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PENNSYLVANIA WORKERS' COMPENSATION

BENEFITS AND PROCEDURE

OUTLINE

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INTRODUCTION

The Pennsylvania Workers Compensation Act was created in 1915. With numerous changes over the 100 years since enacted, and thousands of court decisions interpreting the terms of the law, it is not possible to describe every rule and exception, or identify the unique circumstances present in every case in one short booklet.

This outline simply describes the "highlights" to provide a general understanding of the law.

PURPOSE OF LAW

Before workers compensation laws existed, an injured worker had no right to any benefits, unless they were able to prove the employer's "negligence" caused the injury. Considering the nature of work typically available in 1915 (factories, construction, coal mining, farming) and the level of technology and safety then existing, many workers were injured, lost fingers, arms or legs, or were killed - simply due to the dangers of the job, with no negligence or wrongdoing by the employer. As a result, many workers had no source of benefits or income due to their injury.

Each state created their own system of benefits and procedures around this same time period. Pennsylvania's laws are considered a "wage loss" system, designed to make injured workers whole, as if no injury ever occurred. It is not intended to allow an injured worker to "profit" from being injured, but simply to replace the wages they can not earn due to their injury. It was an effort to **Compromise** the rights and interests of the employee, with the rights and interests of their employers - with the balance intended to favor the injured worker.

BENEFITS AVAILABLE

"The Grand Bargain of 1915" eliminated the worker's obligation to prove negligence, but **in exchange**, the law limited the benefits available for a work injury to wage loss benefits and payment of medical bills for reasonable and necessary treatment related to the work injury.

There is no pain and suffering available in workers compensation claims - even if the employer was negligent. The injured worker may not "choose" to pursue a separate (or alternative) negligence lawsuit - but is limited exclusively to the benefits available under the Workers' Compensation Act. As with most general rules, there are limited exceptions; such as when an employer illegally fails to carry workers' compensation insurance; or where the employer acts in a

"dual capacity" - [such as a Hospital employee injured while working, and worsened by the Hospital's negligent medical treatment - in their capacity as a treatment provider, rather than as employer].

There are also unique circumstances where other benefits may be available - such as 'specific loss' (for the loss of a body part, there is a set schedule of benefits available); a disfigurement or scar (above the collar bone); fatal claim benefits for dependents of a worker killed due to work incident; and 'additional compensation' for minors employed illegally.

WHO IS ENTITLED TO BENEFITS

Only **employees** are entitled to benefits. Independent Contractors and self-employed individuals are not. An owner of a corporation, who is also an employee, may elect to be covered. Just because you 'think' you are or are not employee does not make it so. There are MANY factors the court considers to define a worker's legal status. It is not dictated by what you or the employer chooses to call it, or how you are paid.

Also, dependents of a deceased worker may have a right to Fatal Claim benefits.

HOW THE BENEFIT RATE IS DETERMINED

Workers Compensation does not pay an injured worker's full salary, but a "rate" based on mathematical formulas set forth in the law. Generally, the injured worker's **average weekly wage** over one full year before the work injury is determined first, and the rate is determined by a chart, updated each year by the Department of Labor. There are minimum and maximum rates, and other categories in between. The rate is lower than the full salary because workers' compensation benefits are not taxable. The goal is to (try) to have the injured worker receive the same amount as before the injury - and not "profit" by being injured.

For workers who earn tips, they are generally only included in the calculation of the benefit rate if the worker declared their tips on tax returns. The law does not reward a worker for failing to pay taxes - but then seek the benefit of those tips.

Workers who earn bonuses, or have 'per diems', room and board, mileage reimbursement, etc., each case will be determined by its unique facts and circumstances.

Medical bills are also not paid at the amount a treatment provider might charge, but are paid

at a specified rate set forth on rate tables established by the Department - based on the billing code for any procedure, service, medicine, or equipment. A medical treatment provider located in Pennsylvania may not bill the injured worker for any balance greater than the approved rate. Medical providers with no PA office may have different rights to seek collection, subject to a legal analysis of any conflicting laws.

