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PENNSYLVANIA MOTOR VEHICLE LAW UPDATE

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Pennsylvania Supreme Court Holds That Insurer Not Tasked With Ensuring Compliance Of PRO After Submission Of Claim.

Doctor's Choice Physical Medicine and Rehabilitation Center, P.C. v. Traveler's Personal Insurance Co., 146 MAP 2014 (December 21, 2015)

Angela LaSelva was injured in a motor vehicle accident and sought chiropractic care with Doctor's Choice Physical Medicine and Rehabilitation Center, P.C.. Travelers, Ms. LaSelva's automobile insurer, paid her chiropractic bills for a period of time. Travelers then decided to submit the claim for a peer review per §1797(b) of the Pa. MVFRL to determine whether the ongoing chiropractic care was "reasonable and necessary".

The matter was submitted to IMX Medical Management Services, a certified peer review organization (PRO). IMX selected Mark Cavallo, D.C. to conduct the peer review. Dr. Cavallo found some of the treatment to be reasonable and necessary but that the treatment after a certain date was neither reasonable nor necessary. Travelers denied the bills for ongoing chiropractic care.

Doctor's Choice filed suit against Travelers in Dauphin County claiming the outstanding chiropractic bills and interest as well as attorney's fees. In a non-jury trial Judge Clark found that Dr. Cavallo failed to proceed according to national and regional norms as required by 31 Pa. Code §69.53. Thus the peer review report was "invalid" and the matter was to be treated as if never submitted for review. The court then awarded attorney's fees of approximately $39,000 in addition to the chiropractic charges of $28,000.

Post-trial motions were filed and, while pending, the Pennsylvania Supreme Court issued its decision in *Herd Chiropractic Clinic v. State Farm Mutual Automobile Insurance Company*, 64 A.3d 1058 (Pa. 2013). In that case the Supreme Court held that an insurer is insulated from attorney's fees under §1797(b)(4) once a claim has been "challenged before a PRO." As such, Judge Clark struck the award of attorney's fees. Doctor's Choice appealed to the Superior Court.

On appeal the Superior Court reversed the trial court's decision to vacate the

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SUPREME COURT PERMITS UNILATERAL SETTLEMENT OF SUITS BY INSUREDS

Babcock & Wilcox v. American Nuclear Insurers

By Nicholas A. Cummins, Esquire, Bennett, Bricklin & Saltzburg LLC, Philadelphia PA

When an insurance carrier defends a liability suit under a reservation of rights, the carrier owes a duty to its insured to accept a "fair and reasonable" offer of settlement; and the carrier that refuses such an offer breaches its duty to the insured. In such cases, the insured is permitted to unilaterally settle the claim, over the insurer's objections. Provided the settlement was fair, reasonable, not the product of collusion, and is otherwise shown to be covered under the policy, the insurance carrier must then reimburse the insured for the settlement. This is true even if the insurer did not act in "bad faith" in refusing to settle. This is the three-to-two holding of the Supreme Court of Pennsylvania in *Babcock & Wilcox Co. v. American Nuclear Insurers*[1], which, for the first time, divests an insurer of its right to control the settlement of a claim. This decision has far reaching implications for the issuance of reservation of rights letters, the handling of settlement offers, and, potentially, the way in which the plaintiff's bar litigates liability claims.

A. Overview of the Suit and Opinions

Like most unusual rulings, *Babcock* involved unusual facts. *Babcock* was

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award of attorney's fees finding that the *Herd* case was not controlling as there was no valid peer review since the reviewer failed to adhere to the standards set forth by the Insurance Commissioner in 31 Pa. Code 69.53(e). As such, there was no actual "challenge" as required by §1797(b)(4) in order to insulate an insurer from an award of attorney's fees. The court went on to state that the mere referral to a PRO does not constitute a "challenge." The insurer is obligated to make sure that the review conforms to the Insurance Commissioner's regulations.

In its appeal to the Pennsylvania Supreme Court Travelers argued that the plain meaning of "challenge before a PRO" means a legitimate referral and nothing more. Neither the statute nor the regulations contain any authority for fee shifting on a provider's challenge to a PRO determination. Further, Travelers contended that oversight of a PRO is reserved to the Insurance Commissioner, not the insurance industry.

Doctor's Choice argued that a "challenge" is not only a submission but the rendering of a fully valid peer review determination. The provider noted that insurers have relationships with PROs and are in the best position to ensure that there are no material defects in the review.

The Supreme Court held that the Superior Court's construction of the statutory term was too narrow and that "challenge before a PRO" does not necessarily encompass a valid completed review. As such, §1797(b) does not require an insurer to regulate compliance of the PRO as part of the "challenge." Such a requirement is lacking in the language of §1797(b).

Federal District Court Validates §1734 "Sign Down" Form Lacking Policy Number.
Kidd v. State Farm Mutual Automobile Ins. Co., No. 1:13-cv-2625 (M.D. Pa. December 29, 2015)

Sandra Kidd was the sole named insured on a policy of insurance issued by State Farm which covered four vehicles (613 policy). Ms. Kidd had selected UM/UIM coverage in an amount less than the liability coverage under the 613 policy. In October of 1998 she transferred one of the four insured vehicles to her son, James Brown. A decision was made for Mr. Brown to obtain his own policy on this vehicle now that he was the owner.

Mr. Brown executed a §1791 "Important Notice" as well as a §1734 "sign-down" selecting UM/UIM coverage of $15,000/$30,000 (the liability coverage was $100,000/$300,000). As the new policy number was not yet available, the agent referenced Kidd's existing policy number on the sign-down form for the new policy. When the actual policy number was assigned, underwriting scratched out the old number and added the new number to the form (733 policy).

In March of 2002 Brown's fiancé was added as a named insured to the policy. No new "sign-down" form was obtained at that time.

In January 2010 Brown was injured in a motor vehicle accident caused by a tortfeasor with limited coverage. He made a UIM claim to State Farm demanding UIM coverage in an amount equal to the liability coverage under his policy. The basis for his claim was that State Farm could not produce a "writing" which demonstrated that Brown's 733 policy number was present on the form at the time of execution. State Farm contended that the sign-down form executed in 1998 was valid and enforceable even though it contained his mother's policy number. As such, there was only $15,000 per person UIM coverage available. The undisputed coverage was tendered to Mr. Brown.

Brown then filed a declaratory judgment action to reform the policy as the only sign-down form in existence referenced Kidd's policy. As the form indicated that the sign-down pertained to the "policy identified above" (613 policy) it was invalid with respect to Brown's policy. Brown further contended that §1734 of Pa MVFRL required State Farm to obtain a new "sign-down" form when Brown's fiancé was added as a named insured.

State Farm contended that the sign-down executed by Brown in 1998 could not have pertained to any policy other than the policy created at that time. His mother, Sandra Kidd, had previously elected lower UM/UIM limits under the 613 policy. As Mr. Brown was not a named insured, he could not have "signed down" the UIM coverage for that policy. State Farm also contended that §1734 did not require a new "sign-down" when a named insured was added to the policy.

A non-jury verdict was entered in favor of State Farm finding that the reasonable inference to be drawn from the facts presented was that Brown was selecting lower UIM coverage for his policy which became effective the same day as the execution of the §1791 Important Notice and the §1734 "sign-down". The court also held that the executed §1791 Important Notice created a presumption that Brown was aware of the coverages available under the Pa. MVFRL and no further explanation was necessary from

State Farm. The court also noted that Brown was unable to make coverage changes to his mother's policy and that the Kidd policy already carried lower UIM coverage. Finally the court held that §1734 contains no requirement that a policy number be listed on the "writing" evidencing the election of lower UM/UIM coverage.

Federal District Court Permits Deposition Of Plaintiff's Counsel In UIM/Bad Faith Action.

Adeniyi-Jones v. State Farm Mutual Automobile Insurance Company, No. 147101 (E.D. Pa., October 21, 2015)

Plaintiff filed an action against her automobile insurer for UIM benefits. A bad faith claim was also made with respect to the negotiation of the UIM claim. State Farm's counsel noticed the deposition of plaintiff's counsel and a motion for protective order followed. The insurer wanted to take counsel's deposition with respect to discussions counsel had with State Farm's claims representative prior to the filing of the lawsuit.

The allegations of bad faith in the complaint included the insurer's failure to request an examination under oath or an IME. State Farm contended that an oral agreement existed between the claim representative and counsel that counsel would provide information to State Farm so that the examination under oath and IME would not be required. Thus the existence of any oral agreement was central to the defense of the bad faith claim.

The district court found that plaintiff's counsel had relevant information available only through her. Also, communications with the claims representative were not protected by attorney-client privilege. The deposition was limited to pre-litigation communication between plaintiff's counsel and the State Farm's claim representative.

Federal District Court Prohibits "Net Worth" Discovery Absent Prima Facia Showing Of Right To Recover Punitive Damages.

N'Jai v. Bentz, C.A. 13-1212 (W.D. Pa. November 24, 2015)

Plaintiff filed a motion to conduct "wealth discovery" with respect to the defendant's net worth. At that point there had been no finding of liability on the part of the defendant nor any verdict or award. Plaintiff's argument was that this information was pertinent to the "demand" for punitive damages.

Pennsylvania law has long held that a plaintiff must make a prima facia showing of a right to recover punitive damages before a court will permit wealth discovery. Mere allegations in a complaint are insufficient.

Applying this long standing case law the district court found that the paintiff failed to refute the general proposition that financial discovery is not appropriate until there is a reasonable evidentiary basis to suggest that a punitive damage claim will be submitted to a finder of fact. As such plaintiff's request was denied without prejudice to be revisited at a later date.

Commonwealth Court Holds That Trial Court Correct In Instructing Jury That A Pedestrian Crossing Roadway Outside Of Crosswalk Must Yield To Oncoming Traffic.

Chaudhuri v. Capital Area Transit et al., __ A. 3d. __ (Pa. Cmwlth., December 7, 2015)

Plaintiff was involved in a pedestrian/bus accident in August 2010. Prior to the accident she had been a passenger on defendant's bus traveling in a northerly direction. She exited the bus and attempted to cross the roadway behind the bus. At that time she was struck by a mirror on a southbound bus also owned by the defendant. Plaintiff was knocked unconscious and later sued CAT.

At trial the jury apportioned negligence 75% on the plaintiff and 25% on the defendant driver. In her post-trial motions plaintiff contended that it was error for the trial court to instruct the jury on duties of pedestrians when crossing a roadway other than at a crosswalk. The post-trial motions were denied and an appeal taken to Commonwealth Court.

The record demonstrated that the trial court charged on various provisions of the Pennsylvania Motor Vehicle Code pertaining to pedestrians and traffic on the roadway. Included in this charge was §3543(a) of the Motor Vehicle Code which sets forth that pedestrians crossing a roadway at a point other than in a crosswalk must yield the right of way to vehicles on the roadway. The court also added that it was the "preference" to have pedestrians cross at a crosswalk.

On appeal plaintiff argued that the court's use of the word "preference" essentially directed the jury to find the plaintiff negligent. In addressing this issue the Commonwealth Court cited a long line of Pennsylvania cases holding that a pedestrian has to exercise a high duty of care when crossing a roadway outside of a crosswalk or intersection. The trial court's use of the word, "preference", was merely a passing comment. The trial court never suggested that plaintiff violated any statutory provisions. As such the verdict was affirmed.

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a declaratory judgment action arising from an underlying mass tort claim filed in 1994. In the underlying tort suit, several residents in the area surrounding nuclear processing facilities operated by Babcock & Wilcox and B&W Nuclear Environmental Services (collectively, "B&W") claimed that exposure to radiation from the facilities caused a variety of serious injuries. B&W's insurers, American Nuclear Insurers and Mutual Atomic Energy Liability Underwriters (collectively, "ANI"), assumed B&W's defense subject to a reservation of rights. The coverage issues expanded as the litigation continued, but ANI generally reserved the right to disclaim coverage to the extent the losses fell outside of the "nuclear energy hazard" or the policy period. Later, ANI also reserved the right to disclaim for an alleged breach of the policies' cooperation clauses stemming from B&W and Babcock's refusal to proceed with joint counsel. By the time the underlying suit resolved, however, that issue was apparently moot, as an appellate court had ruled in B&W's favor on the question of separate counsel.

As the years passed, the tort suit grew to encompass more than three hundred claimants. In 1998, a test trial by eight claimants yielded a total verdict of more than thirty five million dollars. The test trial was ultimately reversed due to issues with the science relied upon by plaintiffs' experts to link the claimed injuries with the nuclear facilities. Nonetheless, the test trial result suggested the potential for more than one billion dollars in total exposure if plaintiffs could prove their claims. ANI, for its part, incurred more than forty million dollars in defense costs[2]. Between the two, Babcock and B&W had three hundred twenty million dollars in insurance coverage available to them, which was eroded by defense costs.

Ostensibly in recognition of the significant weaknesses in their claims, the plaintiffs offered to settle all claims against B&W for the comparatively modest total sum of eighty million dollars. ANI rejected this offer, believing that plaintiffs had little chance of success on the merits. B&W, believing the settlement to be favorable, asked ANI to withdraw its reservations of rights if it intended to reject the settlement and continue to defend the claim. ANI refused. Without ANI's consent, B&W then unilaterally accepted the plaintiffs' settlement offer, paying the eighty million dollar settlement out of pocket, and bringing the underlying suit to an end.

