5) If there be neither widow, widower, nor children entitled to compensation, then to the father or mother, if dependent to any extent upon the employee at the time of the injury, 32 percent of wages but not in excess of the statewide average weekly wage: Provided, however, that in the case of a minor child who has been contributing to his parents, the dependency of said parents shall be presumed: And provided further, That if the father or mother was totally dependent upon the deceased employee at the time of the injury, the compensation payable to such father or mother shall be 52 percent of wages, but not in excess of the statewide average weekly wage.

(6) If there be neither widow, widower, children, nor dependent parent entitled to compensation, then to the brothers and sisters, if actually dependent upon the decedent for support at the time of his death, 22 percent of wages for one brother or sister, and 5 percent additional for each additional brother or sister, with a maximum of 32 percent of wages of deceased, but not in excess of the statewide average wage, such compensation to be paid to their guardian, or if there be no guardian, to such other person as may be designated by the Board, as hereinafter provided.

(7) Whether or not there be dependents as aforesaid, the reasonable expense of burial, not exceeding seven thousand dollars ($7,000), which shall be paid by the employer or insurer directly to the

undertaker (without deduction of any amounts theretofore paid for compensation or for medical expenses).

In pursuing a fatal claim there is also the possibility of being confronted with international jurisdictional cases, which requires dealing with extra territorial aspects of Section 307.

The fatal claims that we have tried include a car salesperson who was confronted by his general manager after a car sale went awry and where he pounded the desk of the conference room and suffered a fatal heart attack. We clearly had to show that the mental strain of the confrontation by the general manager caused the death.

During the financial crisis of 2008, we tried a case involving a CFO, whose international business was going into insolvency and he asphyxiated himself (i.e. committed suicide by asphyxiation) in his office on a Saturday. In order to show that he committed suicide because of his work, we had to have testimony that a 2008 financial crisis was an "abnormal" working condition to prove that the claim was compensable as a mental/physical claim the Workers' Compensation Act, which does not otherwise cover self-inflicted injuries.

The other aspect of a fatal claim case is to make sure that you lay a foundation for your expert. This takes the gathering of evidence in order to provide you with a hypothetical based on facts of evidence for your medical expert. Your medical expert then has the foundation to testify based on evidence of record and can give an opinion within a reasonable degree of medical certainty that the decedent died from an injury or disease caused by their employment.

Recently, over the last year we have seen a number of cases involving workers that have passed from COVID-19 and whether or not they contracted COVID-19 while at work.

Often after presenting your evidence on a fatal claim, the employer will consider the financial consequences of a potential lifetime case (assuming the widow does not remarry or enter into a meretricious relationship), which may incentivize the employer to possibly resolve the case. Nevertheless, these cases also have an aspect to them that may make the employer adverse to the idea of incurring any publicity surrounding the death of an employee while on the job. That should be considered by both sides in negotiating the

settlement of a fatal claim, in regard to whether or not the resolution should be confidential, even though there is not a confidentiality article under the Workers' Compensation Act.

In sum, a successful fatal claim requires the trial attorney to establish dependency and to engage in a thorough review of the facts of each specific case, in order to accumulate myriad evidence, which must be analyzed and scrutinized by a qualified medical expert to ensure all elements are met to prevail before the workers' compensation judge.

MENTAL CLAIMS

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Mental claims are recognized under the Workers' Compensation Act ("Act") in Pennsylvania and have become increasingly more popular for several reasons. In addition to the widespread acceptance and promotion of treatment for mental problems in our society, an increasing number of mental claims are being made. Additionally, there are strategies for using mental claims to increase the value of workers' compensation settlements. Mental claims are also used in order to attempt to increase the percentage of whole-body impairment for impairment rating evaluations, now that the threshold for unlimited benefits has dropped to 35% from 50% whole body impairment. Psychological injuries resulting from work accidents, or mental affect, are now used to determine the percentage of whole-body impairment under the newest addition of the AMA guidelines. Further, an increased number of worker's compensation judges (WCJ's) are seemingly accepting mental claims more routinely than in the past.

There are three types of mental claims under Pennsylvania Worker's Compensation law:

A. Physical/mental claims

B. Mental/physical claims

C. Mental/mental claims

A. PHYSICAL/MENTAL CLAIMS

A physical/mental claim is one where there is a physical stimulus that creates a mental problem. For instance, if a person has a significant lower back work injury that prevents him from being able to work again in the future, it can take a toll on him or her mentally as well. Anxiety and depression can set in following a nasty traumatic injury, causing a person to require psychological treatment and/or medication to treat this resulting psychological condition.

The burden of proof required on a physical/mental claim is simply proving that the psychological injury arose out of the physical injury. This is the easiest burden of proof of all three types of mental claims under the Act.

Typically, a claim petition or a review petition is filed alleging that a particular psychological diagnosis arose out of the already accepted physical injury. In addition to testimony of the claimant, a mental health professional should testify on behalf of the claimant that the mental condition arose out of the physical injury, causing the claimant to need psychological treatment and/or work restrictions as a result of the condition.