Out-of-pocket costs for treatment, and over-he-counter medicine and supplies ***may*** be reimbursed, again subject to the facts of each case.

ACCEPTANCE vs. LITIGATION

An employer (or their insurance company) has 21 days from the date they are **Notified** of a work injury to accept or deny the claim - which must be done on specific forms. A claim can be accepted "Temporarily", and/or only in part (acceptance to pay medical bills, but not lost wages). A Temporary acceptance can be revoked by the employer within 90 days, which must also be done by filing the proper forms with the Bureau, and serving a copy on the injured worker.

If a claim is accepted, the employer must state on the official form the description of the injury they are accepting (the body part and diagnosis), and identify the injured worker's average weekly wage and benefit rate. Insurance companies often only accept relatively minor injuries (such as sprain, strains and contusions) and omit more serious medical conditions. The reason is because they only have to pay for medical treatment of the diagnosis they accept; and, when they seek to stop paying benefits, they only need to prove the relatively minor injury has resolved.

A claim could be denied entirely; list only a part of the injuries suffered - or an entirely incorrect description of the injury; accept medical treatment, but deny payment of lost wages; or list an incorrect wage and benefit rate.

If a claim is denied, in whole or part, the injured worker must **file a petition** to seek a court order to correct the description of injury or salary. The injured worker must then present sufficient evidence to prove their allegations are correct.

INJURED WORKER'S DUTIES

The injured worker has many legal duties after a work injury. As one Judge often says, after

a work injury, pursuing the claim becomes the injured worker's new job.

Notice: The employee must notify the employer (someone in a supervisory or management capacity; NOT a co-worker) of the incident and their injury within 21 days of the incident, or benefits are not payable until proper Notice is given.

If proper Notice is not provided within 120 days - no benefits are payable.

With some types of injuries or work-related diseases (such as those caused by repetitive activity; exposure to a toxic substance; or any condition not readily known by a lay person to be due to their employment) the date for providing Notice begins when the worker knows, or should have know of the relationship to their work.

Company Doctor: When an employer has fulfilled their own duty to provide a VALID list of Panel Physicians (company doctors), the injured worker must obtain treatment from one of the Panel Physicians for 90 days after the work injury. An injured worker may also see a doctor of their choice, but the bills of that non-approved doctor are not required to be paid by workers compensation. There are many requirements for a list of company doctors to be "valid." If no list exists, it is invalid, OR if the claim has been denied, the injured worker can seek treatment with a physician of their own choosing.

Expert Exams: Insurance companies are entitled to make the injured worker attend several different types of expert exams "periodically," to determine whether the injured worker is still disabled; whether work is available within their capabilities; or other legal options available to the insurance company to challenge the injured worker's right to ongoing benefits. These exams include Independent Medical exams (IME) [often called a Defense Medical Exam (DME)]; vocational interviews; or an Impairment Rating Evaluation (IRE). Failure to attend an exam may result in the suspension of benefits.

HOW AND WHEN BENEFITS CAN STOP

There are MANY options available to insurance companies to challenge or stop paying benefits - more than those discussed here. The most common include:

- A Petition to Terminate, Modify or Suspend payment (discussed below);
- Properly filing and serving Notification of Suspension or Modification - without needing court approval;
- A Request for Utilization Review of the medical treatment; or, most preferably,
- By settlement.

The reasons or basis to challenge an injured worker's benefits include:

- The opinions of a doctor - whether one actually providing treatment, or hired by the insurance company; the injured worker has, or is able to return to work; Claimant is receiving benefits from another source (unemployment, pension, severance, Social Security etc.)
- The injured worker has been incarcerated following a conviction; or,
- Has died for reasons unrelated to their work injury.

As a matter of business, the REAL reason insurance companies challenge benefits is MONEY. The business of insurance companies is to make money for their owners and stock holders - NOT to pay out on claims. When they can reduce the payments going out - the more money is available for 'the business.'

The 'business' of an attorney representing insurance companies is to save them money - NOT to find the truth. That is the role of a Judge.

