MARSHALL DENNEHEY
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Special Law Alert

HOUSE BILL 373 ENACTED TO CONTROL THE LEVEL OF WORKERS' COMPENSATION INSURANCE PREMIUMS BY MAKING SIGNIFICANT CHANGES IN THE MEDICAL REIMBURSEMENTS ALLOWABLE UNDER THE HEALTHCARE PAYMENT SYSTEM

DE Workers' Compensation • July 31, 2014

The summary to House Bill 373 gives the following reasons behind its enactment:

> This Act makes substantial changes to Titles 18 and 19 of the Delaware Code designed to control the level of workers' compensation premiums in Delaware. The most significant changes are: (a) a 33% reduction in medical costs to the workers' compensation system, phased in over a period of three years; (b) absolute caps, expressed as a percentage of Medicare per-procedure reimbursements, on all workers' compensation medical procedures beginning on January 17, 2017; and (c) increased independence for the Ratepayer Advocate who represents ratepayers during the workers' compensation rate approval process and for the committee that oversees the cost control practices of individual workers' compensation insurance carriers.

Below are some of the key points as to how this new piece of legislation will impact employers and insurance carriers.

What was formerly known as the Health Care Advisory Panel will now be known as the Workers' Compensation Oversight Panel (WCOP).

The WCOP will consist of a group of 24 members, including a diverse group of:

- nine health care providers;
- two representatives of insurance carriers;
- two representatives of employers;
- two representatives of employees;
- two attorneys who regularly represent employees;
- one attorney who regularly represents employers in workers' compensation cases;
- the Insurance Commissioner;
- a representative of Delaware insurance agents; and
- four public members.

The WCOP will collect data from the advisory organization designated by the Insurance Commissioner in order to identify the cost drivers and to guide policy formation. In addition, the WCOP now has the authority to demand directly from any person or entity providing health care services data that will be sufficient for the panel to carry out its duties.

In the near future, the Office of Workers' Compensation will be sending out a mandatory data request to hospitals and ambulatory surgery centers in order to create the new fee schedules. Those fee schedules will be established by October 1, 2014, with an effective date of January 31, 2015. The current fee schedules will remain in effect until the new ones are established. It is anticipated that additional reductions will be phased into the new fee schedules over three years beginning January 2015, January 2016 and January 2017.

The procedures for provider certification and utilization review have not been changed by this legislation.

On another point, the Department of Labor has announced that the new workers' compensation rate effective July 1, 2014, establishes an average weekly wage of $998.35. Accordingly, the maximum compensation rate will now be $665.57, and the minimum compensation rate will be $221.86. II

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Special Law Alert

EMPLOYER BEARS BURDEN OF PROVING CLAIMANT'S LOSS OF EARNING POWER IS DUE TO LACK OF U.S. CITIZENSHIP

PA Workers' Compensation • August 1, 2014

David Cruz v. WCAB (Kennett Square Specialties); 69 MAP 2012; decided July 21, 2014; by Madam Justice Todd

The claimant filed a claim petition alleging that he sustained a work injury on July 19, 2008, while working as a truck driver for the employer. At a hearing held before the Workers' Compensation Judge, the employer's attorney cross examined the claimant, who was born in Ecuador and had lived in the U.S. for 10 years, regarding his citizenship status and his ability to work. Claimant's counsel objected to the line of questioning, but the Judge overruled on the basis that citizenship was relevant. In response to additional questions from the employer, however, the claimant invoked his Fifth Amendment right against self-incrimination.

The Judge granted the claim petition and ordered the employer to pay the claimant's reasonable and necessary medical expenses. However, the Judge also suspended the claimant's benefits from the date of injury, finding that the employer had met its burden to establish that the claimant was not a United States citizen and not authorized to work in this country. Thus, the Judge suspended the claimant's benefits.

The claimant appealed to the Workers' Compensation Appeal Board. The Board partially reversed the Judge's decision by finding that the employer did not meet its burden of proof regarding the claimant's citizenship status solely by relying on an adverse inference created by the claimant's failure to answer the employer's questions. The Commonwealth Court affirmed the Board. The court held that the Judge's adverse inference from the claimant's refusal to answer questions about his immigration status did not support a finding that the claimant was an undocumented alien.