Besides anxiety and depression, post-traumatic stress disorder (PTSD) is a common diagnosis in this arena for people who have experienced traumatic events at work, such as a near-death experience. Once a psychological claim is established, it becomes more difficult to show a full recovery from that condition by the defense. This ultimately results in an increased value of the claim for settlement purposes.

B. MENTAL/PHYSICAL CLAIMS

Mental/physical claims are physical injuries that result from a mental stimulus. For example, a person who witnesses a robbery at work that results in the death of a coworker and experiences PTSD can also develop physical injuries as a result, such as irritable bowel syndrome, aggravation of underlying colitis, or even a heart attack/cardiac event in extreme cases.

It should be noted that if the physical injury/disability results from such a mental stimulus, the Pennsylvania Supreme Court has held that there is no requirement to prove an "abnormal working condition." The abnormal working condition requirement is a further burden for successful mental/mental claims. It is cautioned that proving the causation of a physical injury/disability as a result of a mental stimulus is a difficult burden, and it will be necessary for the medical expert to be able to show within a reasonable medical certainty how the physical condition was caused by the mental stimulus. Important factors in considering these claims would be the existence of any prior similar physical conditions and the severity of the work event.

C. MENTAL/MENTAL CLAIMS

Mental/mental claims are the toughest psychological claims to bring under the Pennsylvania Workers' Compensation Act. The reason is because of the added burden of proof prong: abnormal working conditions.

A mental/mental claim is one where a mental stimulus causes a mental injury/disability. For instance, witnessing a shooting in the workplace environment is a mental stimulus that can create a disabling mental injury, such as post-traumatic stress disorder or severe anxiety/depression.

In order to prevail in mental/mental claims, the requirement of an "abnormal working condition" must be shown to exist. A good example would be a claimant, a clerk in a drugstore in a suburban town that has never had any issues with robbery or violence in the past, witnesses the shooting and killing of several customers and coworkers during a robbery of the store. The claimant is not injured herself, but experiences a significant PTSD as a result of what she observed and becomes psychologically affected to the point where she cannot even leave her house for fear of being killed as a witness to the crime, requiring significant psychological treatment and/or even in-patient hospitalization.

It is easy to conceptualize that this event of witnessing the death of other people in this particular setting is an abnormal working condition; however, in a similar scenario, consider a police officer who also witnesses the shooting and death of several innocent bystanders and other fellow police officers by an active shooter while in the course and scope of being called to that horrific event. Is that an abnormal working condition? The result could be much worse than in the store robbery, but the courts have held that witnessing the shooting death of others as a police officer does not constitute an "abnormal working condition" because it is expected that police officers have to deal with that situation as part of their everyday work duties. The condition then is "normal" for that type of employment.

Each and every mental/mental claim scenario must be cautiously treated and the decision to represent claimants in these mental/mental cases should be scrutinized carefully on a case-by-case basis. The burden of proving "abnormal working conditions" can be very difficult, although there are several strategies to help simplify the requisite proof.

Mental claims should not be overlooked when assessing a workers' compensation claim. The physical/mental type claim is the most common mental claim. It occurs frequently and the burden of proof is not difficult. The biggest pitfall to a mental claim is a significant psychological past history. While an aggravation of underlying pre-existing conditions is compensable under the Act, the stigma of psychological claims still exists in this day and age, and the showing of a significant prior past psychological history can ruin the credibility of the claimant in the eyes of a WCJ.

Tread cautiously when bringing these claims and never hesitate to consult a PAJ certified specialist workers' compensation attorney for guidance.

USE OF EXPERT WITNESSES IN WORKERS' COMPENSATION

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Pennsylvania Rule of Evidence 401 indicates that evidence is relevant if a) it has any tendency to make a fact more or less probable than it would be without the evidence; and b) the fact is of consequence in determining the action. In Pennsylvania workers' compensation practice, judges are not bound by common-law or statutory rules of evidence in conducting a hearing or investigation, *but* all findings of fact must be based on sufficient, competent evidence. Section 422(a), 77 P.S. § 834. The admission of evidence is within the discretion of the WCJ, and a WCJ may properly exclude evidence that is irrelevant, confusing, misleading, cumulative, or prejudicial. *Washington v. WCAB (Commonwealth of Pa. State Police),* 11 A.3d 48 (Pa.Cmwlth. 2011).

During a workers' compensation proceeding, relevant evidence is admitted throughout the pendency of litigation in order to provide the judge, who ultimately decides the case, the story of what happened. Witness testimony, and more specifically, expert witness testimony, may be the most important piece of that evidence.

Pennsylvania Rule of Evidence 702 provides for expert opinion by a witness qualified as an expert by knowledge, skill, experience, training, or education. *Craftex Mills, Inc., v. WCAB (Markowicz),* 901 A.2d 1077 (Pa.Cmwlth. 2006). The most common expert witnesses in a Pennsylvania workers' compensation matter are the doctors. In most disputed cases, the moving party cannot meet its burden without the submission of competent, medical evidence. Likewise, the opposing or responding party cannot defend its position without submitting medical evidence. Qualified doctors are able to provide opinions regarding causation, work-related diagnoses, restrictions, and recovery.