In the resulting declaratory judgment action against ANI, B&W sought reimbursement for its settlement payment, contending that the settlement was reasonable under the circumstances. In response, ANI conceded that the policies otherwise covered the settlements, but asserted that B&W was not entitled to reimbursement because it breached the policies' consent to settle clauses. Those clauses authorized ANI to direct and approve any settlement of the claim, and barred B&W from making any payment to the plaintiffs, except at its own expense[3]. Since ANI's consent to settle clauses were clear and unambiguous, the trial court initially resolved the issue by holding that B&W could not recover unless B&W proved that ANI acted in "bad faith" under the *Cowden v. Aetna*[4] standard. To meet this burden, B&W would have been required to prove by clear and convincing evidence that ANI did not have a good possibility of winning the underlying suit on its merits, and unreasonably refused the plaintiffs' settlement offer[5]. On further consideration, however, the trial court reversed course. Instead, it held that B&W was entitled to reimbursement so long as the settlement was reasonable and non-collusive under the circumstances[6]. Effectively, the trial court barred ANI from arguing that it was entitled to refuse the offer because it was likely to win the case on its merits. Instead, the jury was asked only to determine whether the amount of the settlement was reasonable.

The trial court reached its conclusion by looking to a line of Pennsylvania cases[7] holding that when the insurer incorrectly issues an outright *denial* of coverage, it has breached the insurance policy and may be liable for any reasonable settlement covered by the policy. Those cases reasoned that when the insurer has refused to provide any coverage, it has no right to demand control over the settlement. The trial court, while recognizing that the claim was not one which was likely to exceed the coverage limits, focused its reasoning on ANI's pending reservation of rights. It found little practical distinction between the scenario where the insurer issues an outright denial of coverage, and the one in which the insurer issues a reservation of rights. It reasoned that in both cases, the insurer was seeking to dictate the terms of a settlement with one hand, while repudiating (or potentially repudiating) coverage with the other. Finding a reservation of rights to be the functional equivalent of a coverage denial, the trial court held that B&W could recover so long as the verdict was reasonable and non-collusive. A jury agreed that the settlement was reasonable, and the issue was appealed to the Superior Court.

The majority Superior Court opinion reversed and remanded, but did so only after creating a new rule in Pennsylvania governing the handling of insurance claims defended under a reservation of rights. It did so in an attempt to avoid what it saw as two competing interests at play when a reservation of rights is issued.

On one hand, the Superior Court recognized that an insurance policy is a contract, and that unambiguous terms in an insurance contract are to be enforced as written, absent a material breach of the contract by the insurer. Since no party disputed the clarity of the consent to settle clauses, the majority was troubled by the trial court's decision to effectively treat the issuance of a reservation of rights letter as a breach of the insurance policy. Finding that the issuance of a reservation of rights did not constitute a breach, the majority disagreed with the trial court's decision to impose a reasonable settlement standard simply because a reservation of rights was issued[8]. Such a rule disregarded basic concepts of contract interpretation.

On the other hand, the Superior Court majority was also troubled by the fact

that a reservation of rights creates an inherent conflict of interest which incentivizes an insurer to elevate its own interests above that of its insured. The majority observed that an insurer defending under a reservation of rights is given two chances to avoid liability for the claim. Where an insurer believes it has a meritorious coverage defense, the court reasoned that the insurer may be motivated to turn down an otherwise reasonable settlement, secure in the knowledge that, if it loses on liability, it may still escape liability under its coverage defense. In so doing, the insurer may be denying the insured the opportunity to settle the potentially uncovered claim for far less than the resulting verdict at trial. As such, the issuance of a reservation of rights, the majority reasoned, allowed the insurer to control the defense and settlement of a claim in such a way as to expose the insured to greater potential liability on a claim that ultimately would not be covered by the policy. This, the majority concluded, created a conflict of interest between the insurer and insured, which militated against the insurer's right to control the defense and settlement when a reservation of rights has been issued[9]. The majority went on to reject as "too cavalier," the use of the *Cowden* bad faith standard to resolve and prevent the abuse of this conflict of interest by the insurer.

To balance the need to enforce the contract as written with the conflict of interest between the insurer and insured, the Superior Court majority adopted a hybrid rule[10]. The majority held that any time an insurer offers a defense under a reservation of rights, the insured may either accept or reject the defense. If the insured accepts the defense, the insurer is entitled to assert and rely upon its consent to settle clause. If the insured settles the claim directly, the insurer is only liable for the settlement if it acted in bad faith under *Cowden* (which would constitute a material breach of the policy). Conversely, if the insured rejects the defense, it may control the defense and negotiate settlement of the claim directly and at its own expense. If coverage is later found, the insurer is then liable for any reasonable, non-collusive settlement, along with the insured's defense costs[11]. The majority therefore remanded the case with instructions to apply the bad faith standard, assuming B&W had accepted ANI's defense (which it had)[12]. The Supreme Court of Pennsylvania granted *allocator*.

Fortunately, the Supreme Court promptly rejected the Superior Court's hybrid rule which would have permitted the insured the option of accepting or refusing a defense proffered under a reservation of rights. Having done so, the primary issue before the court was "the appropriate standard to apply in determining whether an insurer is liable under its insurance policy for a settlement made by its insured without securing the insurer's consent, when the insurer is defending the claim subject to a reservation of rights[13]." ANI argued that the consent to settle clause should only be set aside where the insurer acted in "bad faith" under the *Cowden* standard. B&W contended that the court should adopt the reasonableness standard selected by the trial court.

Ultimately, the Supreme Court rejected the *Cowden* standard. It did so by reasoning that, in the traditional *Cowden* scenario, the insured is seeking damages *in excess* of the policy limits as reimbursement for an excess verdict. Since the insurer is to be held liable for extra-contractual damages, the Supreme Court found that the higher bad faith standard was appropriate[14]. By contrast, when the question is whether the insurer refused to accept a reasonable settlement offer in the presence of a reservation of rights, the insured does not seek extra-contractual damages, but rather, damages that fall within the scope of the coverage provided by the policy. This, the Supreme Court reasoned, justified a lower, reasonableness standard[15].

Having rejected the bad faith standard, the Court held that "an insurer breaches its duty [to the insured] by refusing [a] fair and reasonable settlement while maintaining [a] reservation of rights …, thus, subject[ing] an insured to potential responsibility for the judgment[16] … ." In such cases, the insurer, having "breached" the insurance contract, may not rely upon its consent-to-settle clause to repudiate the settlement (provided the settlement was otherwise covered by the policy)[17]. Such a breach occurs when the settlement "was fair and reasonable from the perspective of a reasonably prudent person in the same position of [the insured] and in light of the totality of the circumstances[18]." "[A] determination of whether the settlement is fair and reasonable necessarily entails consideration of the terms of the settlement, the strength of the insured's defense against the asserted claims, and whether there is any evidence of fraud or collusion on the part of the insured[19]." While the Supreme Court noted that this standard "has attributes of the *Cowden* bad faith test," it emphasized that the standard was not one of bad faith[20]. "[T]he insured need only demonstrate that the insurer breached its duty by failing to consent to a settlement that is fair, reasonable and non-collusive …, rather than demonstrating bad faith by the insurer[21] …." In sum, if the proffered settlement is reasonable under the circumstances, the insurer is obligated to settle the claim, and, if its fails to do so, the insured may enter into the settlement directly.

B. Commentary on *Babcock*'s Reasoning

The overarching concern addressed in *Babcock* - the potentially conflicting interests between an insurer and insured when a reservation of rights has been issued - is a valid one. Certainly, a balance should be struck between the insured's interests in avoiding an uncovered judgment and taking a good deal while it is available, with the insurer's interests in fully contesting claims involving weak liability or questionable damages. The chief problem with *Babcock* is its election of a "reasonableness" standard over the long established *Cowden* "bad faith" standard. The reasonableness standard too easily discards the terms of the agreement, does not give proper consideration to the legitimate interests of the insurer in choosing to defend frivolous and unfounded cases, and, arguably, places the insurer under an absolute duty to settle a claim should a low enough settlement demand be proffered.

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Babcock's reasonableness standard measures reasonableness from the standpoint of the insured. Although not entirely clear, this standard presumably does not permit consideration of the insurer's obligations to all of its policy holders to control the cost of insurance, in part, by contesting frivolous and unfounded claims. Looked at purely from the perspective of the insured, it is reasonable to accept a very low settlement demand made on a frivolous claim simply to avoid the risk of any exposure on the suit whatsoever. An insurer, by contrast, may have legitimate reasons for refusing even a nominal settlement offer. An insurer that pays settlements on frivolous claims encourages the filing of further frivolous claims, by creating the expectation that everybody who files a lawsuit is entitled to some recovery. Indeed, this was one of ANI's primary concerns in settling the underlying mass tort suit at issue in *Babcock*. ANI was concerned that paying the relatively modest sum requested would simply encourage further "copy cat" claims. According to ANI's brief before the Supreme Court, this actually came to pass after B&W's unilateral settlement, with an additional fifteen mass tort suits being filed[22]. When an insurer encourages meritless claims by paying some amount in settlement for every claim, it increases its exposure to both defense and settlement costs, which results in increased premiums for its other insureds. While an insurer's desire to take a hard line and avoid encouraging future meritless suits should not take a paramount role in assessing a settlement decision, it is an issue worthy of at least some consideration. *Babcock*'s standard does not appear to leave any room for such factors.

Babcock's reasonableness standard also allows for no consideration of the fact that reasonableness has a range. Under *Babcock* an insured need only show that the settlement fell within this range to recover. An experienced insurer, however, with expertise likely far outstripping that of any insured in negotiating and settling claims, may be able to negotiate a settlement into the lower end of that spectrum. *Babcock* appears to leave no room for this consideration either. Instead, it looks only to whether the settlement falls within the reasonable range.

Cowden's bad faith standard more readily allows for consideration of the insurer's concerns flowing beyond the particular suit at issue, and its greater experience in negotiating settlements. By finding a breach of the policy only when the insurer acts in bad faith, by refusing a settlement when it did not have a good faith *bona fide* belief that it was likely to prevail on the merits, *Cowden* permits a consideration of all relevant factors, both those of the insurer and insured. Moreover, it does so without easily discarding the terms of the insurance contract, which permit the insurer to control the defense and settlement of the claim, provided it does so in good faith, giving due regard to the interests of the insured. The reasonableness, standard, by contrast, strips the insurer of its bargained-for contractual rights simply because an insured and later jury believe this is the more prudent course. Were reasonableness the standard for determining breaches of a contract, many contractual terms could be avoided. For example, a builder who contracts to buy steel at a certain price would presumably not be in breach of the contract in later refusing to pay that price if the price of steel were to fall before the product was delivered, as it would be "reasonable" to pay only the market price at the time of delivery. Outside of *Babcock*, contract law does not set aside a contract term simply because the conduct of one party or another is considered reasonable.

The Supreme Court's analysis is also analytically problematic. The Supreme Court recognized that, in absence of a breach of the contract by the insurer, the law did not justify disregarding the consent to settle clause contained in the policy. Until *Babcock*, it had only been where the insurer first breached the agreement by wrongly refusing to defend or acting in bad faith that a contract term could be set aside[23]. The Supreme Court also could not suggest that the issuance of a reservation of rights letter constituted a breach, given its prior opinions actually encouraging insurers to defend under a reservation of rights when coverage issues arise[24]. In order to find a breach of the contract by the insurer, the Supreme Court was required to create a duty and standard which did not previously exist. In *Babcock*, the Supreme Court ruled for the first time that the insurer is under an obligation to accept reasonable settlement offers when a reservation of rights had been issued. This seems at odds with the court's prior decisions; for, as even *Babcock* recognized, "there 'is no absolute duty on the insurer to settle a claim when a possible judgment against the insured may exceed the amount of the insurance coverage[25].'" While this may be the rule when there is the possibility of an uncovered excess verdict, *Babcock* appears to reject this rule in cases where there is the possibility of an uncovered claim due to a reservation of rights. There seems to be no good reason why an insurer has no absolute duty to settle when the insured is faced with uncovered excess exposure, but does have such a duty when the insured is faced with potentially uncovered exposure within the policy limits.

More to the point, the duty imposed by *Babcock* seems to have been derived from thin air. The insurance contract certainly does not obligate the insurer to accept any reasonable settlement offer when a reservation of rights has been issued. Nor could the duty have been derived from the implied duty of good faith in the contract; otherwise, the *Cowden* bad faith standard would have applied. Thus, the Supreme Court appears to have created a duty simply for the purpose of finding a breach. As observed by the dissent, "applicable Pennsylvania law does not treat an insurer's good-faith decision to defend a claim rather than settle it as a breach of contract that triggers a free-for-all where the insured may take it upon itself to settle the case without permission in violation of the policy terms[26]."