The Pennsylvania Supreme Court affirmed the Commonwealth Court's decision. The Supreme Court held that the employer bears the burden of establishing, through competent evidence, that a claimant's loss of earning power is due to his employment eligibility status under federal law. According to the Court, the Judge found that the claimant had established, at the time of the hearing, that he was still disabled because of his work-related injury and that, because the claimant met his burden of proof of entitlement to benefits, the burden then shifted to the employer to show why its request for a suspension of benefits should be granted. In addition, the Court held that the adverse inference taken based on the claimant's refusal to answer questions regarding his citizenship status under the Fifth Amendment was not sufficient evidence to support a suspension of the claimant's benefits. In the Court's view, any inference drawn was too speculative and, standing alone, was not enough to establish that the claimant's loss of earning power was due to his status as an undocumented worker. II

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MARSHALL DENNEHEY
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Special Law Alert

SUPREME COURT OF NEW JERSEY HOLDS THAT CARDIOVASCULAR DEATH IS NOT COMPENSABLE

NJ Workers' Compensation • August 6, 2014

KEY POINTS:

- For the plaintiff, there remains a heightened burden of proving cardiovascular injuries or deaths.
- The statutory standard of proof for cardiovascular injuries/deaths remains that a petitioner must demonstrate that the injury or death was caused by a work effort or strain involving a substantial condition that exceeds "the wear and tear of the petitioner's daily living" outside of the petitioner's work duties.
- The Court pointed out that the 1979 amendment to Section 7.2 was to prevent recovery from cardiac injuries that, as a matter of circumstance, happen to manifest in the workplace.
- If personal risk factors may have contributed to the cause of death, the petitioner must show that the work duties exposed the worker to greater risks than the activities in the worker's daily life.
- The comparison of work effort to daily non-work activities requires a case-by-case, fact-specific analysis.
- The burden of proving that the work effort or strain involves a "substantial condition, event or happening" does not mean that a worker's ordinary work effort is not sufficient to establish causation. The statute focuses on the intensity and duration of the precipitating work effort or strain in evaluating its capacity to cause cardiac dysfunction.
- Expert testimony should be scrutinized—expert witness conclusions should be carefully evaluated in the context of both the statutory criteria and the prevailing medical standards.

In its July 30, 2014, decision of *James P. Renner v. AT&T* (A-71-11) (068744), the New Jersey Supreme Court reiterated that there remains a heightened standard of proof and causation for cardiovascular claims. The Supreme Court opined in *Renner* that the decedent husband/petitioner failed to sustain his burden of proving a compensable cardiovascular death.

Renner involved a dependency claim filed following the death of Renner's wife, who was employed as a salaried manager and had an agreement with the employer to work from home several days per week. On the day prior to Mrs. Renner's death, she had been working long hours *at home* to meet a project deadline. Testimony eluded to the fact that Mrs. Renner had worked the evening prior to her death, working throughout the night and into the next morning on the project. Testimony was also submitted that Mrs. Renner had been sitting for a prolonged period of time while working throughout the night. Late the following morning, Mrs. Renner called for emergency medical services due to breathing problems. She was pronounced dead upon her arrival at the hospital. An autopsy indicated a pulmonary embolism.

Although cardiovascular claims are more regularly associated with heavy labor jobs, this case involved a sedentary job with an unusual level of inactivity. The decedent's husband/petitioner argued that prolonged sitting was the significant, contributing factor that lead to the pulmonary embolism resulting in his wife's death. The employer/respondent argued that the petitioner's non-work risk factors—including morbid obesity, usage of birth control pills, age and an enlarged heart—were the significant contributing factors to her embolism and death.

The judge of compensation found there to be a compensable cardiovascular death, and the Appellate Division affirmed the lower court's decision. However, the New Jersey Supreme Court reversed those decisions and found that the decedent's husband/petitioner failed to sustain his burden of proving a compensable cardiovascular death under the standards of *N.J.S.A.* 34:15-7.2 (Section 7.2), which

governs the burden of proof for cardiovascular claims.

In its decision, the Court provided an analysis of the evolution of the cardiovascular burden of proof in New Jersey. The Court also provided an analysis of the legislative intent behind the 1979 Amendment to Section 7.2, which is still the governing law for cardiovascular injuries/deaths. The *Renner* decision focuses on the interpretation of the "substantial condition or event component" of Section 7.2. The decedent's extended period of sitting was not a "substantial condition, event or happening" under the facts of this case. Extended periods of sitting were not a job requirement, and the decedent was not confined to a specific space or instructed not to move from her workstation. The decedent had control over her body position, movements and ability to take breaks.