Most of the time, the injured worker presents deposition testimony from his or her treating physician. On the other hand, the employers typically present testimony from a defense medical examiner who examined the injured worker one time for the purpose of rendering opinions in conjunction with the workers' compensation litigation. It must be noted that greater credence may be given to the testimony of a treating physician than to a

physician who examines a claimant solely for the purpose of providing testimony in workers' compensation proceedings. *Zimmerman v. W.C.A.B. (Himes),* 519 A.2d 1077 (Pa. Cmwlth. 1987).

The doctors' depositions are usually taken in lieu of live testimony, and the transcripts from such depositions are submitted as part of the evidence. Depositions are usually necessary as medical reports are generally considered hearsay and would not be admitted to the case as part of the evidentiary record. However, there are times when parties may proceed on reports alone. Medical reports are admissible without the need for sworn testimony where the employee seeks benefits for a loss in earning power for a period of less than 52 weeks. *Ruth Fam. Med. Ctr. v. WCAB (Steinhouse)*, 718 A.2d 397 (Pa.Cmwlth. 1998). Moreover, when disability is not an issue, medical reports are admissible. *CVA, Inc.v. WCAB (Riley),* 29 A.3d 1224 (Pa.Cmwlth. 2011).

Furthermore, a deposition provides the doctor with the opportunity to explain opinions in more detail. It also allows the doctor to reconcile the injured worker's subjective complaints offered in testimony with the objective medical evidence of record.

There are a variety of other expert witnesses that may be presented during a workers' compensation proceeding. The employer may present a vocational expert when litigating a modification petition in which the employer is seeking to lessen the amount of disability benefits being paid to the injured worker. A vocational expert performs labor market surveys and testifies about potential job availability within the injured worker's geographic employment area. An actuary or forensic accountant may be called to testify regarding contributions from pension or disability plans that would allow for a credit on an injured worker's benefits.

No matter who the expert is, it is important for the expert to understand the specific reason why he or she is being called to provide an opinion. For example, a doctor testifying during the litigation of a claim petition may need to establish that the worker's injuries were in fact caused by a work incident. On the other hand, a doctor testifying during the pendency of litigation on a review petition may only need to prove that the injured worker sustained additional injuries beyond those already acknowledged by the employer.

It is also important for the expert witness to have a thorough understanding of other evidence relevant to his/her testimony. By having an understanding of other relevant evidence, the expert witness can provide

competent and credible opinions. For example, if an injured worker's treating physician is providing testimony, the treating physician should also be provided with the defense medical examiner's report and/or testimony if available. That way, the doctor will have an opportunity to comment and potentially dispute any points of disagreement. Moreover, the doctor, and his or her opinions, will be deemed more credible.

For an attorney litigating a workers' compensation case, it is also imperative that he or she has as much information as possible when formulating strategies, including choosing expert witnesses. When identifying a medical expert who is going to testify, the attorney should review records from all treating physicians in order to determine who is best suited to provide testimony in the matter at hand.

After evidence and witness testimony is submitted and the record is closed, it is up to the WCJ to evaluate the weight of the evidence and to determine the credibility of all witnesses. *McDermott v. WCAB (Brand Industrial Servs., Inc.),* 204 A.3d 549 (Pa.Cmwlth. 2019).

Overall, expert witness testimony is a crucial piece of the puzzle in most workers' compensation proceedings. A case may be won or lost based on the presentation of these witnesses. Therefore, careful consideration must be given when identifying expert witnesses. Once the expert is identified, thorough preparation, including providing the witness with all of the necessary evidence to review, is vital. With careful consideration and thorough preparation, an expert witness can provide substantial, competent, and credible, relevant evidence posturing the case for a successful outcome.

SPECIFIC LOSS AND DISFIGUREMENT

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The Pennsylvania Workers' Compensation Act provides benefits for permanent injuries that constitute loss of use and disfigurement benefits. The provisions for loss of use are set out in §306 (c) of the Workers' Compensation Act. That section covers loss of use of body parts; hearing loss; and serious, permanent, and unsightly disfigurement of the head, face, or neck. Benefits range from a low of the loss of a fourth finger in the amount of 28 weeks of benefits, to a high of 410 weeks of benefits for loss of an arm or leg. Disfigurement benefits are limited to a maximum 275 weeks.

Loss of hearing benefits are limited to 60 weeks for one ear and 260 weeks for two ears. However, few hearing loss awards reach the maximum amount. A percentage of impairment is required to be calculated under the Impairment Guide, which is then multiplied times either the 60 weeks or the 260 weeks. No benefits shall be paid unless the percentage impairment exceeds 10 percent. The percentage impairment is determined solely by audiogram. If the hearing impairment is calculated at more than 75 percent under the impairment guide, then a presumption is triggered that the hearing impairment is total and complete. The injured worker would then be entitled to 260 weeks of benefits.

Loss of one half of the fingers of the hand is compensable. Loss of the first phalange of the thumb is considered loss of the thumb. Loss of a substantial part of the first phalange is considered loss of one-half of the thumb. Likewise, loss of any substantial part of the first phalange of a finger is considered one half of the finger. Greater losses entitle the worker to loss of the entire finger.