The business of lawyers representing injured workers is to protect their rights and benefits, and maximize the value of the claim - before the insurance can find a way to cut them off.

AUTHORITY OF JUDGE

When any petition is filed by the Claimant (to obtain benefits, correct the injury description or benefit rate); or by the insurance company (challenging Claimant's right to benefits), the petition will be assigned to a Workers' Compensation Judge (WCJ). These Judges handle ONLY workers compensation claims. They do not have authority or Jurisdiction to hear other type of claims - and no judge in another system (domestic relations, criminal law etc.) has any authority to decide workers' compensation issues.

Each WCJ has their own procedures and preferences - within the scheme of the Workers' Compensation Act. Though rare, failure to follow the Judge's procedures can result in the Dismissal or Granting of a Petition (depending upon which party filed the petition and which party violated the "rules"). It is essential for the lawyer to know each WCJ's rules and procedures. Attorneys unfamiliar with the Workers' Compensation system can jeopardize their client's rights, merely by making a procedural error.

Generally, there will be 2 - 4 hearings, each hearing having a different purpose. Though every case is different - the 'average' length of litigation is 10-12 months, from the date the petition is filed to the date a Decision is issued. The WCJ will accept each party's evidence, and hear "live" testimony from any witness either party wishes to have testify in court. Experts usually testify by deposition, and a typed transcript is presented to the Judge. After all evidence is presented, the attorney for each party will submit a written argument (brief) summarizing the evidence, the relevant laws, and arguing why their client should win. After reviewing the evidence and arguments, the WCJ will issue a written Decision.

A WCJ has discretion to believe or reject the testimony of any witness, so long as they state their reasons for doing so.

RIGHT TO APPEAL

Whichever party is 'dissatisfied' with a WCJ's Decision may file an Appeal to the Workers' Compensation Appeal Board (WCAB).

The second level Appeal is to the Commonwealth Court of Pennsylvania **(CCP)**.

The final possibility for Appeal is to the Supreme Court of Pennsylvania (SCoPA). There is no 'right' to bring a case to the Supreme Court. They pick and choose which cases they wish to hear and decide - usually based on issues of public importance, where the issue involved can impact all future cases - not simply a dispute affecting this Claimant and this employer.

Merely challenging which witnesses the Judge accepted or rejected is not a sufficient basis for Appeal. That is the Judge's job - and ONLY the Judge's job.

The Appeal courts, no matter how far an Appeal may advance, can NOT re-decide the credibility issues - even if they would have believed different evidence than the Judge.

The Appellate Courts' authority is limited to determining

- Whether the evidence summarized by the Judge is actually contained in the evidentiary record;
- Whether the WCJ considered ALL of the relevant evidence;
- Whether the WCJ set forth adequate reasons for which evidence was believed or rejected;
- Whether the WCJ acted within the scope of their authority; and,
- To ensure the decision did not violate any law or constitutional rights.

PETITIONS CHALLENGING BENEFITS: TERMINATION/ SUSPENSION/MODIFICATION

These are the most common petitions an insurance company might file, challenging an injured workers' right to continue receiving benefits. Each of these petitions is usually based on the experts hired by the insurance company, and will be contested by evidence presented by the Claimant - subject to the Judge deciding which evidence/witnesses is believed - and what evidence/witnesses are rejected.

A **Termination Petition** is based on medical evidence, usually from an expert hired by the insurance company, who states (in their opinion) the Claimant is fully recovered from their work injury. If the Judge accepts the insurance company's evidence as believable, *all benefits* are "terminated."

A **Suspension Petition** can be based on several different legal theories:

A. there is work available to the injured worker within their capabilities, and at wages equal to or greater than their pre-injury average weekly wage;

B. the injured worker has in fact returned to work at equal or greater earnings;

C. the injured worker failed to attend a Court Ordered Expert Exam;

D. the injured worker has been incarcerated following a conviction; or,

E. the injured worker has voluntarily removed themselves from the work force (usually by way of retirement).

If the Judge believes the employer's evidence, wage loss benefits are "suspended", but the

Claimant has the right to continue getting medical treatment, paid by Workers' Compensation.