So what does this decision mean for petitioners, respondents and practitioners involved in cardiovascular injury or death cases, especially in a climate where more and more workers are working from home in a sedentary capacity? It means that a respondent does not merely take a petitioner as it finds him or her. It means that a petitioner must continue to meet the heightened burden of proving a compensable injury or death. **II**

See also Marshall Dennehey Warner Coleman & Goggin's article about the 2011 appellate decision in Renner at http://www.marshalldennehey.com/defense-digest-articles/can-excess-mean-less-broader-interpretation-cardiovascular-injuries.

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What's Hot in Workers' Comp

Pennsylvania Workers' Compensation

By Francis X. Wickersham, Esquire (610.354.8263 or fxwickersham@mdwcg.com)


Francis X. Wickersham

A claimant who fails to establish a valid common law marriage to the decedent is not entitled to widow's benefits under §307 (3).

Brett Cooney (deceased) – Amanda Cerrano v. WCAB (Patterson UTI, Inc.); 1681 C.D. 2013; filed 6/12/14; by Judge Simpson

The decedent sustained a traumatic brain injury as a result of a drilling rig accident while working for the employer. The decedent passed away six days following the injury. After the decedent's death, the employer and the claimant entered into an agreement to pay dependency benefits to the decedent's two minor children under §307 (1) (b) of the Act. In the agreement, the claimant reserved the right to file a fatal claim petition for widow's benefits. The claimant did so, but the Workers' Compensation Judge denied the petition.

The claimant was a native of Wyoming and met the decedent in her home town in 2002. The decedent had moved to Wyoming to work in the oil and gas industry. The claimant and the decedent lived together. They combined their income to pay bills. They opened a joint checking account. They bought vehicles together, and the titles to the vehicles were placed in the claimant's name. They had two children together. Although never formally married, one year before the birth of their first child, the decedent gave the claimant a ring and said to her, "You're my wife." The claimant and the decedent also introduced themselves as husband and wife. Later, the decedent, the claimant and their two children moved to Pennsylvania. They continued to introduce themselves as husband and wife.

In denying the claim petition, the Judge recognized that the Supreme Court abolished the Doctrine of Common Law Marriage prospectively from the date of a September 17, 2003, decision in the case of *PNC Bank Corp. v. WCAB (Stamos)*, 831 A.2d 1269 (Pa. Cmwlth. 2003). In addition, by Act of November 24, 2004, §1103 of the Marriage Law was amended to invalidate common law marriage contracted after January 1, 2005. The Judge concluded that, although the claimant and the decedent exchanged words recognizing they were husband and wife when they lived in Wyoming in 2003, Wyoming did not recognize common law marriage as valid. The claimant and the decedent did not move to Pennsylvania until 2009, after Act 144 abolished common law marriage. Therefore, benefits were denied.

On appeal, the Workers' Compensation Appeal Board affirmed. The Commonwealth Court affirmed as well. According to the court, §1103 of Act 144 includes a consideration of where the parties resided when they entered into a common law marriage prior to 2005. The parties resided in Wyoming, which did not recognize common law marriage. As such, the claimant and the decedent were never lawfully married prior to January 1, 2005, even assuming the decedent was not aware that Wyoming did not recognize common law marriage. II

Work-related medical expenses are not payable directly to the claimant where a subrogation lien of a health care carrier had been established by the parties prior to the Judge's decision.

John Evans v. WCAB (Highway Equipment and Supply Co.); 2552 C.D. 2013; filed 6/30/14; by Judge McCullough

A Workers' Compensation Judge granted a claim petition for an injury sustained by the claimant while working for the employer. The Judge awarded ongoing total disability benefits and payment of medical expenses. After this decision, claimant's counsel submitted a subrogation lien from the claimant's personal health care insurer

(Company A) for payment of medical expenses in the amount of $29,995.59. Later, the claimant filed a penalty petition against the employer for failure to pay the January 2009 award in a timely and accurate manner. The claimant submitted to the Judge documentation regarding Company A's subrogation lien. The Judge granted the penalty petition and directed the employer to pay the medical expenses to the "health care provider," less a 20% counsel fee. On appeal to the Appeal Board, the claimant argued that the amount incurred in medical expenses plus interest should be paid directly to the claimant. The Board remanded the case to the Judge on this issue, and the Judge found that the submission of an October 2008 letter proved that a subrogation lien was established prior to the Judge's January 2009 decision. Thus, medical expenses were not payable directly to the claimant. The claimant appealed to the Board again, and the Board affirmed.