Babcock is also problematic in that it provides no guidance on when the duty to settle applies. The body of the opinion suggests that the insurer has a duty to

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accept reasonable settlement offers whenever a reservation of rights is issued. Such a rule is problematic, because not all reservations of rights create conflicts of interest between insurer and insured. Many reservations of rights are issued because the complaint suggests a claim that may be uncovered, but, realistically, the interests of the insurer and insured are aligned with respect to the defense. For example, reservations that underscore the applicable policy limits, that advise the insured punitive damages are not covered, or which point out an exclusion which could, but is not likely to come into play (i.e. a mold exclusion in a water damage case), are ultimately unlikely to have any bearing on the outcome of the suit, and almost certainly will not result in a disclaimer of coverage. Where a reservation does not actually create a conflict of interest between an insurer and insured by exposing the insured to an uncovered loss, there is seemingly no reason that the insurer should be put to a duty to accept any reasonable settlement offer. In a footnote, the Supreme Court recognizes that "not all reservations of rights are equal," and "[t]he mere fact that an insurer restates that it will not cover what the insurance policy does not cover, where it arguably might be part of the damages sought, does not automatically result in allowing the insured to settle the entire suit[27]." Unfortunately, the Supreme Court offers no guidance on where the duty to settle begins, observing only that "[p] arties and courts may need to consider whether a particular reservation of rights justifies diverging from the contract's cooperation clause, a question which is not squarely before this Court[28]." In other words, the rule applies, except when it doesn't. With no guidance on which reservations are sufficient to trigger a duty to settle, insurers are left to guess at their obligations going forward.

In sum, *Babcock* imposes a new duty on insurers, not derived either from the contract or existing law, to accept a reasonable settlement demand when the insurer has issued certain, unspecified types of reservation of rights letters. An insurer's refusal of such a demand, even if made in good faith, constitutes a breach of the contract which allows the insured to unilaterally settle the case, ultimately using the insurer's money if coverage is found to exist. This holding has potentially far reaching consequences.

C. The Practical Implications of *Babcock*

Perhaps the most obvious implication of *Babcock* is that it will force insurers to choose between potentially covering damages falling outside of the policy, or giving up control of the settlement of a claim. Take the example of a water damage claim. In such a case, an insurer will typically issue a reservation of rights based on a mold exclusion in the policy. Most plaintiff's attorneys, aware of the exclusion, will not present damages for mold during the course of the litigation. If a settlement offer is made, however, the insurer must now choose between waiving its mold exclusion, or allowing the insured to settle a case the carrier would like to defend. Perhaps there is little harm in the carrier waiving the mold exclusion. On the other hand, once the exclusion is waived, perhaps the plaintiff decides it should now present mold related claims as well. Unless discovery is closed, the insurer is forced to act blindly.

The same is true with reservations which advise the insured of the policy limits or the exclusion of punitive damages. Must an insurer faced with a settlement offer now agree to accept excess exposure or punitive damages, even if the odds of an excess verdict or punitive damages award are low, in exchange for maintaining control of the settlement? The carrier in such a position faces a dilemma with no clear answer, a dilemma that is compounded by the Supreme Court's observation that perhaps not all reservations will even trigger the insured's right to settle. Thus, *Babcock*'s decision will routinely place insurers in the difficult position of predicting the future development of a claim. Indeed, faced with the loss of control of the defense, some insurers might elect to issue outright denials in questionably covered claims in cases where they would otherwise have defended under a reservation of rights. Such an outcome is bad for insurers and insureds alike.

At first blush, it might seem that *Babcock* would have limited impact because many insureds will not have the financial resources to fund their own settlements. While this might be true in personal lines claims, there are many commercial lines insureds who have the financial wherewithal to fund their own settlements. While few commercial insureds are likely to be able to fund the eighty million dollar settlement at issue in *Babcock*, a large number would likely be able to fund more routine settlements in personal injury cases. Thus, *Babcock* has the potential to become a recurring issue in suits against commercial insureds.

Perhaps more troubling, *Babcock* does not state that the insured must actually fund the settlement in advance to pursue a recovery. Presumably, a plaintiff's attorney could reach a "settlement" with the insured, and accept an assignment of the insured's right to recover the settlement from the insurer in lieu of collecting from the insured. Such a scenario not only extends the reach of *Babcock* to personal lines case, but also potentially allows a clever plaintiff's attorney to force a settlement in weak liability or questionable damages cases.

Take, for example, a case defended under a reservation of right which at full value could garner a judgment of up to $300,000.00, but where the odds of the plaintiff prevailing on liability at trial are very low. The plaintiff could make a settlement demand of $25,000.00 in view of the liability weaknesses in the case. An insurer, confident of success at trial, might with good reason reject such a demand. Following the rejection, the plaintiff might then be able to induce the insured to accept the settlement and the provision of an assignment in order to avoid even the remote chance that the insured could face excess or uncovered exposure. This is a particular risk in passenger versus driver auto accident suits, in which the plaintiff and defendant are frequently friends or relatives. The plaintiff, now armed with the assignment, could file a reimbursement action against

the insurer in the name of the insured seeking to recover the "settlement." In the reimbursement action, the plaintiff would not need to convince a jury of the insured's liability by a preponderance of the evidence. Instead, the plaintiff would merely be required to show that, under the circumstances, the settlement demand was reasonable. In this way, a clever plaintiff's attorney could force a recovery on a claim with very little possibility of recovery at trial without ever having to prove the merits of the case to a jury. Though it is true that the Supreme Court warned courts to be on the look out for collusive settlements, it is difficult to know how that term is defined. Whenever a plaintiff settles with a defendant without any money changing hands, is the settlement "collusive." One doubts that the courts will so hold, but the potential for abuse is obvious.

As noted, an insurer faced with an assigned reimbursement claim does have some defenses available to it (aside from the viability of the assignment). The insurer could contend that the settlement was collusive, because it did not require the insured to pay anything. Likewise, *Babcock* theoretically leaves open the possibility that a sufficiently strong liability defense could render any settlement, no matter how small, unreasonable. While this is a theoretical possibility, it would seem difficult to convince a jury of this position. At some point, the size of the proposed settlement in comparison to the potential risk and defense costs is likely to render the settlement "reasonable" in a jury's eyes. As such, for all practical purposes *Babcock* requires an insurer to accept some settlement figure. Last, the insurer could argue that the reservation at issue falls within that unspecified class which does not impose an obligation to settle. Since the law on this issue is presently undefined, any such argument faces an uncertain result.

At this point, there is little an insurer can do to avoid the effects of *Babcock* other than to more closely evaluate reservations of rights before they are issued, and consider the possibility of foregoing a reservation if the only coverage issues suggested by the complaint are somewhat speculative and unlikely to come to fruition. Once the suit progresses to settlement discussions, the insurer should be willing to at least consider the possibility of waiving the reservation of rights, particularly if the insured is pressing for settlement of the claim. In so doing, however, the insurer should first verify that all relevant discovery is complete and that it has an accurate picture of the claim. To do otherwise raises the possibility of an otherwise excluded claim becoming an issue in the suit after the reservation is withdrawn. Pending further guidance from the courts, insurers should treat all reserved cases with extra caution, realizing that the reservation could ultimately result in an unwanted settlement.

ENDNOTES

[1]2 WAP 2014, -- A.3d ---, 2015 WL 4430352 (Pa. Jul. 21, 2015).

[2]ANI's Supreme Court Brief at 13.

[3]The consent to settle clauses gave ANI the right to make any settlement of the claim that it deemed expedient, and prohibited B&W from "mak[ing] any payment, assum[ing] any obligation or incur[ring] any expense," "except at [their] own cost." ANI's Supreme Court Brief at 4.

[4]*Cowden v. Aetna Cas. Ins. Co.*, 389 Pa. 459, 134 A.2d 223 (1957), and its progeny, generally hold that an insurer may only be liable for a verdict in excess of the insured's policy limits if the insurer acted in "bad faith" in unreasonably refusing an offer of settlement. *Cowden* held that to act in "good faith," "the decision to expose the insured to personal pecuniary loss must be based on a bona fide belief by the insurer, predicated upon all circumstances of the case, that it has a good possibility of winning the suit." Id. at 478, 134 A.2d at 228. "Good faith requires that the chance of a finding of nonliability be real and substantial and that the decision to litigate be made honestly." Id.

[5]*Babcock*, 76 A.3d at 6 (Pa. Super.).

[6]*Babcock*, 76 A.3d at 7 (Pa. Super.).

[7]*Alfiero v. Berks Mut. Leasing Co.*, 347 Pa. Super. 86, 500 A.2d 169 (1985).

[8]*Babcock*, 76 A.3d at 11-13 (Pa. Super.).

[9]*Babcock*, 76 A.3d at 14-17 (Pa. Super.).

[10]The majority found that adopting either the "reasonable settlement" standard espoused by the trial court, or the "bad faith" standard advanced by ANI, "tilted the playing field too far" in favor either the insurer or insured. *Babcock*, 76 A.3d at 17 (Pa. Super.).

[11]"[W]hen an insurer tenders a defense subject to a reservation, the insured may choose either of two options. It may accept the defense, in which event it remains unqualifiedly bound to the terms of the consent to settlement provision…. Should the insured choose this option, the insurer retains full control of the litigation…. In that event, the insured's sole protection against any injuries arising from the insurer's conduct of the defense lies in the bad faith standard articulate in *Cowden*. Alternatively, the insured may decline the insurer's tender of a qualified defense and furnish its own defense, either *pro se* or through independent counsel retained at the insured's expense. In this event, the insured retains full control of its defense, including the option of settling the underlying claim under terms it believes best. Should the insured select this path, and should coverage be found, the insured may recover from the insurer the insured's defense costs and the cost of settlement, to the extent that those costs are deemed fair, reasonable and non-collusive." *Babcock*, 76 A.3d at 22 (Pa. Super.).

[12]The Superior Court's dissent contended that settled Pennsylvania insurance law required that the contract be enforced as written absent a material breach of the contract under the *Cowden* standard. It argued that the majority had improperly adopted new tenets of law in contravention of settled Supreme Court precedent. *Babcock*, 76 A.3d at 23-24 (Pa. Super.) (Olsen, J., dissenting).

[13]*Babcock*, 2015 WL 4430352 at *9 (Pa.).

[14]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[15]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[16]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[17]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[18]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[19]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[20]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[21]*Babcock*, 2015 WL 4430352 at *16 (Pa.).

[22]ANI's Supreme Court Brief at 20 n. 6.

[23]See *Alfiero*, supra, and *Cowden*, supra.

[24]See American and Foreign Ins. Co. v. Jerry's Sports Center, Inc., 606 Pa. 584, 616-17, 2 A.3d 526, 545-46 (2010).

[25]*Babcock*, 2015 WL 4430352 at *11 (Pa.) (quoting, *Cowden*, 134 A.2d at 228).

[26]*Babcock*, 2015 WL 4430352 at *19 (Pa.) (Eakin, J., dissenting).

[27]*Babcock*, 2015 WL 4430352 at *13 n. 15 (Pa.)

[28]*Babcock*, 2015 WL 4430352 at *13 n. 15 (Pa.)

IN RESPONSE TO: *"TINCHER: …ANOTHER UNWORKABLE CONSTRUCT…"* AN ALTERNATE INTERPRETATION

By Benjamin Sloan Tilghman, Esq., Law Clerk to the Honorable Judge Karen Shreeves-Johns

An article was published in the April 2015 edition of COUNTERPOINT entitled "Tincher: The Death of Azzarello. The Birth of Hope Within Another Unworkable Construct. And a Proposal to Return Pennsylvania Product Liability Law to Simple, Easy to Apply Legal Principles." ("the Article"). The Article's subject, *Tincher v. Omega Flex, Inc.*, 104 A.3d 328 (Pa. 2014), is a landmark case in which the Pennsylvania Supreme Court, among other holdings, explicitly outlined the Commonwealth's new strict products liability construct. The Article's authors maintain that the new construct is unworkable because it could lead to inconsistent factual findings from juries, an issue left "unresolved" by the *Tincher* court.

However, I wish to offer an alternate interpretation of the *Tincher* decision which could squarely resolve the issue of inconsistent factual findings. First, I will give a brief overview of the new construct and the Article's arguments against its workability. Next, I will cite *Tincher*'s two-part answer which, admittedly, could have been more direct. Last, I will explain the significance that strict liability plays in justifying the new construct's logic.

I must note that logical need not mean correct. This response does not seek to make any policy justifications and the Article's proposal may indeed ring true. This response only regards the potential workability of *Tincher* and Pennsylvania's new strict products liability construct.

The Construct

In its simplest terms, a defendant is liable for harm caused by a product if "the product is in a 'defective condition'… by a preponderance of the evidence." *Tincher* at 355. In other words, a plaintiff need only prove a product is "defective" to win her case. This point is the same pre and post-*Tincher*, but it will be important in the following sections.

What *Tincher* changed is the way in which a plaintiff may prove a defective condition exists. "The plaintiff may prove defective condition by showing either that (1) the danger is unknowable and unacceptable to the average or ordinary consumer, or that (2) a reasonable person would conclude that the probability and seriousness of harm caused by the product outweigh the burden or costs of taking precautions." *Id*. In other words (1) an ordinary user is surprised by unacceptable harm, or (2) an alternate, safer design should have been used according to a reasonable cost-benefit analysis. These tests are called the "consumer expectations test" (*Tincher* at 387) and the "risk-utility test" (*Tincher* at 389), respectively.

After *Tincher*, there are two different ways for a plaintiff to show defective condition and win her case. However, "the plaintiff is the master of the claim in the first instance" and may file a claim "premised upon either a 'consumer expectations' or 'risk-utility' theory, or both." *Tincher* at 406.