A **Modification Petition** can again take several different forms:

A. that work is available to the Claimant, but at wages less than their pre-injury earnings;

B. that the Claimant has in fact returned to work at lower earnings;

C. that the injured worker's condition is reasonably presumed to be permanent, and an Impairment Rating Evaluation has determined their impairment is less than 35%, pursuant to AMA Guidelines.

If benefits are "modified," the insurance company must still pay some weekly wage loss benefits - at a rate determined by the "facts," as decided by the Judge. The right to ongoing medical treatment continues as well.

JOB AVAILABILITY

The term "job availability" stated above is based on legal criteria. For injuries suffered before 1996, the insurance company must prove a number of elements, the most significant is that there was an **actual job offered** to the injured worker. The 1996 amendments to the Workers' Compensation Act eliminated the insurance company's obligation to prove an actual job "offer." The insurance company's vocational expert now only needs to prepare a document called a Labor Market Survey (or "Earning Power Assessment"), demonstrating the types of jobs that are **available** in the general labor market within the Claimant's physical capabilities (which capabilities are typically based on the opinions of the insurance companies doctor).

However, if the employer with whom Claimant was employed has a position available within Claimant's capabilities - that job MUST be offered to Claimant - before the court can consider a Labor market survey.

OTHER COMMON PETITIONS

PETITION TO COMPEL EXPERT INTERVIEW

As stated above, the insurance company can 'compel' the Claimant to be evaluated,

examined or interviewed by a variety of experts they hire and pay a substantial fee - hoping, and usually getting an opinion sufficient to challenge the injured workers' right to benefits. Merely failing to attend an exam of this type can result in a Petition to 'force' the injured worker attend, or even stop their benefits for repeated failure to attend.

REINSTATEMENT OF BENEFITS

If an injured worker's benefits are terminated, modified or suspended, the injured worker can still file a Petition to Reinstate wage loss benefits. The elements the injured worker needs to prove (to the satisfaction of the Judge) and the likelihood of success, vary depending on how and why the benefits were discontinued.

UTILIZATION REVIEW

A Request for Utilization Review challenges whether past or future treatment is reasonable and necessary. It can be filed by either party, but overwhelmingly is a tool used by insurance companies to cut-off an injured worker's right to treatment - even where the insurance company acknowledges that the disability continues.

Though it is the insurance companies burden to prove the elements required by law to stop medical benefits - in reality, it is often the injured worker's burden to 'convince' the Judge they need the treatment. More and more frequently, WCJ's are 'stopping' opioid pain medication, due to the media and politically created 'opioid crisis.' Many WCJs, who have not themselves experienced debilitating pain, sincerely believe they are 'helping' the injured worker. It should be the injured workers' right to balance the dangers of such medication with the daily, unrelenting pain they experience - but the authority rests with the Judge - not the injured worker.

TOTAL vs. PARTIAL DISABILITY

There is no such thing as a "permanent" injury (with one exception, explained below). There is ONLY **total** or **partial** disability. These are legal definitions, not medical or even based on plain English.

Totally disabled applies when an injured worker is not working, and there is no evidence

of jobs 'available' (as explained above). Under this definition, wage loss benefits theoretically can last for life.

Partial disability applies where an injured worker has returned to work, or a Judge determines they can work, AND there are jobs available within their capabilities. Partial disability provides wage loss benefits for a maximum of 500 weeks, but no limit on medical treatment. [The 500 weeks is a maximum - NOT a guarantee. Wage loss and medical benefits cut be further reduced or stopped based on other evidence/reasons.]

Partial disability can also be based on an **Impairment Rating Evaluation** (described in greater detail in next section). This is a tool originally created in 1996; and amended in 2018 - after the law was found **unconstitutional** by the PA Supreme Court. THIS FIRM, and many other 'Claimant' lawyers and law firms are currently challenging the Constitutionality of the new law.