The Commonwealth Court affirmed the decisions below. The claimant argued that Company A did not preserve its subrogation lien and, therefore, medical expenses were directly payable to him. The claimant argued that in accordance with the case of *Frymiare v. WCAB (D. Pelliggi & Sons)*, 524 A.2d 1016 (Pa. Cmwlth. 1987), the Judge wrongly ordered payment of the medical expenses to the health care provider because Company A did not seek to protect its subrogation lien before the Judge awarded benefits. According to the Commonwealth Court, however, in this case, the claimant submitted into evidence a letter stating that Company A had a subrogation lien for the awarded medical expenses and the Judge properly found that the letter established that an agreement for the subrogation lien was in place before the claim petition was decided. II

An employer does not violate any provision of the Act or accompanying regulations by failing to serve the claimant with a copy of a utilization review determination.

Richard Marrick v. WCAB, 2128 C.D. 2013; filed 7/16/14; by Judge McCullough

The claimant filed a penalty petition alleging the employer violated the Act by unilaterally ceasing payment of medical bills for a 1995 work injury. According to the claimant, the bills were denied because of a utilization review (UR) that was filed. The claimant was requesting penalties because the carrier was advising that they would not pay because of a favorable UR which the claimant was unable to locate. At a hearing on the penalty petition, the employer submitted into evidence a UR packet which included a UR request, a UR determination face sheet and a UR report. The UR request properly identified counsel for the claimant. The UR determination face sheet identified the name and address of the claimant, but not the claimant's counsel. The UR report and face sheet also suggested the claimant had notice of the UR request, since the claimant submitted a statement to the URO regarding the treatment in question.

The Judge denied the penalty petition, concluding that the employer did not violate the Act because there was no evidence of any statutory or regulatory provision requiring an employer or its insurance carrier to serve a copy of a UR determination on a claimant and/or a claimant's counsel. The Appeal Board affirmed on appeal, and so did the Commonwealth Court. The court held that §127.476 of the Medical Cost Containment Regulations imposes no service requirement on the employer and that the plain language of the section imposes the requirement on the URO to serve the determination on all parties. II

Side Bar

The court points out that, although the employer was relying on the UR determination to excuse its obligation to pay the claimant's medical bills, the UR determination at issue was actually in the claimant's favor. However, the claimant limited his argument before the Judge and the Board to the service issue only.

A decision from a Workers' Compensation Judge dismissing the claimant's utilization review petition on the sole basis that the claimant's medical provider's opinions were not convincing does not constitute a "reasoned decision" as required under the Act.

Joe Cucchi v. WCAB (Robert Cucchi Painting, Inc.); 108 C.D. 2014; filed 7/17/14; by Senior Judge Friedman

Following the claimant's work injury, the employer filed a utilization review request. The UR reviewer determined that the claimant's treatment was unreasonable and unnecessary. The claimant then filed a UR petition. The Workers' Compensation Judge appointed a physical therapist to conduct an independent UR. The Judge later dismissed the UR petition, crediting the opinions of the UR reviewer and the independent reviewer. The Judge also discredited the opinions of the claimant's treating provider as "not convincing." The claimant appealed to the Appeal Board, which affirmed.

The Commonwealth Court vacated, agreeing with the claimant that the Judge failed to issue a reasoned decision. According to the court, the Judge failed to articulate any objective bases for deeming the opinions of the UR reviewer and the independent reviewer more credible and persuasive then those of the claimant's treating physician. In the decision, the Judge simply stated that the treating provider's opinions were not convincing, with no explanation as to why. Because the Judge failed to issue a reasoned decision under §422 (a) of the Act, the Board's order was vacated with instructions to remand to the Judge to explain in detail the bases for his prior credibility findings. II

New Jersey Workers' Compensation

By Dario J. Badalamenti, Esquire (973.618.4122 or djbadalamenti@mdwcg.com)

Dario J. Badalamenti

The Appellate Division interprets the definition of "employment" under N.J.S.A. 34:15-36 of the Act in the context of off-premises employment.