The Workability Problem

According to the Article, since a plaintiff may try to prove defective condition by both theories at once, "…a jury could find a defect under only one of those analyses, in effect concluding the product was simultaneously defective and non-defective." The Article at 11. This is particularly troubling because "*Tincher* does not say what verdict should then follow." The Article at 12.

Alternate Interpretation

The Article accurately points out that *Tincher* creates new complications for strict products liability litigation, many of which The Court declined to resolve, opting to wait for later cases. However, the workability problem might be solved by an alternate interpretation.

The court unveils the new construct on page 401, providing the two aforementioned, alternative tests which "[remain] subject to [their] theoretical limitations, as explained above." *Tincher* at 401. "As explained above," refers, at least, to pages 387 – 392, in which the consumer expectations and risk-utility tests are explained.

However, one could also interpret the court's reference to extend until page 395 which would include the section entitled "Combined Tests." This section details the jurisdictions that already employ Pennsylvania's alternative strict products liability construct: California, Illinois, and the Fifth Circuit. *Tincher* at 391. Furthermore, the court describes the construct as follows: "One approach is to state the two standards in the alternative; **a plaintiff's injury is compensable whether either test is met.**" *Id*. (emphasis added).

Clearly, the court's reference is oblique, but should one interpret the case in the above manner, *Tincher* squarely resolves the Article's workability problem. If a jury finds defect under only one analysis while finding no defect under the other, the following verdict is: defective. As stated above, a plaintiff need only prove a product is defective to win her case.

Logical Justification in Strict Liability

But is this fair?

Suppose a person is hurt by a product, but it was designed in the most cost-effective way and including any extra safety designs would render the product unviable. The manufacturer took every step and conducted every test to make it as safe as it feasibly could. Still, the verdict is defective and plaintiff wins.

Tincher, by overruling *Azzarello*[1] and introducing the risk-utility test, certainly marks a return of negligence principles to Pennsylvania's strict products liability construct. However, it would be inaccurate to then dismiss strict liability principles out of hand.

The above hypothetical was loaded, as stated. Remember, a person must be hurt by both an *unknowable* and *unacceptable* harm. In terms of strict

liability, Pennsylvania's policy is that a manufacturer's carefulness in designing the safest, most economically viable product is irrelevant if consumers will be harmed in unknowable and unacceptable ways. Likewise, a manufacturer could make a foolproof product, but the type of harm a plaintiff suffers is irrelevant (in terms of liability) if a safer, cost-effective design exists for the product. Of course, the type of harm matters greatly when deciding damages.

Tincher stands for the proposition that negligence principles, i.e. a manufacturer's risk-utility analysis in designing a product, may be relevant in a strict liability paradigm. However, in strict liability, the manufacturer's negligence is not determinative. Both tests can be met regardless of defendants' reasonableness.

Conclusion

Upon an alternate reading of *Tincher*, the Commonwealth's new strict products liability construct seems eminently workable, even if it is more complicated. Plaintiffs now have two avenues toward proving product defect and defendants may benefit from the addition of reasonableness language in jury charges, previously banned by *Azzarello*, where appropriate. Plaintiffs still need only prove product defect to win her case, and if a product is found defective on either a consumer expectations or risk-utility ground, the product is considered defective.

But, is the new construct the correct construct? For that answer, I will have to defer to people like the authors of the Article, scholars, and Pennsylvania Supreme Court Justices.

ENDNOTE

[1]*Azzarello v. Black Brothers Co., Inc.,* 480 Pa. 547 (1978) (Holding that use of term "unreasonably dangerous" in instructions to jury in strict liability was prejudicial error against plaintiffs.)

SURREBUTTAL TO: "IN RESPONSE TO: *TINCHER*… ANOTHER UNWORKABLE CONSTRUCT - AN ALTERNATIVE INTERPRETATION"

By Bill Ricci, Esquire, Ricci, Tyrrell, Johnson & Gray, Philadelphia PA and
Tom Finarelli, Esquire, Lavin, O'Neil, Cedrone & DiSipio, Philadelphia, PA

Mr. Tilghman's proposed approach is not a new one. Personal injury lawyers have attempted to simplify the issue by stating it in burden of proof terms. As they see it, they are required to prove the product defective (and unreasonably dangerous, a presumably unintentional omission on Mr. Tilghman's part), and so long as the jury makes that finding, under either test, they have met their burden. They simply ignore that a simultaneous finding of defect under one test and no defect under another would be an illogical result, and that resolving it by a flip of the coin in plaintiffs' favor a legally unsupportable result.

It can't be ignored, if for no other reason than this: Contrary to the attempted justification in *Tincher* that similar paradigms exist, the approach is without legal precedent. For good reason. At the trial of a negligence claim, and as *Tincher* correctly observes product liability has negligence roots, the two tests for one fact determination is the equivalent of adding a second definition of negligence. By way of example, if Mr. Tilghman's logic were applied to a medical malpractice action, a judge could instruct the jury to decide negligence by determining whether the medical provider had acted or failed to act in accordance either with the applicable standard of reasonable care, or with the expectations of the ordinary consumer.

It seems more than a little unlikely that the Supreme Court would look favorably on that innovative approach, and permit recovery in the face of an inconsistent pair of answers in a negligence action. The same should be true in a product liability action. The *Tincher* majority should have recognized the problem. It didn't, but the solution is not Mr. Tilghman's flip of the coin in favor of the plaintiff. The solution is for trial judges to instruct the jury on just one test, and avoid the possibility of an inconsistent verdict.

PENNSYLVANIA'S VALIDATION OF AN IMPAIRMENT RATING EVALUATION (IRE)

By Kevin L. Connors, Esquire, Exton PA

"Facts are meaningless. You could use facts to prove anything that's even remotely true." Homer Simpson.

A recent Decision by the Pennsylvania Commonwealth Court in *Duffey v. WCAB (6/26/15)*, recently resulted in the court, in an Opinion authored by Judge Cohn Jubelirer, validating an Employer Impairment Rating Evaluation that the claimant sought to invalidate by alleging that the IRE had not considered all of the claimant's work-related injuries. The claimant argued, thankfully unsuccessfully, that the IRE, which had considered the claimant's accepted work-related injuries in the course of determining the claimant's impairment rating under the AMA's Guides, resulting in a conversion of the claimant's temporary total disability benefits (lifetime absent death, or change in medical condition effectuating full recovery or ability to return to available work), to temporary partial disability benefits (capped at 500 weeks), had not taken into account the medical opinions of treating physicians who testified that the claimant was suffering from post-traumatic stress disorder as a result of the work injury.

With the above sentence seemingly setting a syntactical record for inconsequentially-related phrases, it would be simple enough to leap to the end point, being that the Commonwealth Court affirmed the underlying Decision of the Appeal Board (charged with the first level of appeals of comp claims in Pennsylvania), reversing the underlying Decision of the Workers' Compensation Judge, who had invalidated the Employer's IRE, which preceded the employer filing a Notice of Change, converting the claimant's temporary total disability benefits to temporary partial disability benefits, in reliance upon the testimony of the claimant's treating physicians, that the Notice of Compensation Payable, describing the claimant's originally-accepted work-related injury, should be amended to include the newly-adjudicated injury of post-traumatic stress disorder.

No doubt, another run for your money piecing together the above paragraph.

In any event, this is an important Decision since it fixes the effective timeline for validating an IRE used by an employer to mitigate the potential lifetime exposure for temporary total disability benefits into the more limited exposure of 500 weeks for temporary partial disability benefits, still representing a significant chunk of time in both the life of the claimant and the workers' compensation claim, represents 9.6 years during which an injured claimant might still be entitled to receive indemnity workers' compensation benefits for wage loss.

Like Homer, ready for a few facts?

It begins with the March 6, 2009 injury of the claimant, who injured his hands, when picking up hot wires while working for Trola-Dyne, Inc. This occurred while the claimant was repairing a machine for his employer.

In the course of accepting the claimant's injuries as being work-related, the employer issued a Notice of Compensation Payable (NCP), under which the claimant's injuries were described as "bilateral hands, electrical burn, stripping some electric wires".

Such description always tugs at the inherent conflict between exclusion versus inclusion, as descriptions that focus on body parts as opposed to medical diagnoses are almost always vulnerable to future enlargement and expansion, with the practical tip being to avoid describing injuries in terms of body parts, as opposed to describing the work injuries in terms of reasonable medical diagnoses.

With the issuance of the NCP, the claimant began receiving his temporary total disability benefits for wage loss, with the employer requesting an IRE under Section 306(a.2)(1) of the Act after the claimant had received 104 weeks of wage loss benefits.

In requesting an IRE, the employer described the claimant's work injuries as "bilateral hands-nerve and joint pain", which, technically, was already expanding the description of injury under review by the IRE, with the IRE resulting in a determination that the claimant had a 6% impairment rating, in terms of the work injuries, resulting in his compensation benefits being converted from the lifetime temporary total disability benefits to the partial disability benefits subject to the 500 week cap under Section 306(b).

Challenging the conversion of his compensation benefits, the claimant filed a Review Petition, alleging that the IRE was invalid, as it had not included a complete description of injury, since the claimant alleged that the IRE should have also considered the claimant's post-traumatic stress disorder, although that injury had never formally been accepted as compensable and work-related by the employer, nor had there been any litigation adjudicating a determination that the claimant's PTSD was related to his 2009 work injury.

Conflicting medical testimony was then presented by the parties, in support of and in opposition to the claimant's Review Petition, with the claimant's physicians testifying that the PTSD was related, and the employer's medical expert testifying that the PTSD was not related, as well as that the claimant was fully recovered from that diagnosis.

Finding in favor of the claimant, the WCJ granted the claimant's Review Petition, amending the description of injury to include the PTSD diagnosis, as well as invalidating the IRE, on grounds that the IRE had not considered the claimant's PTSD.

Appealing the WCJ's Decision, the employer was successful in convincing the Appeal Board to reverse the WCJ's Decision, with the Board finding the IRE to be valid as the claimant had never formally sought to amend the

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Pennsylvania's Validation *continued from page 12*

NCP to include the diagnosis of PTSD and depressed mood, and the WCJ had accepted the testimony of the IRE physician that the claimant was at MMI as of the IRE, requiring the IRE to be valid when performed.

Petitioning for review before the Commonwealth Court, the claimant again argued, as he had before the WCJ, that the IRE failed to consider all of his work-related injuries, as the PTSD had not been considered, with the employer countering that acceptance of the claimant's argument would essentially eviscerate the IRE provisions of the Act, as claimants could always challenge IRE determinations on grounds that the IRE failed to consider injuries never formally accepted or adjudicated as being work-related, although they might be injuries of an overlay nature, as was the case in *Duffey*.

In the course of affirming the Appeal Board's determination that the IRE was valid, based upon the claimant never challenging the accepted description of injury prior to the IRE and the claimant being at MMI in terms of work injuries as of the IRE being performed, the court determined that both the statutory language and IRE legal precedents required the validity of an IRE to be dependent upon two factors, one being the claimant's medical state, whether at MMI or not, when the IRE is performed, as well as, secondarily, the IRE focusing on the injuries that were determined to be work-related, whether described on an NCP, or determined in a Decision issued by a WCJ.

Relying upon *Westmoreland Regional Hospital v. WCAB, 29 A.3d 120 (Pa. Cmwlth. 2011)*, the court held that "the IRE produces a snapshot of the claimant's condition at the time of the IRE, not a survey of the claimant's work-related injuries over a period of time".

For that reason, the *Duffey* court held that the validity of the IRE is determined by "the claimant's physical condition at the time of the IRE".

The court also ruled that it interpreted Section 306(a.2) of the WCA to not infer that the General Assembly intended to nullify performed and otherwise valid IREs, being challenged with claims of new or additional injuries not considered by the IRE physicians.

This ruling does not necessarily foreclose claimants from challenging the conversion of their compensation benefit status from total disability to partial disability, if claimants obtain impairment ratings of at least 50% under the AMA Guides.

Holding that an IRE that considers a claimant's work injury as defined and existing at the time the IRE is performed, to be valid notwithstanding an after-the-fact expansion of the scope of a claimant's work-related injury, the court held that to find otherwise would be inconsistent with the WCA, and the court's own prior precedents.

As Shakespeare might have said in Richard III, "My Kingdom, My Kingdom for an IRE!"

The Inherent Bias of a Treating Physician in Pennsylvania Workers' Compensation

By Joseph E. Vaughan, Esquire and Shannon Piccirillo Mickle, Esquire, O'Hagan LLC, Philadelphia, PA

There's an old proverb that states: "People in glass houses shouldn't throw stones." Increasingly over the last several years, Claimants' attorneys have raised the issue of whether true "independence" exists for physicians who perform Independent Medical Examinations ("IME") in the Workers' Compensation arena. This standpoint, however, ignores the fact that treating physicians similarly are not always independent. Of course, some degree of bias is present in all opinions (including medical ones). But a blanket accusation of bias against IME physicians simply ignores the corresponding bias of certain treating doctors. Let's pull back the curtain and discuss some of the reasons behind this potential bias.

Treating physicians, logically, are paid to treat Claimants. However, a treating physician's interest may not necessarily be to provide treatment that could cure Claimant. Unfortunately, some treating physicians view treatment as being a "payday," and prescribe therapy and medication that are of questionable benefit and cause no appreciable improvement in a Claimant's condition. In these situations, a treating physician's interest may not be in providing treatment that could cure the Claimant, but rather it may be to prolong treatment in order to both increase the direct payments to the doctor and increase the "value" of the case for potential settlement. Examples of this so-called "treatment" include the current hot-button issues of narcotic medication and unregulated "pain creams." In fact, there has been ample news coverage recently of "treating physicians" running "pill mills," "diet clinics," and "pain farms," which certainly undermines the independence of these treating physicians.