Injured workers are also entitled to a healing period. According to §306 (c) (25), the healing period ends: 1) when the Claimant returns to employer without impairment and earnings, or; 2) on the last day of the period specified in the section. A certain number of weeks are applied to each loss of body part as a healing period.

For disfigurement to be compensable, the disfigurement must be serious, permanent, and unsightly. For a disfigurement to be considered permanent, it must be present at a date at least six months removed from the

date on which the disfigurement occurred. It also must not be normally incident to the employment. For instance, steelworkers who worked near blast furnaces often suffered pockmarked disfigurement on their faces from flying metal particles. The Appellate Courts have determined that this disfigurement was normally incident to the employment in the job. Therefore, it was not compensable.

Certain disfigurement is amenable to plastic surgery. Practitioners may wish to counsel clients to exhaust the benefits of plastic surgery prior to seeking an award for disfigurement. If an award for disfigurement is paid and the injured worker subsequently seeks plastic surgery, the workers' compensation carrier does not have to pay until the bill exceeds the amount paid for the disfigurement.

Disfigurement can be paid for loss of a tooth or teeth. Case law indicates that if the injured worker wears a removable dental device — and does ***not*** intend to undergo the surgical implantation of a permanent tooth or teeth — disfigurement benefits are awarded based on the worker's appearance without the removable device. However, if the injured worker intends to have a permanent implant of a tooth or teeth, the workers' compensation judge may not assess disfigurement until after the permanent implantation has been accomplished.

Each loss of use case should be analyzed to determine whether the injured worker received other injuries separate from the loss of use that would disable the worker. Loss of use payments would begin after the end of the period of total disability benefits. Loss of both hands or arms and both feet or legs or both eyes is treated as total disability.

SUBROGATION LIENS AND THIRD-PARTY SETTLEMENT AGREEMENTS

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SUBROGATION LIENS

Subrogation liens in workers' compensation cases typically arise when an injured worker is initially denied workers' compensation benefits but begins receiving payments for disability or medical expenses from the employer's other insurance carrier, rather than the employer's designated workers' compensation insurance carrier. These subrogees are typically group health insurance carriers and short-term disability policies purchased through the employer. If it is later determined that the injury is compensable under the Act, the employer or insurance company making the initial payments are entitled to subrogation if that right is agreed to by the employee and the party making the payments, or if that right is established at the time of hearing before the workers' compensation judge (WCJ) or Board. Typically, an insurance carrier asserting a subrogation claim will contact the injured workers' attorney and put them on notice of their right to subrogation. At that point, the attorney is under a duty to make all parties to the workers' compensation claim aware of the subrogation claim. These types of subrogation claims are covered under section 319 of the Act, specifically 319, 77 P.S. § 671. Subrogation under this section is not absolute or self-executing and must be asserted with reasonable diligence. If the subrogation claim is not asserted by the party looking for reimbursement during the initial proceedings, the claim will be deemed waived.

As a practical matter, any attorney receiving notice of a potential subrogation claim should immediately put all parties on notice, as well as obtain an itemized copy of any and all charges the subrogee is claiming. The itemization should be entered into the record as evidence in the case in chief should there be an award of benefits by the WCJ. That said, the attorney in a workers' compensation case is under no duty to try and ascertain if any subrogation liens exist. That burden rests solely with the company claiming a right to subrogation in any given case. These subrogation claims are most typically made by group health insurers whose policies are purchased through the employer.

In cases where a short-term disability policy has begun payments to an injured worker and the policy was purchased through the employer, it is important to figure out what percentage of the premiums were paid by the employer versus the employee through payroll deductions. The policy provider is only entitled to subrogation of the amount paid by percentage. For example, if an employee receives $500 per week, and the employee contributed 50% of the premiums on that policy, the employer is only entitled to subrogation of $250 per week. Defendant's counsel will bear the responsibility of obtaining this information from the employer and providing it to Claimant's counsel for review. Claimant's counsel should also request pay stubs to verify what amounts were paid through payroll contributions to the policy premium.

Lastly, in cases where an injured worker has purchased a disability policy on their own, and not through the employer, it is that insurer's responsibility to assert a subrogation lien. That said, it would be wise to counsel the injured worker that an award of indemnity might trigger a reimbursement clause in the policy. In these cases, it is prudent to have the injured worker obtain a copy of the short-term disability policy language to see what rights and obligations an award of benefits might have on them.

THIRD-PARTY SETTLEMENT AGREEMENTS

Third-party settlement agreements and subrogation relating to recoveries from third parties is governed by section 319, 77 P.S. § 671 and the proper calculations can be found on LIBC form 380. When workers' compensation benefits have been paid, or are being paid, as a result of the act or omission of a third party, the employer shall be subrogated to the right of the employee to the extent of the compensation payable under this article. When a settlement or judgment is reached against a third party, reasonable attorney's fees, costs, and other proper disbursements shall be prorated between the employee and the employer per the calculations set forth on the Third-Party Settlement form, which is LIBC 380. The Third-Party Settlement form is self-explanatory and the calculations to be performed are explained in detail on the form.