Ford v. Durham D&M, LLC, Docket No. A-2071-13T4, (App. Div., decided 7/11/14)

The petitioner was employed by the respondent as a school bus aide and was responsible for helping children on and off the bus, assisting them with their seatbelts and ensuring that they remained well-behaved on the way to and from school. The petitioner was paid "by the run" and usually had a number of runs per day. Typically, the petitioner obtained a ride from a friend to and from the bus yard each morning and evening where all runs began and ended. That notwithstanding, the petitioner had made arrangements with the respondent for the bus driver to drop her off at home if the last run ended near her residence. On January 26, 2012, this particular run was the petitioner's last run. After all of the children had been dropped off, the bus driver drove the petitioner to her home. As the petitioner was stepping from the bus, she fell onto the pavement and was injured.

The petitioner filed a claim with the Division of Workers' Compensation seeking medical and indemnity benefits. The respondent denied that the petitioner's accident arose out of and in the course of her employment and invoked *N.J.S.A. 34:15-36* of the Workers' Compensation Act. This so-called "premises rule" provides that:

> Employment shall be deemed to commence when an employee arrives at the employer's place of employment to report for work and shall terminate when the employee leaves the employer's place of employment, excluding areas not under the control of the employer.

The respondent argued that, because all of the children had already been dropped off, and the petitioner was being driven home rather than to the bus yard, her work day had ended prior to her fall. At the conclusion of a bifurcated trial as to the issue of compensability, the Judge of Compensation rejected the respondent's argument and found that the petitioner's injuries did indeed arise out of and in the course of her employment. The respondent appealed.

In affirming the Judge of Compensation's ruling, the Appellate Division characterized the respondent's contention that the petitioner's injuries did not arise out of and in the course of her employment as inconsistent with N.J.S.A. 34:15-36. As the Appellate Division reasoned:

> The most logical interpretation of N.J.S.A. 34:15-36 in this instance . . . is that petitioner's employment commenced when she arrived at the bus yard to start the day and ended when she returned there or to an otherwise authorized location. The fact that she was given permission to get off the bus at home as opposed to the bus yard does not detract from the fact that she had to get off the bus as an incident of employment.

Accordingly, the Appellate Division concluded that the Judge of Compensation properly determined that the petitioner's work day began when she arrived at the bus yard in the morning and ended when she exited the bus at night. II

Side Bar

In order to illustrate that the definition of "employment" under the Act includes situations in which the employee is physically away from the employer's premises but, nevertheless, engaged in performing duties directed by the employer, the Appellate Division utilized the following analogy:

> The analogy of petitioner leaving one's office is appropriate. The bus, in essence, is petitioner's office. There was no increased risk by the petitioner descending the bus step where she did as opposed to at the bus yard. In fact, in this case, getting off at her home actually lessened the time she was on the bus in that the location of her home was close to the last drop off. She, thus, left the bus sooner than she would have if she went to the bus yard.

News from Marshall Dennehey

Niki Ingram, **Tony Natale** and **Jim Pocius** will be featured speakers at the Workers' Compensation Summit sponsored by the Pennsylvania Chamber of Business and Industry. The purpose of the Summit is to provide a basic understanding of workers' compensation and remove confusion from the "gray areas" of the law, explain the relationship between Medicare and workers' compensation, cover new and hot topics, and provide solutions to companies' biggest mistakes. Niki and Tony will presented "Social Media and Workers' Compensation, and Handling Unusual WC Situations," and Jim will present "Workers' Compensation and Medicare Update and the Top 10 Mistakes Companies Make in Complying." For detailed information, visit the Event Listings page of our website at www.marshalldennehey.com.

WE ARE MOVING!

Effective Monday, August 25, the Bethlehem office will be relocating to the address below:

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Our main number will remain the same: 484.895.2300
Our new fax number is: 484.895.2303
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MARSHALL DENNEHEY
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What's Hot in Workers' Comp

Pennsylvania Workers' Compensation

By Francis X. Wickersham, Esquire (610.354.8263 or fxwickersham@mdwcg.com)

Francis X. Wickersham

A diagnosis of malingering can be a sufficient change in condition as a matter of law to support a modification of benefits based on the results of a labor market survey.

Gregory Simmons v. WCAB (Powertrack International); 2168 C.D. 2013; filed 7/24/14; Judge Leadbetter

Following a 2001 work-related closed head injury resulting in post-concussive syndrome, the claimant underwent numerous independent medical examinations, and the employer filed termination petitions on two occasions. In the decisions dismissing those petitions, the credited medical experts generally opined that the claimant's condition was consistent with a post-concussion syndrome—with no signs of symptom magnification or malingering—and that the claimant was not capable of returning to work. Later, the employer filed a petition to modify the claimant's benefits based on the results of a Labor Market Survey. In connection with that petition, the employer offered a medical report from a new IME physician, who administered new tests to the claimant and concluded that the claimant was malingering and was able to return to work. The claimant testified that he was unable to perform the jobs in the employer's Labor Market Survey due to lack of concentration, light headedness, dizziness and an inability to sit or stand for long periods of time.