IMPAIRMENT RATING EVALUATIONS (IRE)

Worker's Compensation was originally created as a "wage loss system" in 1915. Impairment Ratings were adopted by the Pennsylvania Legislature in 1996. 'Impairment' is based on an injury that is *'reasonably presumed to be permanent'* the one exception to total vs. partial disability discussed above.

First - what is an IRE? It is a different type of examination than an IME. A doctor appointed by the Bureau of Workers' Compensation uses an arbitrary mathematical formula set forth in American Medical Association Guides, to calculate the percentage of the Claimant's bodily "impairment" due to the work injury - to determine the injured workers' right to future wage loss benefits.

If the impairment is under 35%, the injured worker's benefit status can be automatically, or by petition, changed to partially disabled, rather than totally disabled - thereby limiting the injured worker to 500 weeks of benefits - even with no evidence of a change in their "disability", work capabilities or work availability.

Sounds confusing, right?

Even the doctors who created the formulas do not agree on its use or value.

Nonetheless, many states do use this type of system, but in the **opinion** of this law firm, the two systems are inconsistent and incompatible with each other - and the law is

UNCONSTITUTIONAL.

In June of 2017, the Supreme Court of PA found the 1996 law unconstitutional. In October, 2018 the Pennsylvania Legislature re-enacted the law, with very slight changes. As of the date of this update - virtually every ***Certified Workers' Compensation Specialist*** attorney in Pennsylvania is again challenging the Constitutionality of this new version. This law firm is well in the hunt to be that Firm.

SOCIAL SECURITY AND MEDICARE

The interaction between Workers' Compensation "disability" benefits, and an individual's potential right to simultaneously receive Social Security and/or Medicare Benefits has significant pros and cons, which must be carefully considered on a **case-by-case basis.** The Federal Government (which pays Social Security/Medicare) has rights against the injured worker's weekly benefits and/or settlement. These rights are determined by Federal Law - not the PA Workers' Compensation Act.

Below is a very simplified outline of these rights.

Medicare has a right to demand a piece of a WC settlement, through something called a Medicare Set Aside. Whatever amount the Federal Government demands, the defendant must either agree to pay, keep medical "open" (or simply decide not to settle). Medicare does not pay for any and all treatment, but pays the types of services approved by Medicare Guidelines. They also do not pay 100% of the bills, but require the recipient of benefits (you) to make a co-payment. In deciding whether or not to agree to a "Set-Aside," your future treatment needs and costs must be carefully considered - as well as the risks that Workers' Compensation could be stopped at some point.

Social Security works VERY differently - depending on the type of benefits being received - for 'disability' or, the 'Age Related' benefit.

With the SS disability benefit, WC pays the full benefit rate and the Federal Government pays a reduced rate, calculated based on the WC benefits being received - or as pro-rated over the Claimant's life expectancy.

With the SS "Age related" benefit, it works the opposite. Social Security would pay the full benefit rate, and WC pays a **significantly** reduced benefit rate.

Failure to report the benefits being received from another source can result in allegations, or charges of insurance fraud. The injured worker can not simply claim "I didn't know."

OTHER ISSUES:

Among the many issues NOT covered here include the interplay between a Workers' Compensation claim, and the right to benefits from other laws, such as a

- Pension;
- Short or Long Term Disability;
- Unemployment Compensation; or,
- a privately funded insurance plan (like AFLAC);
- a separate 'negligence' or personal injury lawsuit against a Third Party (not the employer) responsible for causing their injury;
- the right of one insurance company to get paid back from another insurance company - or any other lawsuit related to the work injury - (called subrogation); and,
- Alternative Claims for certain employees which include benefits pursuant to
    - the Laws Enforcement Disability Benefit Act (Heart & Lung Act);
    - the Construction Workplace Misclassification Act;
    - the Longshoreman's Act;
    - the Railroad Workers Act, etc.

To discuss the UNIQUE FACTORS of your case, and for specific, not general answers, it is essential to speak with your lawyer - and not rely on these General Guidelines.