Additionally, both treating physicians and IME physicians alike are paid for their time giving a deposition. Generally, the fees charged are comparable. Defense attorneys cannot have any communication with treating physicians, nor can they attend Claimant's medical appointments or send a proxy. By contrast, Claimants are given the benefit of inviting a health care professional of their choosing to an IME. An IME doctor merely has the ability to review Claimant's medical records, diagnostic studies, and physical findings prior to issuing an opinion. However, often the

Claimant possesses the only available copy of an MRI or X-ray film and, despite being instructed to bring it with them to the IME appointment, Claimants very rarely do so. Therefore, IME physicians are limited to the information that Claimants provide to them, which may or may not be the "full story."

Finally, Workers' Compensation defense attorneys must be cognizant of potential referral arrangements between treating physicians and claimant law firms which, obviously, could lead to a biased medical opinion in favor of a Claimant. Certainly, the majority of treating physicians do not run afoul of their "independent" status. However, there are a few "bad eggs." Fortunately, the Workers' Compensation system has the ultimate independent check in place: the Workers' Compensation Judges. These Judges know the experts, the lawyers, the system, and the medicine. They are the only true independent party in this adversarial process and they ultimately make the decision after weighing all the factors at issue. Judges routinely reject opinions of IME physicians who find Claimants fully recovered in the face of strong medical evidence to the contrary. These same Judges also often reject the testimony of a treating physician who has a reputation for over treating or a questionable relationship with a law firm. In the vast majority of claims that are denied, the problem lies not with the doctor, the law firm or the Judge, but instead with the legitimacy of the claim.

PENNSYLVANIA WORKERS' COMPENSATION UPDATES

By Francis X. Wickersham, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, King of Prussia, PA

The Supreme Court holds that an employer is not obligated to issue a Notice of Ability to Return to Work before offering alternative employment when the injured employee has not yet filed a claim petition and, thus, has not yet proven an entitlement to workers' compensation benefits.
School District of Philadelphia v. WCAB (Hilton); 34 EAP 2014; decided May 26, 2015; by Mr. Justice Baer

A Workers' Compensation Judge granted the claimant's claim petition and awarded benefits; however, he limited the claimant's benefits to a closed period. Finding that there was work available that the claimant was capable of performing, the Judge suspended her benefits. On appeal, the Workers' Compensation Appeal Board reversed, in part. The Board affirmed the Judge's award of benefits but reversed the suspension on the grounds that the employer never provided the claimant with a Notice of Ability to Return to Work before making another position available to the claimant. The Commonwealth Court then reversed the Board, holding that the employer had no duty to issue a Notice of Ability to Return to Work because a §306 (b)(3) notice is part of the earning power assessment process that is required when an employer seeks to modify or suspend benefits on the basis of medical evidence. According to the court, the purpose of the notice provision is to require employers to share new medical information about a claimant's physical ability to work and its possible impact on existing benefits.

The Pennsylvania Supreme Court affirmed the Commonwealth Court, holding that §306 (b)(3) notice is required when the employer is seeking to modify existing workers' compensation benefits based on medical evidence establishing that the injured employee is able to return to work in some capacity. Because the injured employee in this case had not yet received workers' compensation benefits when the offer of alternative employment was tendered, the employer had no duty to provide a §306 (b)(3) notice.

When the parties cannot agree on an IRE physician, the date the insurer requests a physician be designated to perform an IRE is the determinative date as to whether the IRE request is timely under § 306 (a.2)(1).
Village at Palmerton Assisted Living v. WCAB (Kilgallon); 334 C.D. 2014; filed June 12, 2015; by Judge Cohn Jubelirer

The claimant sustained a work injury on March 3, 2007, and began receiving temporary total disability benefits as of September 27, 2007, and had received 104 weeks of temporary total disability as of November 28, 2009. The employer filed a Request for Designation of a Physician to Perform an IRE (LIBC-766) on September 21, 2009. The claimant advised the employer that she would not attend an IRE, and the employer filed a petition for physical examination. The claimant challenged this petition by arguing that the initial IRE request was premature since it was filed at a time when the claimant had not yet received 104 weeks of benefits. While proceedings were pending, the employer filed form LIBC-765 (IRE appointment) with the Bureau of Workers' Compensation, scheduling an IRE for November 16, 2009. Later, the employer realized that its initial IRE request was premature and, in December 2009, began extended efforts to correct the situation directly with the Bureau. The employer also withdrew its petition, conceding that its initial IRE request was premature, and filed another IRE request in February 2010.

On March 25, 2010, a designation of a new IRE physician was made. The employer then filed an IRE appointment form on April 13, 2010, stating that the claimant's 104 weeks of total disability ended on October 3, 2009, and that the IRE was scheduled for May 18, 2010. The employer also filed another petition for physical examination to compel the claimant to attend the IRE, which was granted by the Workers' Compensation Judge. The claimant did submit to the IRE on July 27, 2011.

On September 14, 2011, the employer issued a Notice of Change of Workers'

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Compensation Disability Status (notice of change), indicating that the claimant's impairment rating was 11% and that the date of the claimant's disability status change was May 18, 2010—the IRE date. The claimant then filed a review/reinstatement petition, alleging that the employer was not entitled to an automatic change in status because the IRE request and resulting IRE were untimely. The claimant also filed a penalty petition, and the employer filed modification and review petitions, seeking an IRE change in status date of November 28, 2009. The Judge found that the February 2010 IRE request was untimely and that the employer was not entitled to an automatic change in status. The employer appealed to the Appeal Board, and they affirmed. According to the Board, in order for an IRE request to be timely under §306 (a.2)(1) of the Act, the insurer must file both the IRE request and the IRE appointment forms within 60 days of the expiration of the claimant's receipt of 104 weeks of temporary total disability benefits.

The employer appealed to the Commonwealth Court, which reversed the Board. According to the court, when the parties cannot agree on an IRE physician, the date the insured requests a physician be designated to perform an IRE is the determinative date as to whether the IRE request is timely under §306(a.2)(1) of the Act. The court held that there was no requirement that the employer file both the IRE request and the IRE appointment forms within the 60-day window following payment of 104 weeks of benefits in order for an IRE request to be timely and allow for an automatic change in benefit status.

The Commonwealth Court also agreed with the employer's argument that it made a timely IRE request when they wrote a letter to the Bureau on December 16, 2009, requesting designation of an IRE physician—18 days after the claimant received 104 weeks of temporary total disability benefits—and the Bureau acknowledged the request by letter dated December 24, 2009. In that letter, the Bureau stated that it would consider the previous assignment of the IRE physician to be effective as of the date of the employer's most recent request. The court concluded that the employer's December 2009 letter was filed within the required 60-day time period for an automatic change in the claimant's disability status.

The claimant's petition to reinstate benefits was not time barred under §413 (a) because it was filed within three years after the date of last payment of compensation for a work injury that the claimant was receiving in lieu of compensation for another injury.
William Kane v. WCAB (Glenshaw Glass); 1172 C.D. 2013; filed June 25, 2015; by Judge Brobson

In 1991 the claimant sustained an injury to his right shoulder while working for the employer, and the employer's then insurer acknowledged the injury via a Notice of Compensation Payable (NCP). The claimant later returned to his regular job, and benefits were suspended. Then, in 1995, the claimant suffered a work-related injury to his left shoulder. The employer, now self-insured, issued an NCP and paid the claimant benefits. The claimant returned to modified-duty work with the employer.

Later, the claimant filed a claim petition—alleging a new injury to his right shoulder in June of 1999—and a reinstatement petition—alleging, in the alternative, a recurrence of his 1991 right shoulder injury. The Workers' Compensation Judge found that the claimant suffered a new injury to the shoulder, and he was awarded benefits for a limited period based on his return to modified-duty work, following two surgeries. In 2004, the employer ceased operations and eliminated the claimant's job. The employer reinstated the claimant's benefits for his 1995 left shoulder injury via Supplemental Agreement.

While receiving benefits for the 1995 left shoulder injury, the claimant filed a reinstatement petition for his 1999 right shoulder injury. The judge denied the petition since the claimant was still receiving benefits for the 1995 injury under the Supplemental Agreement. The judge's decision was affirmed by the Appeal Board and the Commonwealth Court (*See, Kane v. WCAB (Glenshaw Glass, Co.)*, 940 A.2d 572 (Pa. Cmwlth. 2007) (*Kane I*), appeal denied, 956 A.2d 437 (Pa. Cmwlth. 2008)). Thereafter, the parties entered into a Compromise and Release of the 1995 left shoulder injury.

In September of 2010, the claimant filed a reinstatement petition for the June 1999 right shoulder injury. It was the employer's position that the reinstatement petition was barred by the 500-week limitation under §413 (a) and §306 (b) of the Act. The judge granted the petition and reinstated the claimant's benefits effective September 23, 2010, concluding that disability from the 1999 right shoulder injury recurred as of the date the plant closed in 2004. He also concluded that, because the claimant's benefits were suspended for the 1995 left shoulder injury, the 500-week statue of repose under §413 (a) of the Act did not apply.

On appeal, the Workers' Compensation Appeal Board reversed, concluding that the reinstatement petition was barred by the 500-week period set forth in §413 (a) of the Act and by collateral estoppel because the issues being litigated were already decided in the claimant's first reinstatement petition (*Kane I*). The Board also held that the reinstatement petition was outside the three-year limitation period because the claimant had not received indemnity benefits for his 1999 right shoulder injury since August 1, 1999, as per a stipulation by the parties.

The Commonwealth Court reversed the Board's decision on appeal, concluding that the claimant was not collaterally estopped from seeking reinstatement for his 1999 right shoulder injury as a result of the court's decision in *Kane I* and that the claimant's petition for reinstatement was not time barred pursuant to §413 (a) of the Act. The court noted that the issues in *Kane I* were not identical to the issues presented in the reinstatement petition since, in *Kane I*, the court reserved for consideration at a future date the issue of reinstating the claimant's benefits for his 1999 right shoulder injury once benefits for the 1995 left shoulder injury ceased. The court further held that the claimant's application for reinstatement was not time barred under §413 (a) of the Act because

it was filed within three years after the date of last payment of compensation for the claimant's 1995 left shoulder injury, which the claimant received in lieu of compensation for the 1999 work injury. According to the court, the claimant suffered two disabling injuries, either of which would have entitled him to total disability benefits, but the claimant could not receive benefits for both at the same time. Therefore, the claimant must be permitted to seek reinstatement under §413 (a) of the Act within three years after the date of the most recent payment of compensation received in lieu of compensation for the 1999 injury to which he otherwise would have been entitled.

An IRE that considers a claimant's work injury as it is defined and exists at the time the IRE is performed is valid notwithstanding an after-the-fact expansion of the injury.
Michael C. Duffey v. WCAB (Trola-Dyne, Inc.); 1840 C.D. 2014; filed June 26, 2015; by Judge Cohn Jubelerier

The claimant sustained work-related injuries to his hands on March 5, 2009, and the employer acknowledged the injury by issuing a Notice of Compensation Payable (NCP). When the claimant reached 104 weeks of total disability benefits, the employer requested an IRE. In its IRE request, the employer described the claimant's work injury consistent with the NCP's description. It was determined by the IRE physician that the claimant had a 6% impairment rating, and the employer issued a Notice of Change of Workers' Compensation Disability Status. The claimant then filed a petition to review compensation benefit offset, asserting that the IRE was invalid because the description of injury was incomplete.

During litigation of the claimant's petition, the claimant presented deposition testimony from medical experts who opined that the claimant was suffering from an adjustment disorder and depressed mood, as well as Post-Traumatic Stress Disorder (PTSD), related to the work injury. The Workers' Compensation Judge accepted the claimant's evidence and added these conditions as work-related injuries. Additionally, because the claimant established that he sustained these additional injuries, the judge found the IRE to be invalid since it did not address all of the claimant's work injuries.

On appeal, the Appeal Board reversed, holding that the IRE was valid. It pointed out that the claimant never sought to amend the NCP until December 16, 2011, long after the June 2, 2011, IRE had already taken place.

The claimant appealed to the Commonwealth Court, which affirmed the Appeal Board. In doing so, the court rejected the claimant's argument that, because he challenged the IRE within the initial 60-day appeal period, he could contest the IRE as being invalid based on the fact that the description used by the IRE physician did not include all of the claimant's injuries, which ultimately included PTSD and adjustment disorder with depressed mood. The court said that they do not believe that the General Assembly intended to nullify an already performed and otherwise valid IRE due to claims of new or additional injuries not yet determined to be work related. The court concluded that an IRE that considers the claimant's work injury, as it is defined at the time the IRE is performed, is valid notwithstanding the fact that the scope of a claimant's work-related injury is expanded at a later time.