The Workers' Compensation Judge found that the claimant was sufficiently recovered from his injury and able to return to the work force. The Judge granted the modification petition and, in doing so, found the claimant to be mostly incredible. The claimant appealed, and the Workers' Compensation Appeal Board affirmed.

On appeal to the Commonwealth Court, the claimant argued that the employer failed to demonstrate that his condition had changed since the last termination proceeding. According to the claimant, the only change recognized by the IME physician was symptom magnification and/or malingering, which the claimant argued did not constitute a change in condition as a matter of law. The court rejected this argument, concluding that a diagnosis of malingering can be a sufficient change in condition as a matter of law to support a modification of benefits if it leads the medical expert to conclude that the claimant's disability or ability to work has changed. II

A claimant who quits his job just before suffering an injury may be within the course and scope of employment. The employer is not judicially estopped from arguing that the claimant was not an employee at the time of the work injury, even when employment was admitted in the employer's answer to a civil action complaint.

Paul Marazas v. WCAB (Vitas Healthcare Corporation); 337 C.D. 2014; filed 8/11/14; Judge Simpson

The claimant worked as a driver-technician for the employer. After a weekend on call, the claimant reported to work to receive his daily itinerary. After reviewing a list of the assigned stops, which would take him until midnight to complete, the claimant went to the employer's office and advised his manager that he was tired after his on-call weekend and asked for some stops to be removed. The

manager refused, and the claimant said he was quitting and turned in his keys and phone. The manager informed the claimant that he needed to remove his personal belongings from his company truck and escorted the claimant to the truck, pursuant to the employer's policy. After removing items from the truck, the claimant tripped over a pallet jack and fell, sustaining injuries. Days later, the claimant called the manager to report his injury and requested a referral to a panel physician. The claimant was informed that such physicians were limited to active employees.

Initially, the claimant filed a civil suit seeking damages for his injury. The employer, however, pled that the claimant was in the course and scope of his employment at the time of the injury. Consequently, the claimant withdrew his complaint and filed a claim petition, which was granted. The Appeal Board vacated and remanded the Workers' Compensation Judge's order, directing the Judge to assess whether the claimant was within the scope of employment at the time of injury. At a hearing on the remand, the Judge admitted into evidence the complaint the claimant filed and the employer's answer and new matter. In the answer, the employer admitted that the claimant was an employee. Ultimately, the Judge found that, although the clamant quit his employment prior to the injury, he was within the scope of his employment when he fell. The Judge concluded that the claimant fell on the employer's premises and that he was furthering the employer's interests at the time of injury because he was directed to go and perform a requested task. The Board again reversed the Judge on appeal.

The Commonwealth Court, however, reversed the Board. In doing so, the court held that, even though the claimant quit, he remained on the premises and was furthering the employer's interests by removing his belongings from the employer's truck while under his manager's supervision. Thus, the claimant was under the employer's control at the time of the injury. Moreover, the court noted that §301 (c) (1) of the Act does not preclude a claimant from seeking benefits for such an injury after the employment relationship has ceased, provided it can be established the injury occurred in the course of employment. The court also rejected the claimant's argument that the employer was judicially estopped from arguing that the claimant was not in the scope of employment at the time of the injury because the employer had already admitted in its answer to the claimant's civil action complaint that the claimant was an employee at the time of the injury. According to the court, judicial estoppel did not apply since the claimant voluntarily withdrew the complaint. **II**

Although the claimant began each work day by reporting to the employer's facility to receive assignments and pick up equipment, he was a traveling employee and the injuries sustained in a motor vehicle accident while driving to work were compensable.

Dane Holler v. WCAB (Tri-Wire Engineering Solutions, Inc.); 2209 C.D. 2013; filed 8/22/14; Judge Brobson

The claimant sought benefits for injuries he sustained in a motor vehicle accident that occurred while he was driving to his employer's facility. The claimant worked as a cable technician and began each workday by reporting to the employer's facility, where he received his assignments and picked up equipment. The claimant then spent the rest of his workday traveling to various customer locations. The employer permitted the claimant to take his company vehicle home each night and use it to report to work in the mornings, but they did not allow passengers, other drivers or use of the vehicle for personal reasons.