There are three underlying purposes for the section 319 right to subrogation. Per the Supreme Court, section 319 prevents an employee from receiving a double recovery for the same injury, ensures that the employer is not forced to pay for the acts of negligent third parties, and prevents a third party from escaping liability for its negligent act. An employer's statutory subrogation rights under section 319 are absolute and not

subject to other equitable principles unless there is a finding of bad faith on the part of the employer. However, an employer is only entitled to subrogation for those injuries covered by a third-party judgment or settlement. For example, if a third-party settlement addresses specific injuries covered under that settlement, but not all injuries that have been paid by the employer, the employer may only subrogate the amounts paid per the injuries outlined in the third-party agreement. Other than this potential reduction of employer's subrogation rights, the courts have routinely and consistently held that the employer's right to subrogation is absolute to their full statutory authority. As a practical matter, counsel for the injured party should always try to reduce the lien amount owed if it is more than one-third of the gross amount of the third-party settlement, even though principles of equity do not apply. Many insurance companies would make sure they obtain some recovery rather than potentially receiving nothing, because it would not benefit the injured worker to settle the third-party claim and also end up with nothing.

A recent case from the Commonwealth Court, Whitmoyer v. WCAB (Mountain Country Meats), 186 A.3d 947 (Pa. Cmwlth. 2018), further defined what constitutes "future installments of compensation" for cases in which a Claimant is still receiving workers' compensation benefits at the time of the third-party settlement. Prior to Whitmoyer, both indemnity benefits and medical benefits were subject to a pro-rata deduction on all future benefits paid by the employer until such time as their full lien was recovered. What this meant was that an injured worker would bear the brunt of paying a portion of every medical bill incurred due to their injury. The Court in Whitmoyer changed this, so that only the indemnity portion of the injured workers benefits can be reduced, leaving the employer to remain responsible for the full amount of any future medical bills. Again, these calculations and provision can be found on LIBC form 380.

MEDIATIONS

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As is often the case with civil cases, workers' compensation cases frequently settle prior to going to decision. While these settlements sometimes occur simply between claimant's counsel and defense counsel (or the adjuster) and without the need for a third party, these resolutions are often accomplished at mandatory mediations and voluntary mediations.

Mandatory mediations are scheduled by the workers' compensation judge (WCJ) at the first hearing, and while they are required to take place no later than 30 days prior to the date set for filing proposed findings of fact and conclusions of law (see 77 P.S. § 710), they are typically scheduled within the first month or two subsequent to the first hearing. The parties often desire to have them scheduled prior to certain evidentiary deadlines (if possible) so as to avoid having to pay extensive litigation costs such as expert deposition fees. Mandatory mediations are not conducted by the adjudicating WCJ, and are conducted by another WCJ sitting in the same field office.

Voluntary mediations, on the other hand, can be heard by an adjudicating WCJ (with the consent of both parties). Oftentimes, voluntary mediations are conducted by a WCJ of the parties' mutual approval and by a WCJ who may not even preside in the adjudicating WCJ's field office.

Most WCJs require both parties to submit mediation memorandums, which generally lay out the facts of the case, procedural posture, strengths, weaknesses, and, of course, where settlement negotiations stand and what have been the respective demands and counteroffers, if any. It is good practice to consult the mediating WCJ's procedural questionnaire on the Workers' Compensation Automation and Integration System (WCAIS), as this will often outline the specifics for the mediation memorandum, such as page length, content, format, how often in advance they are required to be submitted, and if one is even required at all. That being said, even if the mediating WCJ does not require a mediation memorandum, it is still good practice to submit one so that the mediating WCJ has a grasp of the facts and the parties' positions.

Defense counsel will typically push for a global resolution of your client's claim, meaning they will want to settle both the wage and medical portion of the claim. This is something to discuss with your client before mediation and making a demand. While there may be some scenarios where your client is at a point in his or her medical treatment where global settlement is attainable and more palatable, oftentimes it is advisable to gauge whether Defendant/Employer is willing to enter into a wage-only settlement while leaving the medical portion of the claim open. Of course, as mentioned above, this will vary from case to case.

In addition to the wage and medical issues, there are other important ancillary issues to take into account with settlement. For example, if your client is receiving Medicare or is Medicare-eligible, and the settlement amount is greater than $25,000.00, then the defense must fund a Medicare Set Aside (MSA), or, alternatively, the medical portion of the claim must be left open. This is also true if your client has a reasonable expectation of becoming Medicare-eligible within 30 months of the settlement date and the settlement amount is greater than $250,000.00. Additionally, even if an MSA is not required, it is still good practice to take Medicare's interests into account by way of an allocation in the Compromise and Release Agreement.

Another issue to take into account at mediation is whether there is concurrent third-party litigation and a Section 319 lien exists. If so, it is desirable, if possible, to gauge whether the lienholder is willing to negotiate down the amount of the lien, or even waive it in its entirety, as part of the workers' compensation settlement.

Other issues to take into account at mediation are whether or not the employer requires a letter of resignation as part of the workers' compensation settlement, whether a general release is also required, whether there are any future potential offset issues (i.e., Social Security Disability and Retirement), whether sick and/or vacation time will be reimbursed (if no letter of resignation), or whether there are any Act 109 child support arrearages. These are all items to go over with your client in detail prior to engaging in mediation and/or settlement.