A claimant who sustained injuries while attempting to help another injured employee was in furtherance of the employer's business and, therefore, within the course and scope of his employment.
Pipeline Systems, Inc. and Continental Western Insurance Company v. WCAB (Pounds); 1577 C.D. 2014; filed July 7, 2015; by Senior Judge Colins

The employer had obtained a contract to install a new addition to a plant, which included the installation of pipelines and manholes. The claimant began working on the project for the employer, and the job site contained a concrete pit with a ladder attached to the side. On the date of the incident, the claimant and three fellow employees were at the plant installing new pipeline approximately 30 feet away from the concrete pit. The claimant heard an employee call out for help, and the clamant and two of his co-workers rushed to the pit to provide assistance. An employee was lying at the bottom of the pit. The claimant, with others, descended the ladder to examine the employee, who had deceased. The claimant then stood up and immediately felt that something was wrong. He tried to climb out of the pit, but he lost consciousness and fell from the ladder approximately 20 feet to the bottom of the pit, suffering multiple injuries. It was later determined that there was gas in the pit.

The employer issued a notice of temporary compensation payable but, later, denied the claim. The claimant filed a claim petition, and the employer defended the petition on the basis that the claimant was not in the course and scope of employment at the time of his injuries. The Workers' Compensation Judge issued an interlocutory decision finding the claimant was in the course and scope of employment and, later, a final decision granting the claim petition. The employer appealed to the Appeal Board, which affirmed.

The Commonwealth Court upheld the decisions below. The court pointed out that in 2003, the General Assembly amended §601 (a) of the Act to allow as compensable injuries suffered by employees who go to the aid of a person by rendering emergency care, first aid or rescue at the scene of an emergency. The employer argued that this provision was not intended to encompass all employees but, rather, a limited class of voluntary emergency personnel. Additionally, the employer argued that, even if the provision did encompass all employees, the section nevertheless does not provide that an employee remains within the course of employment just because an emergency arises and the employee renders aid. In other words, the employer argued that the claimant's compulsion to act as a "Good Samaritan" was not employment related.

The Commonwealth Court noted that, at the time the claimant heard a call for help, he was installing pipe in performance of the employer's contract. He and his co-workers responded by

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quickly traversing the 30 feet between where they were working and the area of the pit. The claimant descended the ladder to provide aid to the employee at the bottom of the. Then, while ascending the ladder, he fell back down into the pit, sustaining injuries. The court found that the facts demonstrated that, at the time the emergency arose, the claimant was actually engaged in the furtherance of the employer's business and, therefore, within the course and scope of his employment. According to the court, the facts further demonstrated that the claimant went to the aid of another and sustained injuries as a result of attempting to render emergency care. It was the court's finding that attempts to render aid to another do not, in and of themselves, constitute an abandonment of employment.

An employer does not violate the Act by paying the claimant simple interest, instead of compound interest, on a back award of compensation benefits.
James Tobler v. WCAB (Verizon, Pennsylvania, Inc.); 2211 C.D. 2014; filed July 9, 2015; by Judge Simpson

The claimant sustained a work-related injury that was acknowledged by the employer via a Notice of Compensation Payable in October 1998. In February 2012, a Workers' Compensation Judge circulated a decision reinstating the claimant's compensation benefits as of November 21, 2002, and the employer issued payment to the claimant in the amount of $117,278.74. The claimant filed a penalty petition alleging the employer violated the Act by incorrectly using simple, rather than compound, interest in calculating the interest due on the award. The Judge dismissed the petition and determined that the claimant was entitled to simple interest under §406.1 (a) of the Act. The Appeal Board affirmed, noting that §406.1 (a) does not contain any language indicating whether the interest that accrues is "simple" or "compound."

On appeal to the Commonwealth Court, the claimant argued that an award of compound, rather than simple, interest most accurately calculates a worker's actual loss of use of the unpaid funds over time and serves the humanitarian and remedial purposes of the Act. The court, however, rejected the claimant's arguments and affirmed the decisions below. Like the Appeal Board, the court pointed out that §406.1 of the Act does not expressly provide for compound interest. Also, the court noted that there is longstanding judicial policy disfavoring the awarding of compound interest, absent explicit statutory language providing for it. Therefore, the court dismissed the claimant's appeal.

An employer does not violate the Act by recouping retroactive disability benefits after their reporting by the claimant on an LIBC 756 form, and the form satisfies an employer's duty to notify the claimant of her reporting obligations.
Stacy Gelvin v. WCAB (Pennsylvania State Police); 1503 C.D. 2014; filed July 13, 2015; by Judge McCullough

The claimant, a state trooper, was awarded workers' compensation benefits by a Workers' Compensation Judge for disability resulting from work-related post-traumatic stress disorder as of December 21, 2006. A few weeks before the decision was circulated, the employer had accepted liability for the injury by filing a Notice of Compensation Payable.

In February 2011, the claimant applied for disability pension benefits with the Pennsylvania State Employment Retirement System and began receiving them in February of 2012. The pension was retroactive to February 2011—the date on which she applied—and the claimant received a lump sum payment. On March 16, 2012, the claimant reported the disability pension benefits on an Employee Report of Benefits form (LIBC-756). Thereafter, the claimant received a Notice of Workers' Compensation Benefit Offset from the employer, informing her that her benefits would be suspended starting on April 21, 2012, and restored on March 5, 2013.

The claimant filed reinstatement and penalty petitions, alleging that the employer unilaterally stopped her indemnity benefits and improperly took an offset based on her receipt of a disability pension. The claimant testified she suffered a hardship because she went nearly a year without receiving any compensation and exhausted all financial resources to pay her bills. The Workers' Compensation Judge found that the employer was entitled to a retroactive credit as of March 16, 2012—the date the claimant returned the LIBC-756 form—and granted the claimant's reinstatement petition as of April 21, 2012, at a reduced rate to reflect her receipt of disability pension benefits. The Judge further found that the employer violated the Act and imposed a penalty on the employer of 50% of benefits payable during the time the employer suspended the claimant's benefits. The Judge additionally awarded an unreasonable contest counsel fee.

The employer appealed to the Workers' Compensation Appeal Board, which reversed. The Board held that the employer was entitled to recoup from the claimant's retroactive payment of disability pension benefits and that the employer did not violate the Act or unreasonably contest the claimant's petitions.

The claimant appealed to the Commonwealth Court, which affirmed the Board. According to the court, the employer satisfied its duty to notify the claimant of her reporting requirements by way of the LIBC-756 form, which was sent in December of 2011. The claimant received disability pension benefits in February of 2012. The employer sent another LIBC-756 form in March of 2012. Although the claimant was subjected to a large retrospective offset, the amount the employer recouped was not related to a lack of diligence on the employer's part. Additionally, the court found that the claimant's contention that the Workers' Compensation Judge found financial hardship in the case was incorrect. The Judge merely summarized the testimony given by the claimant that she experienced a severe hardship, which does not constitute a finding.

An employer is not required to first seek an agreement from a claimant on an IRE physician before filing a request with the Bureau to designate an IRE physician.
William Logue v. WCAB (Commonwealth

of Pennsylvania); 1882 C.D. 2014; filed July 14, 2015; by Senior Judge Colins

In 2002 the claimant sustained a work-related injury to his right wrist. In November of 2012, the employer filed a request with the Bureau of Workers' Compensation to designate a physician to perform an IRE under §306 (a.2) of the Act. The Bureau designated an IRE physician, but the claimant objected, arguing that the employer was required to reach an agreement with the claimant on an IRE physician before filing a request with the Bureau to designate an IRE physician. The claimant refused to appear for the IRE with the physician. Thereafter, the employer filed a petition to compel the claimant to appear for the IRE. The employer's petition was granted, and the claimant appealed to the Workers' Compensation Appeal Board, which affirmed.

The Commonwealth Court disagreed with the claimant's position and dismissed the appeal. According to the court, §306 (a.2) (1) merely lists two alternative methods for selecting the IRE physician and does not state that the designation by the Bureau is limited to a situation where the parties are unable to agree. According to the court, if, in fact, the legislature intended the parties' attempt to agree on an IRE physician before asking the Bureau to designate one, §306 (a.2) would have read, "[s]hall be chosen by agreement of the parties, or, if the parties cannot agree, as designated by the department." The court, therefore, interpreted the claimant's appeal as a request of the court to rewrite §306 (a.2), which the court said it was not able to do.

Under the Construction Work Place Misclassification Act, an individual in the construction industry is required to sign a written contract prior to injury in order to be considered an independent contractor and not an employee.

Scott Lee Staron, d/b/a Lees Metal Roof Coatings and Painting v. WCAB (Farrier); 2140 C.D. 2014; filed July 17, 2015; by Senior Judge Friedman

In response to an advertisement seeking a painter, the claimant told the employer he had 20 years of experience, was self-employed, did his own work and owned his own truck, tools and equipment. The employer agreed to pay the claimant $100 per day for the job. The employer also told the claimant he would need to sign a document, Independent/Sub-contractor Agreement, in order to work for the employer. The claimant began working for the employer, primarily using his own painting equipment. However, the employer forgot to have the claimant sign the Independent/Sub-contractor Agreement before he started work on the job. Later, the claimant suffered injuries after falling off a roof, and he signed the agreement at a meeting with the employer after he was released from the hospital. The agreement was dated May 6, 2011, the date of the injury.

The claimant filed a Claim Petition, which the employer defended on the basis that the claimant was an independent contractor, not an employee. The Workers' Compensation Judge granted the Claim Petition and found that the claimant had not entered into the agreement at the time he sustained his work injury on May 6, 2011; therefore, he was the employer's employee and not an independent contractor. The employer appealed to the Workers' Compensation Appeal Board, which affirmed.

The Commonwealth Court affirmed the Board and dismissed the employer's appeal. The court pointed out that the claimant worked for the employer for several days in exchange for remuneration and did not sign the Independent/Sub-contractor Agreement until after he was injured. The court further pointed out that §3 (1) of the Construction Work Place Misclassification Act was unambiguous, saying "[a]n individual who performs services in the construction industry for remuneration is an independent contractor only if . . . he has a written contract to perform such services." 43 P.S. §933.3 (a) (1).

A Claim Petition filed against the Uninsured Employers Guaranty Fund is not barred because the claimant files a civil action against the uninsured employer for protection against the running of the statute of limitations in the civil case.

Jose Osorio Lozado v. WCAB (Dependable Concrete Work and Uninsured Employer's Guaranty Fund); 21 C.D. 2014; filed August 5, 2015; by Judge Cohn Jubelirer

The claimant filed a Claim and Penalty Petitions against the employer for injuries sustained on May 11, 2007. After it was filed, the Bureau of Workers' Compensation informed claimant's counsel that its research indicated the employer did not have workers' compensation insurance on the date of injury. Shortly thereafter, as the statute of limitations was about to expire, the claimant filed a personal injury action against the employer via writ of summons, seeking damages for his injuries. In January 2010, the claimant also filed a petition against the Uninsured Employers Guarantee Fund (Fund).

While the petitions against the employer and the Fund were pending, an arbitrator in the claimant's action against the employer awarded the claimant a default judgment totaling $50,000 in damages, which the claimant appealed. The Judge then issued two separate decisions denying the petitions filed against the employer and the Fund.

With respect to the petition against the employer, the Judge found that the claimant chose a tort remedy, instead of seeking benefits under the Act, and dismissed that petition. With respect to the petition filed against the Fund, the Judge found that the claimant did not file the Notice of Claim within the required 45 days of learning the employer was uninsured and the claimant filed his Claim Petition against the Fund concurrently with a Notice of Claim—instead of waiting 21 days as required.

The claimant appealed, and the Appeal Board affirmed, reasoning that §302 (d) of the Act barred all of his petitions because of the tort action. The claimant then appealed to the Commonwealth Court as to the dismissal of the Fund petitions.

The issue considered by the court was whether a Claim Petition against the Fund was barred by §305 (d) of the Act where, after learning that an employer is uninsured, a claimant preserves a simple remedy by filing a "savings action" at law against an uninsured employer.

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The court also considered whether a claimant's failure to give timely notice to the Fund that the employer is uninsured acts as a complete or partial bar to a claim against the Fund. The court held that the claimant did not violate §305 (d) when he filed a civil action to preserve his ability to recover in tort prior to the expiration of the statute of limitations. The court pointed out that the claimant faced a practical dilemma at the time. The court further pointed out that after a default judgment was awarded, the claimant appealed and later filed a Motion to Stay Proceedings, pending resolution of the workers' compensation petitions. According to the court, this showed that the claimant's first choice was not to recover tort damages.

However, the court did hold that the claimant failed to file the Notice of Claim with the Fund within the 45-day requirement of §1603 (b) of the Act. The court said the claimant had 45 days from the date he received the letter from the Bureau informing him that the employer did not have workers' compensation insurance on the day of the alleged injury to file his Notice of Claim. Instead, the claimant waited until January of 2010 to do so, well beyond the requirement of the Act. As for the harm caused by the late filing, the court held that §1603 (b) does not serve as a bar to all compensation but, rather, delays the provision of compensation to the date notice is given.

The claimant was not entitled to benefits in Pennsylvania for an extraterritorial injury because his employment was not principally localized in Pennsylvania and the claimant signed a written agreement that his employment would be principally localized in Alabama.
William Watt v. WCAB (Boyd Brothers Transportation); No. 53 C.D. 2015; filed September 15, 2015; by Judge Simpson

The claimant, an interstate truck driver for the employer, alleged that he sustained an injury to his low back in New Jersey while untarping a cargo load. He filed a claim petition, seeking benefits under the Pennsylvania Workers' Compensation Act. The claimant was receiving benefits through Alabama's workers' compensation system.