On the morning of the accident, the claimant was driving the company vehicle to the employer's facility to begin his workday when he was injured in a single vehicle accident. The claimant filed a claim petition, and the employer, relying on the "coming and going rule," argued that the claimant was not in the course and scope of employment. The Workers' Compensation Judge dismissed the claim petition, and the Appeal Board affirmed. The claimant appealed to the Commonwealth Court and argued that he was entitled to benefits because he had no fixed place of employment.

The Commonwealth Court agreed with the claimant and reversed the decisions below. Citing an unreported opinion in which it was determined that a cable technician was a traveling employee, the court held that the claimant had no fixed place of work and was entitled to a presumption that he was working for the employer during the drive from his house to the employer's facility. **II**

Side Bar

The court pointed out that the facts of the unreported case it cited were factually indistinguishable. In that opinion, as in this one, the court held that the fact that the claimant initially stopped at the employer's office at the beginning of the workday was not dispositive of the issue of whether the claimant was a traveling employee.

Delaware Workers' Compensation

By Paul V. Tatlow, Esquire (302.552.4035 or pvtatlow@mdwcg.com)

Paul V. Tatlow

The employer's payment of medical bills for treatment to a body part that is not part of the accepted work injury does not create an implied agreement of compensability where the evidence establishes that the payments were made by mistake but not under a feeling of compulsion.

Heather Taylor v. General Motors, Corp., IAB No. 1200319

This case came before the Board on the claimant's petition to determine additional compensation due, which sought compensability for a low back condition that was allegedly related to the acknowledged work injuries in 2001 and 2005. The accepted work injuries included the claimant's bilateral upper extremities, shoulders and cervical spine. The claimant alleged the medical evidence would establish that the low back condition was causally related to the accepted work injuries. Alternatively, the claimant asserted that the employer had made medical payments for treatment to the low back condition under a feeling of compulsion, resulting in an implied agreement of compensability. The evidence did establish that between 2005 and 2008, the employer had paid approximately $11,000 in medical bills to a provider who had treated the claimant's low back condition.

The claimant presented medical evidence from the provider who had been paid for treatment to the low back indicating that the physician's opinion was that the low back condition was causally related to the accepted work injuries. This provider also testified that his bills had been paid with no indication that the low back was not an accepted work injury. The employer presented medical evidence from a physician who had performed a DME and a records review. This expert testified that the low back condition was not work-related since there was no documented history of low back problems resulting from the work activities and also based on the indication that the claimant had a fibromyalgia condition, which could explain the low back symptoms. The Board accepted the employer's evidence on this issue and determined that the low back condition was not causally related to the accepted work injuries.

On the medical payment issue, the claimant testified that she had treated for her back and believed that it was part of the accepted injuries. The employer presented the claim adjuster who had handled the case during a portion of the time when the disputed medical payments were made, and she testified that those payments were made by mistake but not under a feeling of compulsion. This witness further testified that the claim notes reflected the accepted injuries, which did not include the low back, and the employer's evidence also showed that numerous agreements had been issued on this case but that none of them referenced the low back or lumbar spine.

The applicable law, as set forth in *Tenaglia-Evans v. St. Francis Hospital*, 913A.2d 570 (Del. 2006), stands for the proposition that an implied agreement to pay compensation may be found where the employer has paid medical expenses or compensation out of a "feeling of compulsion." The simple payment of expenses is not enough though. There must be a finding of "compulsion" on the part of the employer to pay those expenses. The Board applied this legal standard to this case and held that the medical payments made for the low back condition were done in error but not under a feeling of compulsion, and as such, they did not create an implied agreement or obligation under the Act. The Board accepted as credible the testimony of the claim adjuster presented by the employer on this issue. Claimant's counsel had objected to some of that testimony on hearsay grounds, contending that this witness had not made all of the payments. However, the evidence did establish that the witness made several of the payments at issue and clearly had firsthand knowledge to provide the testimony that the Board accepted. Accordingly, the claimant's petition seeking to establish the low back condition as compensable was dismissed. II

Side Bar

This case involved total medical payments made to date of over $154,000. In such cases, it is not uncommon that some medical bills may be paid for conditions that are not part of the accepted work injury. Even if such medicals are not paid, under the payment without prejudice provision of the Act, the employer still needs to be mindful that a defense can be raised that the medical bills were paid in error but not under a "feeling of compulsion." The successful assertion of such a defense can prevent the employer from being liable for what could otherwise be a serious medical condition that will greatly increase the exposure on the case. This particular case is being handled by this writer and is currently before the Superior Court on an appeal filed by the claimant.