FINALLY: the most important Question most clients ask:

CAN I GET A SETTLEMENT?

SETTLEMENT - BACKGROUND INFORMATION

There are FOUR values for any given case. These values, in descending order, are:

1. What the injured person thinks is fair.
2. What the claim is actually worth.
3. **What the defendant is willing to pay.**
4. What the defendant thinks it's worth.

1. An Injured person lives with the pain, disability and stress every day. There is not enough money in the world to compensate for everything that has and may continue to affect them since the injury occurred.

2. What a claim is "actually worth" is based on statistics. What have other people with similar injuries and lost incomes received by way of settlement. It's not what is "fair", but simply a hard/cold mathematical calculation based on other, similar cases. However, there really is *no average* case. EVERY case has unique facts.

3. Skipping to number 4 - the lowest figure is what the defendant thinks your case is worth. Insurance companies believe everyone is faking or exaggerating. They tend to offer a *nuisance value*, just to avoid the cost of continuing to pay their own lawyers.

4. The "ultimate" settlement figure is #3 - **whatever the defendant is willing to pay**.

Regardless of every other "value" - if the insurance company refuses to pay it - then a deal won't happen. **No Judge can force a settlement.** Not even the Appeal Courts. In Workers' Compensation, there is no verdict by a Judge or Jury to end the case. Instead, a Judge's decision on any given petition simply determines whether the weekly checks continue - or stop. It is basically an **"all or nothing"** system - unless both sides agree; on the amount of settlement money, and every condition. Without an agreement - there is no settlement. The insurance company can not be forced to pay more than they want to pay; and the injured worker can not be forced to take less than they want.

However, failure to settle does not mean a Claimant stays on comp forever. Based on this outline, there are NUMEROUS ways an insurance company can challenge the injured worker's right to benefits - and if the Judge rules against the injured worker - they could end up with nothing - no weekly checks, no payment of medical bills, and no settlement.

WHAT IS YOUR CLAIM WORTH?

Every case is UNIQUE. Multiple clients with the same exact injury diagnosis will be offered different settlement figures, based on literally dozens of factors, including, but not limited to:

- What is the weekly benefit rate?
- How long have you been disabled?
- How much wage loss has been paid to date?
- How much is payable "per year"?
- What is the accepted injury?
- Should other injuries be included ?
- How much in medical bills have been paid?
- What future treatment is necessary?
- What is the cost of future treatment?
- Is there other insurance available?
- Is there litigation pending?
- What are the risks of litigation?
- Who is the Judge?
- Who is the Defense Lawyer?
- Who is the insurance company?
- Who is the Defense Doctor?
- Do you have any other medical conditions?
- What is your financial need?
- Do you WANT to return to work?
- Is there work you think you can do?
- **ETC.**

WHAT IS THE LAWYER'S JOB?

Your lawyer's job is to demonstrate to the insurance company that THEY are better off settling for more than they really want to pay, because WE will fight longer and harder than most

other lawyers - and the only way to get rid of US, is by settling with YOU, at a figure that YOU are willing to take. Insurance companies keep records on every attorney - who fights, and who just wants a quick settlement; who is a good attorney, and who is just doing a basic job. The lawyers who are known to fight do get slightly better settlements - but even then only within the range an insurance company is willing to pay.

SCHMIDT, KIRIFIDES & RASSIAS is well known to be a law firm that fights for every client, to maximize the value of their claim, whether it be for ongoing weekly benefits, or for a lump-sum settlement. EVERY ONE of our Workers Compensation Attorneys are ***CERTIFIED WORKERS' COMPENSATION SPECIALISTS***, pursuant to the requirements of the Supreme Court of Pennsylvania, and the PA Bar Association.

The primary considerations right now are:

1. Do you want to settle, or do you want to continue receiving weekly checks?
2. Do you need future treatment, and do you have a means or coverage to pay for it?
3. Do you want this all over with - and no risk of what "might happen" in the future, or take the risk of future litigation, and outcome?

Answering these *initial* questions will make your decision much easier to make.