In support of his petition, the claimant testified that he was a Pennsylvania resident and had completed an online application for the employer on his personal computer in Pennsylvania. The claimant attended an orientation in Ohio and, at that time, was provided by the employer with a packet of documents, which included one called "Workers' Compensation Agreement" (WC Agreement), which he read and signed. The WC Agreement stated that all workers' compensation claims shall be exclusively governed by the workers' compensation laws of the state of Alabama and that, for purposes of workers' compensation, the claimant's employment was principally localized within the state of Alabama and that the company's principal place of business is Clayton, Alabama.

The Workers' Compensation Judge found that the claimant sustained a work injury in the course of his employment with the employer in New Jersey and that the claimant worked for the employer under a contract of hire entered into in Ohio. However, because of the WC Agreement, the judge found that the claimant's employment was principally localized in the state of Alabama; therefore, he dismissed the claim petition. The claimant appealed to the Appeal Board, which affirmed.

On appeal to the Commonwealth Court, the claimant argued that he spent more time working in Pennsylvania for the employer than any other state and, therefore, was entitled to Pennsylvania benefits since his employment was principally localized in Pennsylvania. The claimant maintained that he kept his truck in Pennsylvania and that the employer would occasionally dispatch him from his home in Pennsylvania. Additionally, daily trip logs showed that he drove more and worked more hours in Pennsylvania than in any other individual state where he worked.

The court, though, found that the evidence did not support a finding that the claimant spent a substantial part of his working time in Pennsylvania. In the court's view, the percentages of time and miles driven by the claimant in other states exceeded the time he worked in Pennsylvania; therefore, they found that the judge did not err in concluding that the claimant's employment was not principally localized in Pennsylvania. Moreover, the court held that the WC Agreement the claimant signed at the time he was hired by the employer, agreeing that the state of Alabama's workers' compensation law would govern workers' compensation claims, did not violate public policy or the claimant's rights under the Act, and, thus, the judge did not err in finding the claimant's employment was principally localized in Alabama.

A divided Commonwealth Court holds that use of the 5th and 6th Editions of the AMA Guides to the Evaluation of Permanent Impairment under the Pennsylvania Workers' Compensation Act is unconstitutional and, therefore, IREs performed under Section 306(a.2) of the Act must use the 4th Edition of the AMA Guides.
Protz v. WCAB (Derry Area School District); No. 1024 C.D. 2014; (Pa. Cmwlth. September 18, 2015)

The claimant sustained a work-related injury to her right knee in April of 2007. The employer paid workers' compensation benefits until she returned to work, at which time benefits were suspended. Later, due to a recurrence of disability, the claimant's benefits were reinstated per a Supplemental Agreement.

The employer then requested an Impairment Rating Evaluation (IRE), which was performed in October of 2011. The physician performing the IRE used the 6th Edition of the AMA Guides to the Evaluation of Permanent Impairment (Guides), the most recent version at the time. The employer then filed a modification petition, seeking to convert the claimant to partial disability status.

The Workers' Compensation Judge granted the employer's petition, finding that the claimant was less than 50 percent impaired under the 6th Edition of the Guides. The claimant appealed to the Appeal Board, arguing that §306(a.2) was an "unconstitutional delegation of

authority by the state legislator." The Board affirmed the judge's decision, essentially finding that the issue of the constitutionality of the provision had already been decided by the Commonwealth Court.

On appeal to the Commonwealth Court, the claimant argued that §306(a.2) of the Act was unconstitutional because it gave the AMA, rather than the General Assembly, authority to establish criteria under which a claimant is adjudicated partially or totally disabled. The claimant pointed out that, since IREs started being performed, the Guides have undergone two revisions and the current edition provided substantially different standards than those in the 4th Edition, thereby causing some claimants who would have been considered more than 50 percent impaired under the 4th Edition to be less than 50 percent impaired under the 6th Edition. The employer argued that the issue of the constitutionality of §306(a.2) had already been decided.

The court agreed with the claimant and granted the appeal. In doing so, the court said that the mere requirement under §306(a.2) that the most recent version of the AMA Guides be used to determine a claimant's impairment rating was, under this basis alone, enough to find §306(a.2) unconstitutional. The court further found that the Act lacked a mechanism requiring governmental review of the Guides by the promulgation of regulations. In the court's view, the General Assembly adopted as its own the methodology enumerated by the AMA at the time it enacted §306(a.2), the methodology contained in the 4th Edition of the Guides. The General Assembly has not reviewed and readopted the methodology contained in subsequent editions. The court noted that this lack of review of subsequent editions of the Guides left "unchecked discretion" completely in the hands of a private entity and gave the AMA "carte blanche authority" to implement its own policies and standards. The court concluded that §306(a.2) was an unconstitutional delegation of legislative authority because it proactively approved versions of the AMA Guides beyond the 4th Edition without review. The court vacated the Board's decision and remanded the matter to the Workers' Compensation Judge to apply the 4th Edition of the AMA Guides.

It must be emphasized that the court's focus in this opinion was on the part of §306(a.2) that states, "If such a determination results in an impairment rating of less than 50 percent impairment *under the most recent edition* of the AMA 'Guides to the Evaluation of Permanent Impairment,' the employee shall then receive partial disability benefits ... ." The remand by the court to the judge to allow a decision to be made based on the 4th Edition of the Guides seems to indicate that IREs can be performed, provided that the 4th Edition of the Guides is used.

The claimant cannot seek a reinstatement of benefits where the injury is acknowledged by a Medical Only NCP because the Medical Only NCP does not recognize disability.

Sandra Sloane v. WCAB (Children's Hospital of Philadelphia) and Children's Hospital of Philadelphia and Risk Enterprise Management v. WCAB (Sloane); No. 53C.D. 2015; filed October 1, 2015; by Senior Judge Colins.

In this case, the claimant sustained an injury to her right elbow in April of 2004. The employer accepted the injury by issuing a Notice of Compensation Payable (2004 NCP). The claimant returned to work in a light-duty capacity, with reduced wages, and received partial disability benefits for the injury. She then suffered a second injury to her right elbow and her right knee in 2006. The 2006 injury was accepted by the employer through a Medical Only NCP (2006 NCP). The claimant returned to light-duty work and received partial disability for the 2004 injury until November 16, 2007, when she underwent surgery for her right knee. The claimant then filed a petition to reinstate temporary total disability benefits for the right knee injury.

The Workers' Compensation Judge granted the reinstatement petition, concluding that the claimant was totally disabled in November of 2007 based on both her 2004 and 2006 work injuries. The employer appealed to the Workers' Compensation Appeal Board, and they reversed a portion of the Judge's decision, granting disability benefits based on the 2006 work injury. The Board concluded that the claimant was required to comply with the three-year limitation of §413(a) of the Act for modification of an NCP rather than the 500-week period for reinstatement of suspended benefits. Because the claimant did not file the petition within three years of the issuance of the 2006 NCP, the Board concluded the claimant was time-barred from receiving benefits for that injury.

In her appeal to the Commonwealth Court, the claimant argued that the issuance of the Medical Only NCP in 2006 put her disability in suspended status, which could be reinstated within 500 weeks of that NCP. The Commonwealth Court, however, rejected that argument and affirmed the Board. According to the court, the effect of issuing a Medical Only NCP is distinct from the effect of a ruling that a claimant has suffered a loss of earning power and that grants a claim petition, but also immediately suspends benefits. The court held that, because no disability had ever been recognized by the employer or established by a Workers' Compensation Judge for the 2006 injury, disability had not been suspended when the 2006 NCP was issued. Therefore, the claimant could not seek to have disability benefits reinstated and the 500-week period of reinstatement of benefits did not govern the case. The court went on to hold that, since no disability compensation had been paid for the 2006 injury, the claimant was required to establish an entitlement within three years of the date of the injury. Thus, the petition the claimant filed in 2011 was untimely under §413 (a) of the Act.

A company whose main business is the sale of franchises to franchisees is not a statutory employer under the Act and is not responsible for payment of workers' compensation benefits.

Saladworks LLC and Wesco Insurance Company v. WCAB; No. 1789 C.D.2014; filed October 6, 2015; by Judge McGinley

While working at a franchise of a national restaurant, the claimant injured

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his knees when he walked out of the back of the restaurant to throw away a box. The claimant filed a petition for benefits naming the Franchisor, though that name was later amended to name the Franchisee. The claimant subsequently filed a separate claim petition against the Uninsured Employers Guaranty Fund. The Fund filed a joinder petition against the Franchisor, alleging it was a statutory employer of the claimant and, therefore, liable for payment of benefits. The Franchisor moved for the dismissal of the joinder petition on the basis that they had no employment relationship with the claimant and were solely a franchisor. The Workers' Compensation Judge granted the motion and dismissed the joinder petition. Ultimately, the Judge granted the claimant's claim petition against the Franchisee.

The Fund appealed the denial of its joinder to the Appeal Board, arguing that the Franchisor was the claimant's statutory employer. The Board agreed and reversed the Judge. According to the Board, the Franchisor had a contractual obligation to ensure that the Franchisee had appropriate coverage in place, which would have protected the Franchisor from liability and ensured the claimant had coverage for his work-related injuries.

In its appeal to the Commonwealth Court, the Franchisor argued that § 302(a) of the Act (statutory employer) does not apply to franchise or franchisee agreements. According to the Franchisor, the key question was whether the work performed by the Franchisee, under their agreement, was a regular or recurrent part of the business, occupation, profession or trade of the Franchisor. The court's analysis of that agreement showed that the Franchisor's main business was the sale of franchises to franchisees that desired to use their name, "system" and marketing expertise. While the Franchisor was connected to the Franchisee through the agreement, the court found that the Franchisor was not in the restaurant business or the business of selling salads. Additionally, the court distinguished this case from the Pennsylvania Supreme Court's landmark decision in *Six L's Packing Company v. WCAB (Williamson)*, 44 A.3rd 1148 (Pa. 2012), by pointing out that, in that case, a subcontractor hired the claimant to perform an essential part of the general contractor's business—the transportation of produce from a warehouse to a processing facility. The court concluded that the Franchisee was the claimant's employer at the time of the injury and liable for payment of benefits. Because they did not have workers' compensation insurance, the Uninsured Employers Guaranty Fund was responsible for payment.

A claimant's permanent relocation from Pennsylvania to another state, standing alone, does not support a finding of a permanent and voluntary withdrawal from the workforce.

Mary Ellen Chesik v. WCAB (Department of Military and Veterans Affairs); 758 C.D. 2015; filed November 9, 2015; by President Judge Pellegrini

The claimant sustained a work-related injury to her neck in 2009. In 2013, the employer filed a petition to suspend benefits, alleging the claimant had voluntarily removed herself from the workforce due to her relocation to Nevada. The claimant testified regarding the reasons she moved to Nevada, which included the warmer climate being better for her Lupus and fibromyalgia. The claimant said that she did not receive any medical clearance from a doctor prior to the relocation. Additionally, the claimant retired from her position with the employer in October of 2012 and had applied for disability pension benefits. The claimant testified that she moved for a better quality of life for her body. She also testified it was not her intention to remove herself from the workforce when she moved to Nevada.

The Workers' Compensation Judge granted the employer's suspension petition, explaining that the employer did not need to demonstrate that the claimant is physically able to work or that available work has been referred when the claimant has voluntarily retired or withdrawn from the workforce. The judge found that the claimant removed herself from the workforce for reasons other than her medical condition with regard to her work injury. The claimant appealed to the Workers' Compensation Appeal Board, which affirmed.

However, the Commonwealth Court reversed the decisions of the judge and Board. The court held that the judge erred as a matter of law in relying on the claimant's permanent relocation to Nevada, standing alone, to support a determination that she permanently removed herself from the workforce. According to the court, such a relocation is specifically contemplated by and provided for in §306 (b) (2) of the Act. The court also concluded that the judge could not solely rely on the claimant's receipt of disability pension to support a suspension of benefits on the basis that she has permanently separated from the workforce. Citing precedent from the Pennsylvania Supreme Court, the court pointed out there is no presumption of retirement arising from the fact that the claimant seeks or accepts a pension. Rather, the acceptance of a pension entitles the employer only to a permissive inference of retirement that must be considered within the totality of the circumstances.

A claimant's collective statements to the employer, that his increased working hours as a line cook were making his back pain from a prior work injury worse, were sufficient notice of a work injury under § 311 of the Act.

Jamie Gahring v. WCAB (R and R Builders and Stoudt's Brewing Company); 534 C.D. 2015; filed November 23, 2015; by Judge Leavitt

The claimant sustained a work-related low back injury while working for Employer I in 1997 and, thereafter, underwent surgery. In 2002, the claimant settled his claim for indemnity benefits via a Compromise and Release Agreement, and Employer I's liability for future medical treatment continued.

In 2010, the claimant began working for Employer II as a line cook. In 2011, he began to experience increased back pain, which led to another surgery on November 17, 2012. In 2013, the claimant was released to return to work with restrictions that Employer II could

not accommodate. The claimant returned to work for another employer.

The claimant then filed a claim petition against Employer I, alleging that Employer I was responsible for the surgery performed in November 2012. Employer I filed a joinder petition against Employer II, alleging that the claimant's injuries and the resulting surgery were due to the claimant's work for Employer II.