New Jersey Workers' Compensation

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Dario J. Badalamenti

The Appellate Division upholds exclusion of the petitioner's medical expert's testimony as an inadmissible "net opinion."

Russo v. Scott Schaffer, DMD, Docket No. A-2948-12T4, A-2949-12T41, (App. Div., decided 8/8/14)

The petitioner was employed as a dental hygienist by the respondent from August 1991 to March 2005. She filed a claim with the Division of Workers' Compensation alleging that she began having problems with her right wrist two or three years after she began working for the respondent. The petitioner testified that the nature of her work required her to use her hands with pinch force on instruments to remove plaque and calculus and required constant flexion, extension and abduction of the wrists with prolonged periods of static posture.

The petitioner's expert in orthopedics testified that he had no specific knowledge of the work that the petitioner performed as a dental hygienist, had not read any literature regarding the work, and had not viewed a surveillance video of the petitioner shopping, carrying packages, lifting large plants with her hands and gardening without much difficulty. The Judge found that the petitioner's expert's testimony was a "net opinion" based on very little knowledge of the petitioner's occupation or alleged injuries. Pursuant to N.J.R.E. 703, the so-called "net opinion" rule, an expert's opinion must be based on "facts, data, or another expert's opinion, either perceived or made known to the expert, at or before trial." Specifically, N.J.R.E. 703 provides:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence.

Accordingly, the Judge concluded that she could give no weight to the petitioner's expert's opinion and that it was inadmissible.

In affirming the Judge's conclusion that the testimony of this expert could not be relied upon, the Appellate Division provided the following reasoning:

> [T]he only witness [Petitioner] presented to prove that her orthopedic injuries were work related was [her expert]. As we have noted, the judge found he had very little knowledge of the Petitioner's occupation or alleged injuries, rendering his testimony a net opinion. The judge cited specific aspects of [this expert's] testimony could not be relied upon to determine what orthopedic injuries were work related was supported by the record and is, therefore, entitled to our deference. II

Side Bar

The "net opinion" rule has been succinctly defined as "a prohibition against speculative testimony." Experts must identify the factual bases for their conclusions, explain their methodology, and demonstrate that both the factual bases and the methodology are reliable. As the Judge of Compensation in the instant case explained, "[T]he reasons and mechanics of a medical witness' assertion are more important than the assertion. [The petitioner's expert's] lack of knowledge, and his lack of explanation as to how and in what matter the employment caused the disability, leave an irreparable void in the proofs."

News from Marshall Dennehey

The Philadelphia Association of Defense Counsel's 2014-2015 luncheon CLE program series begins on Tuesday, September 16, 2014. The program, "What You Need to Know About Workers' Compensation to Keep You Out of Trouble in Your Liability Case," will be co-presented by **Niki Ingram** (Philadelphia).

Niki Ingram, **Tony Natale** (Philadelphia) and **Jim Pocius** (Scranton) will participate in the October 1, 2014, Pennsylvania Chamber of Business and Industry's Workers' Compensation Summit in Harrisburg, PA. The purpose of the Summit is to provide a basic understanding of workers' compensation and remove confusion from the "gray areas" of the law, explain the relationship between Medicare and workers' compensation, cover new and hot topics, and provide solutions to companies' biggest mistakes. Niki and Tony will present "Social Media and Workers' Compensation, and Handling Unusual WC Situations." James will present "Workers' Compensation and Medicare Update, and The Top 10 Mistakes Companies Make in Complying." For more information or to register, visit http://www.pachamber.org/events/details.php?id=1426#d2.

Tony Natale (Philadelphia) successfully defended a large mushroom distribution company in Reading, Pennsylvania, in a claim petition. The claimant slipped and fell at work and landed on her knee. Within a month she had meniscal repair surgery and, a few months later, total knee replacement surgery. Between surgeries, the claimant was discharged from employment for violation of the company absenteeism policy. Despite original testimony to the contrary, Tony was able to force the claimant to admit that she violated the company policy at issue by failing to produce medical records certifying the cause of her various absences. Tony cross-examined the claimant's medical expert and, as a result, the WCJ found the claimant's surgery not to be work related. The WCJ also found the claimant to be fully recovered from any and all injuries sustained during the slip and fall. II