Finally, although litigation costs are typically reimbursed by the defense as part of the settlement, it is good practice to confirm the same, as certain carriers may balk at reimbursement if the amount is fairly high, or if the case is not in active "litigation" and thus not technically considered to fall under litigation costs.

COMPROMISE AND RELEASE AGREEMENTS

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As was previously mentioned, injured workers are entitled to two primary benefits under the Pennsylvania Workers' Compensation Act ("Pa WC Act" or "Act"). Those benefits are wage loss or replacement benefits, and medical benefits or payment of their work-related medical bills. Both types of benefits can now be settled under the Act. Prior to the 1996 amendments to the Pa WC Act in Act 57, the parties could only settle wage loss benefits through a **COMMUTATION** under Section 316 of the Act. In a Commutation, medical benefits remained open indefinitely. Insurance carriers lobbied hard for a vehicle that would allow them to end all liability in a workers' compensation claim. As a result, the **COMPROMISE and RELEASE,** or what is more commonly referred to as a C & R, was born.

Act 57 added Section 449 to the Act, which allows the parties to settle both wage loss and medical benefits, by agreement. All settlements under the Pa WC Act must be approved by a workers' compensation judge ("WCJ") or the appeal board. The specific terms of the settlement or Compromise and Release must be enumerated in Bureau form LIBC-755. The specific content of Bureau form LIBC-755 is outlined in Section 449 (c) of the Act. One provision of the C & R Agreement that is worth highlighting is the requirement that the Agreement be "explicit with regard to the payment, if any, of reasonable, necessary and related medical expenses" (See 1st para. of Sec. 449 of the Act).

A hearing must then be conducted, at which time the WCJ will determine whether the injured worker or claimant understands the "full legal significance of the agreement" (See 1st para. of Sec. 449 of the Act). This understanding by the claimant is typically established by claimant's counsel asking the claimant a series of questions, in open court, to prove to the judge that the claimant completely understands what he is getting and what he is giving up in the settlement. The Act requires that C & R hearings and decisions be expedited to facilitate bringing finality to the claim as agreed to by the parties.

If there is litigation pending in a case at the time it settles, the parties must advise the judge whether the C & R resolves all or some of the litigation. Best practice is to include a statement in the C & R Agreement as to how the parties want the judge to treat the pending petitions.

It is also a good idea to include Social Security offset language in the C & R Agreement in order to protect your client from a full or significant suspension of their Social Security Disability ("SSD") benefit until they exhaust or spend the settlement proceeds. (See Sciarotta v. Bowen, 837 F.2d 135 (3rd Cir. 1988). This offset does not apply to claimants who are receiving Social Security retirement benefits. Be advised that if the claimant is on SSD and is in possession of a Medicare card, the parties will need a Medicare Set Aside or MSA to settle this claimant's right to future medical benefits. This is a requirement of the Social Security Administration ("SSA") so they can protect Medicare's interest in the payment of the claimant's future work-related medical bills. In other words, SSA wants to make sure that the workers' compensation carrier, who is primarily liable for the payment of medical bills in the compensation claim, pays their fair share of future medical expenses before those expenses will be paid by Medicare. Generally, the workers' compensation carrier will obtain an MSA or an estimated MSA as part of the C & R Agreement since they are the party who is seeking a release of their obligation for paying future medical expenses. The C & R Agreement also addresses conditional payment of medical expenses by Medicare that should have been paid by the workers' compensation carrier. If these payments were made, claimant's counsel needs to make sure the C & R Agreement specifically says the workers' compensation carrier will reimburse Medicare for these payments.

Claimant's counsel should be on notice that C & R Agreements, once approved by a judge, are final. Issues regarding the description of the work injury, the payment of medical bills and wording that might affect non-workers' compensation claims against the employer such as a claim under the Family and Medical Leave Act must be considered before approval (See Zuber v. Boscov's, 871 F.3d 255 (E.D. Pa. 2016). These issues might also affect your client's ability to use his private health insurance if he plans to continue treating the work injury after settlement. Counsel should also advise his client that any side agreements such as a general release or resignation from employment, which are typically requested by the employer as part of the settlement, could jeopardize a future wrongful discharge or employment discrimination claim, as well as a claim for

unemployment compensation. Note, WCJs do not have jurisdiction over these side agreements, so they need to be put on separate documents, and separate consideration must be given to make them enforceable. These side agreements should not be contingent on the judge approving the C & R. In fact, these side agreements should not be attached to the C & R Agreement or given to the judge.

The payment of the settlement proceeds under a C & R Agreement is typically made within 30 days of the C & R hearing, or at a time when the 20-day appeal period from the decision approving the Agreement has expired. The parties can waive the appeal period to expedite payment. If desired, this should also be mentioned in the body of the C & R Agreement. Finally, some Judges will sign bench orders at the hearing approving the C & R Agreement so defense counsel has something tangible to send to the adjuster that day to start processing payment of the settlement. If the claimant agrees to accept the bench order as a final order, it will be treated as such.

PENALTY PETITION

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What is a penalty petition? Section 435 of the PA Workers' Compensation Act gives the employee only the right to ask the workers' compensation judge (WCJ) to issue an order granting a monetary award, or penalty, against the employer for any violation of the Act or judicial order. A typical example is when the employer fails to pay for benefits awarded either by agreement or order, but it can also be granted for not paying medical bills, issuing notices timely, and other similar conduct. The penalty can be as much as 50% of the amount of the late or unpaid award, bill, weekly check, etc., but the usual award is for 10%-20%, with escalating awards for unreasonable delay. The award is within the sole discretion of the WCJ, and only can be challenged on appeal for an abuse of discretion.

How do I file a penalty petition? There is a special Bureau form (LIBC 378) that is online on the Workers' Compensation Automation and Integration System (WCAIS) although it still can be filed by mail for unregistered users of the online system, usually pro se claimants who need representation. You can theoretically file it orally before the WCJ, but given the forms and the evolution of the e-filing practice, it is strongly suggested to file it electronically so it has a dispute number associated with it.

What happens at the first hearing? Usually, the WCJ will hold a pretrial hearing and see if the differences can be worked out or set a trial schedule where each side gets a date to submit evidence. But often, you are already in the midst of litigation, like a claim and penalty filed together if, for example, your client gets hurt at work and reports it to her supervisor but the insurance carrier does not issue a notice of denial or other notice acknowledging the incident. As stated in another chapter, this failure to pay the claim or reasons for denying it must be reported this way to the employee within 21 days. The employer's failing to do anything forces the employee to hire you to pursue the wage loss claim. You would file a claim and penalty petition for failure to file a timely notice in this instance.

Who has the burden of proof? There is the general rule that the moving party has the burden, but where the allegation is a violation of the Act, the employee has the burden to make out a prima facie case of a

violation which would support an award if unchallenged. The burden then shifts to the employer to show why it did not violate the Act or create a factual dispute of whether any violation occurred at all. Such example, using the facts above, is if the employer can successfully persuade the WCJ that the employee did not report the injury to his or her supervisor, and thus notice was only when the claim petition was filed. The employer would not have violated the Act in failing to issue a notice accepting or denying the claim.

Can I request unreasonable contest attorney's fees on a penalty petition? The short answer is yes: in any contested matter the ability to ask for unreasonable contest fees is available as a remedy, which was covered in another chapter in greater detail. You must make a measured judgment if it is realistic and practical to succeed on such a request, as the standards for succeeding are very high and difficult to achieve. Most judges are receptive to awarding attorney's fees if the employer was unreasonable in denying, delaying and defending against the petition. It is important to argue that the employer filed an answer with a blanket denial of all the allegations, forcing you to prove all the elements even though some of them should have been admitted, for instance. You should introduce both your petition and the answer as exhibits.

What is my fee? Starting with the basics, you can charge up to 20% of whatever recovery you achieve on behalf of your client. That would include enforcement of the underlying late payment, and the additional penalty on top of that. However, if you are successful in achieving an unreasonable contest, the same rule applies: to the extent you are paid the unreasonable contest fees, your client receives a credit against the contingent fee you otherwise would have been paid, until the unreasonable contest attorney fee is exhausted. You would then receive any balance from the underlying award.

What if I didn't like the decision in some respect? Can I file an appeal? As in all cases, you can file an appeal within 20 days to the Workers' Compensation Appeal Board and even to the Commonwealth Court, if there exists a legal issue that maybe the WCJ disregarded, or there was an abuse of discretion, such as despite the egregiousness of the delay, no penalty was awarded, which would be very fact-specific. It is important to include the penalty petition and answer, and sometimes if the argument in the brief of the employer has material mistakes, you can ask the appeal board to expand the record to add the parties' briefs to support your appeal

reasons. It is important to list all of the errors, both factually and legally, to preserve them for appeal. Otherwise, they could be waived.

APPEALS OF WORKERS' COMPENSATION JUDGE DECISIONS AND BEYOND

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Appeals from a decision of a workers' compensation judge (WCJ) are governed by Section 423 of the WC Act, Pa. Stat. Ann. tit. 77, §853 – 854.2, and 34 Pa. Code §111.1. et. seq. Appeals can be taken from a final order of a WCJ within twenty (20) days of the decision to the Workers' Compensation Appeal Board (WCAB). The specifics of the requirements are on the face sheet of any WCJ decision. There is no right to appeal an interlocutory order a WCJ issues and the WCAB will not entertain such an appeal. This time period to appeal is rarely ever extended unless a request is made before the twenty (20) days runs. Tone Grande, Inc. v. WCAB (Rodrigues), 455 A.2d 299 (Pa. Cmwlth. 1983).

All appeals, as with any pleading in a WC case, must be filed by an attorney through the Workers' Compensation Automation and Integration System (WCAIS). It is not necessary to have a separate document to upload with the reasons for the appeal. The form in WCAIS has sufficient space to provide all the reasons for the appeal. There is the option to have the case heard solely on briefs if both parties decline argument. That can be done when filing the appeal on WCAIS by the appellant.

It is required that specific exception be taken to each finding of fact and/or conclusion of law that the party wishes to challenge. This includes listing the specific finding of fact or conclusion of law in the form on WCAIS. This requirement is so the WCAB and the opposing party are on notice as to the issues being challenged. Failure to specifically state the issues waives any issue for consideration on appeal even if it is argued in the brief that is filed. Marx v. WCAB (United Parcel Service), 990 A.2d 107 (Pa. Cmwlth. 2010); GA & FC Wagman, Inc. v. WCAB (Aucker), 785 A.2d 1087 (Pa. Cmwlth. 2001). For example, just saying that substantial evidence does not support the decision of the WCJ is insufficient without specifying what evidence is being challenged.

After the filing of the appeal, the parties receive an acknowledgement from the WCAB of the appeal. This includes the date of the hearing and when briefs are due. Currently the appellant's brief is due at the time of the hearing, while the appellee's brief is due thirty (30) days after the hearing. The form of the brief is

specified in the regulations at 34 Pa. Code §111.16. This practice should change in 2022 as there are regulations awaiting final approval. The briefing schedule will change so that the appellant's brief would be due thirty (30) days after acknowledgement and the appellee's brief thirty (30) days thereafter. This will afford the WCAB to be a hot bench when argument occurs, which is not the current (2021) practice. In addition, the briefs will then include a summary of argument which they do not now.

At the present time (2021), the WCAB takes about 11 months from the filing of an appeal to final decision. That decision is mailed to all parties (including the injured worker) unless an attorney has selected service electronically through WCAIS. The authority of the WCAB is to review de novo any errors of law raised or to decide if substantial evidence supports the factual findings of the WCJ. The WCAB does not have the authority to rule on any constitutional challenges to the statute and will defer such a decision to the appellate courts.

Service of a final WCAB decision then triggers the thirty (30) day appeal period to Commonwealth Court. Pa. Stat. Ann. tit. 42, §763. If the case is remanded to the WCJ, it is premature to seek review in Commonwealth Court, as the court considers that an interlocutory appeal. Instead, after the remand decision if the issue is still ripe, then another appeal should be filed. Counsel can then ask the WCAB to just issue a summary decision permitting an appeal to Commonwealth Court without having to go through the entire process before the Board. Shuster v. WCAB (Pennsylvania Human Relations Comm'n), 745 A.2d 1282 (Pa. Cmwlth. 2000).

Review is sought in Commonwealth Court by the filing of a Petition for Review with the court, not with the WCAB. The contents of the Petition for Review are governed by PA Rule of Appellate Procedure 1511. After the filing of the Petition for Review, Commonwealth Court will send notice to counsel for the filing of a Docketing Statement, which contains self-explanatory instructions. Once the WCAB files the record with the court, a briefing schedule is set, which allows the Petitioner forty (40) days to file the brief and reproduced record. Within ten (10) days of receiving the briefing schedule, the Petitioner is to file a Statement of Issues and Contents of the Reproduced Record. PA Rule of Appellate Procedure 2154. Finally, by the deadline the brief and reproduced record are filed with the court. It cannot be stressed strongly enough to make sure you are

familiar with the Rules of Appellate Procedure on all aspects of filing the brief and reproduced record. Cases have been lost for failure to conform.

Commonwealth Court hears only selected argument on cases. Notice will be provided approximately one month before the case is to be heard. If it is to be heard on brief with no argument, a petition can be filed requesting argument. These are rarely granted. On rare occasions, the court, after the date the case was to be decided, will send notice that the matter will be heard en banc. That is only evidence that there is a strong split in the court regarding the disposition of the case. That is neither good nor bad news on the case.

A decision is eventually sent to the parties. There is an option for an application for rehearing en banc but those are granted even less frequently than a request for oral argument. This must be filed within fourteen (14) days of the decision. It stays the period to file an appeal to the Supreme Court for up to sixty (60) days. If no decision on the application is made by that time, the application is deemed denied.

An appeal to the Supreme Court is an extraordinary undertaking. It is done by Petition for Allowance of Appeal and must be filed within thirty (30) days of the decision of Commonwealth Court unless rehearing is requested. PA Rules of Appellate Procedure 1101, et. seq. The standards for the Court accepting the appeal are governed by PA Rule of Appellate Procedure 1114(b). The Court takes very few cases and only the most important issues should be taken up or if counsel is attempting to have the Court reconsider earlier decisions. If one wishes to pursue this avenue, we say good luck.

One final point regarding appeals. The PAJ has a very active Amicus Curiae Committee composed of members throughout the Commonwealth who practice in all fields. The Committee is available to provide support in important cases before Commonwealth Court. It will almost always agree to participate should you get your case before the Supreme Court. A request for amicus should be made at the earliest possible time in cases at Commonwealth Court, primarily when you file your Petition for Review. At the Supreme Court, please wait until the case is accepted. Note that if you have amicus at Commonwealth Court and decide to file a Petition for Allowance of Appeal with the Supreme Court, the Committee can file a brief in support of the Petition. You can find the form to request the amicus on the PAJ website, under the Connect To drop down menu, and the form has all the instructions needed to apply.