The Workers' Compensation Judge found that the claimant sustained a work injury requiring surgery on November 17, 2012, as a result of the work the claimant performed as a line cook for Employer II. Construing the joinder petition as a claim petition, the judge found that the claimant proved that he suffered a work-related aggravation of his pre-existing back condition while working as a line cook. However, the judge also found that the claimant did not give timely notice of the aggravation within 120 days of the last date of his employment with Employer II, which barred his claim under § 311 of the Act. According to the judge, Employer II first learned that the claimant may have sustained an aggravation of his preexisting back injury on April 8, 2013, the date of a hearing conducted by the judge, which was 148 days after the claimant stopped working. The Appeal Board affirmed, concluding that statements made by the claimant to Employer II were not specific enough to put Employer II on notice that the claimant's work as a line cook was causing his more recent back complaints.

The Commonwealth Court reversed the opinions of the judge and the Board. According to the court, when a work injury results from cumulative trauma—as opposed to a single accident—the "collective communications," or statements made by the claimant to Employer II, were sufficient to put Employer II on notice that he may have a work-related injury. A claimant's notification to an employer that he has an injury can be accomplished in "collective communications." In reviewing the record, the court pointed out that the claimant reported increasing back pain to his supervisor at Employer II. That supervisor admitted when he testified that the claimant not only reported an increase in back pain, but correlated the additional pain to additional hours that Employer II was requiring him to work. The claimant's statements to his supervisor were sufficient to inform Employer II of the possibility that the pain was work related. Although there was a belief that the claimant's back problems were a recurrence of his 1997 injury, the claimant learned otherwise from the testimony of his treating physician who, at a deposition of June 21, 2013, opined that the claimant sustained an aggravation to his preexisting condition. In the court's view, the claimant's several conversations, taken together, put the employer on notice of a potential work-related injury.

The employer had adequate notice that the claimant considered a medical condition part of the work injury, and the Workers' Compensation Judge was authorized to expand the description of injury to include that condition to correct a material defect in the NCP, even in the absence of a petition to review.
Melissa Walter v. WCAB (Evangelical Community Hospital); 139 C.D. 2015; filed November 23, 2015; by Judge Leavitt

The claimant sustained a work-related injury to her left shoulder, which was acknowledged by the employer as a left shoulder strain. The employer later filed a termination petition, and the claimant responded by filing review petitions to amend the injury description on the NCP. The Workers' Compensation Judge denied the employer's termination petition and granted the claimant's review petitions, amending the NCP to add multiple conditions to the work injury. Following the review petitions, the claimant underwent a second shoulder surgery paid for by the employer. Thereafter, the employer filed another termination petition, alleging the claimant had fully recovered from her work injury as of the date of an IME. During litigation of that petition, the claimant presented testimony from her medical expert, who said that another left shoulder condition was part of the work injury and that the second surgery was performed to correct the second condition.

The judge partially granted the termination petition, finding that the claimant had fully recovered from some conditions, but not all of them. Additionally, the judge credited the testimony of the claimant's medical expert, that an additional shoulder condition was part of the 2007 work injury, from which the claimant had not fully recovered. The employer appealed to the Appeal Board, which reversed, concluding that it was error for the judge to add this condition in the absence of a review petition. According to the Board, the employer did not have adequate notice of the injury description at issue in the proceeding.

The Commonwealth Court reversed the Board and analyzed the Board's rationale for reversing the judge's decision. The Board noted that a claimant must provide notice of a corrective amendment early in the proceedings, and the notice must be overt, not implied. However, the claimant maintained on appeal that the employer had adequate notice of the corrective amendment since it was announced on the first day of the hearing on the termination petition and was addressed by the medical experts at their depositions. The court agreed and held that the employer had adequate notice and opportunity to contest a corrective amendment to the NCP.

While an expert must recognize the occupational causal presumption given to firefighters under §301(a), this does not preclude an expert from attributing lung disease to non-occupational factors, such as preexisting bronchitis and smoking.
Thomas J. Sweigert v. WCAB (City of Williamsport); 493 C.D. 2015; filed December 23, 2015; Judge Covey

In his claim petition, the claimant alleged that he developed Chronic Obstructive Pulmonary Disease (COPD) as a result of 22 years of work as a firefighter for the employer. During that time, he was exposed to smoke, fumes, heat and gases. The claimant also alleged that the COPD

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caused him to stop working as of August 9, 2011. The Workers' Compensation Judge denied his petition, concluding that the claimant did not benefit from the presumption that his lung condition was a work-related occupational disease under §301 of the Act. The judge also concluded that the claimant did not meet his burden of proving a work injury because his medical evidence was equivocal. The Workers' Compensation Appeal Board affirmed the judge's decision.

In his appeal to the Commonwealth Court, the claimant argued that the employer's medical expert was incompetent because he refused to acknowledge the occupational causal presumption given to firefighters under the Act. By law, expert testimony that adamantly rejects any causal relationship between exposure to the hazards of firefighting and lung disease is incompetent. In reviewing the testimony given by the expert, though, the court concluded that he did not say that a causal relationship did not exist between exposure to the hazards of firefighting and lung disease. Rather, he opined that if an individual has other significant causal factors, he would not attribute firefighting as the number one cause.

Under § 319, an employer is entitled to subrogation against a claimant's recovery of uninsured motorist's benefits from the policy of a co-employee.
Karen Davis v. WCAB (PA Social Services Union and Netherlands Insurance Company); 216 C.D. 2015; filed December 30, 2015; Senior Judge Friedman

While in the course of her employment, the claimant was involved in a motor vehicle accident as a passenger in the vehicle owned by a co-worker. The driver of the vehicle that struck the co-employee's vehicle was unknown. The claimant sustained injuries to her neck and low back and was paid a total of $56,213 in wage loss benefits and $33,572.22 in medical benefits.

Later, the claimant filed an uninsured motorist's claim with the co-worker's motor vehicle insurance carrier. The workers' compensation carrier then asserted a lien. The claimant settled the uninsured motorist claim, and, thereafter, the employer filed a petition to recover its lien from the proceeds from the uninsured motorist settlement.

The Workers' Compensation Judge concluded that the workers' compensation insurance company was entitled to subrogate against the claimant's settlement. Noting that the co-employee purchased the motor vehicle insurance, the judge concluded that, because insurance had been purchased by someone other than the claimant, the employer was entitled to subrogation under §319 of the Act. The Appeal Board affirmed, and the claimant appealed.

The Commonwealth Court also affirmed. In doing so, they rejected the claimant's argument that subrogation was improper because a co-worker paid for the uninsured/underinsured motorist's coverage. According to the claimant, the employer should have the right to subrogation only where **it** has paid for the uninsured/underinsured motorist's coverage. The Commonwealth Court held, however, that the employer has the right to subrogation not only when the employer has paid for the policy, but also when a third party, such as a customer or co-worker, has paid for the policy.

Although the MCARE Act precludes subrogation against medical malpractice proceeds incurred before trial, an employer is entitled to subrogation against future medical expenses and wage loss.
Maryann Protz v. WCAB (Derry Area School District); 402 C.D. 2015; filed January 6, 2016; President Judge Pellegrini

The claimant sustained a work-related injury to her right knee that led to a total knee replacement. That procedure, unfortunately, resulted in a transected popliteal artery. The claimant filed medical malpractice actions against the surgeon and the hospital where the operation was performed. In connection with the medical malpractice case, the claimant submitted a medical report from her expert stating that the claimant underwent a total knee replacement due to her work-related injury and that, due to the negligent manner in which it was performed, she suffered a laceration of the popliteal artery, which required a popliteal artery repair. The medical malpractice action eventually settled, and the employer filed a petition to recover their workers' compensation lien under §319 of the Act. The claimant took the position that the employer was not entitled to any recovery under the Medicare Care Availability and Reduction of Error Act (MCARE).

The Workers' Compensation Judge granted the employer's petition. According to the judge, the employer established that the claimant's third-party settlement was for the malpractice injury sustained during surgery performed to treat the work injury and the complications that sprang from that injury. The judge precluded the employer and its workers' compensation insurer from obtaining subrogation against the medical malpractice proceeds with regard to payments for past medical expenses and past lost earnings under §508 of the MCARE Act. However, the judge also found that §508 did not preclude the employer from seeking subrogation with respect to future payments. The claimant appealed to the Appeal Board, and they affirmed.

In her appeal to the Commonwealth Court, the claimant argued that §508 of the MCARE Act is silent as to subrogation of future medical expenses and wage loss in medical malpractice actions and, therefore, must be construed as a prohibition of subrogation. The court disagreed and dismissed the claimant's appeal, holding that, while §508(c) of the MCARE Act disallowed subrogation with respect to benefits paid up until the time of trial, it did nothing to alter the pre-existing law with regard to future benefits. The court noted that, prior to the passage of the MCARE Act, employers and workers' compensation carriers were entitled to subrogation with respect to both past and future benefits.

PENNSYLVANIA EMPLOYMENT LAW UPDATE

By Lee C. Durivage, Esquire, Marshall Dennehey Warner Coleman & Goggin, Philadelphia, PA

The Third Circuit determines that a retailer could be subject to liability under Title VII based upon discrimination claims asserted by a temporary worker assigned by a staffing agency.
Faush v. Tuesday Morning, Inc., 2015 U.S. App. LEXIS 19977 (Nov. 18, 2015)

The Third Circuit vacated summary judgment in favor of a retailer on a plaintiff's claims of discrimination during the plaintiff's assignment through a staffing agency at the store. In determining that the plaintiff could proceed to trial on his allegation that the retailer was a "joint employer" for purposes of the anti-discrimination laws, the Third Circuit analyzed the factors previously set forth by the United States Supreme Court in *Nationwide Mutual Insurance Company v. Darden*. In so holding, the Third Circuit found that, although the retailer paid the staffing agency (and not the plaintiff) directly, "[t]hose payments were functionally indistinguishable from direct employee compensation," because the retailer paid the staffing agency for each hour worked by the plaintiff. In addition, the Third Circuit noted that, while the staffing agency had the authority to hire the plaintiff and assign him to certain locations, the retailer nonetheless had "[u]ltimate control over whether [plaintiff] was permitted to work at its store." Similarly, the Third Circuit further reasoned that the retailer's control over the plaintiff's daily activities, along with testimony that the temporary employees did many of the same things as "regular employees," "overwhelmingly favors plaintiff."

This opinion makes clear that employers must observe and remediate any actions toward anyone that could be perceived as discriminatory, including actions toward staffing employees or customers. Otherwise, plaintiffs' attorneys will use this as an opportunity to further expand the contours of "joint employers" under the law.

The Third Circuit adopts the predominate benefit test to determine whether meal breaks are compensable pursuant to the Fair Labor Standards Act.
Babcock v. Butler County, 2015 U.S. App. LEXIS 20393 (3d. Cir. Nov. 24, 2015)

A class of prison guards sued the county, alleging that they were not properly compensated for meal break periods at the prison, in violation of the Fair Labor Standards Act. It was undisputed that the prison guards, pursuant to their collective bargaining agreement, received one hour for a meal break during their shift, 15 minutes of which was uncompensated. It was also undisputed that the prison guards were not permitted to leave the prison during their meal breaks due to the potential need to respond to emergency situations at a moment's notice. The Third Circuit initially noted that there were two tests that have been suggested by other courts of appeal to determine this issue. The first looks to "whether the employee has been relieved of all duties during the mealtime," and the second looks to "the party to which the 'predominant benefit' of the mealtime belongs." Ultimately, the Third Circuit, like the overwhelming majority of its sister courts, adopted the predominant benefit test. In applying this test, the Third Circuit noted that other courts have stated that "the essential consideration in determining whether a meal period is a bona fide meal period or a compensable rest period is whether the employees are in fact relieved from work for the purpose of eating a regularly scheduled meal." In applying this test, the Third Circuit determined that the "restrictions [by the prison] did not predominantly benefit the employer" and upheld the dismissal of the case.

District Court rejects plaintiff's attempt to argue that his employer was equitably estopped from asserting that it was not subject to the FMLA.
Palan v. Inovio Pharmaceuticals, Inc., 2015 U.S. Dist. LEXIS 112850 (E.D. Pa. Aug. 26, 2015)

The employee asserted that his former employer interfered with his rights under the Family and Medical Leave Act and retaliated against him when it terminated his employment on the day he was scheduled to return from medical leave. The employer's employee handbook specified that employees were entitled to take medical leave in accordance with the statutory requirements in the FMLA. The employee took a short medical leave, and, during the time period when he was on leave, the employer determined that he failed to adequately prepare the employer for its move to a new office. As a result, his employment was terminated, and the employee later filed his FMLA lawsuit. After discovery was completed, the employer moved for summary judgment, arguing that it was not subject to the FMLA because it never employed 50 or more employees. The employee, however, argued that the employer was "equitably estopped" from arguing that it was not subject to the FMLA because its employee handbook expressly provided for FMLA coverage and leave. The court, however, rejected the employee's argument, noting that, while the employee handbook's provision satisfied the employee's burden of establishing a "misrepresentation," the employee nonetheless failed to demonstrate that he detrimentally relied on that misrepresentation. In so finding, the court reasoned that the plaintiff never read the employee handbook and there were no facts in the record to establish that the employee's "decision to have the surgery was contingent on his understanding of his FMLA status."

This opinion should serve as notice to employers with fewer than 50 employees (within a 75-mile radius of their office location) in Pennsylvania to review their employee handbooks to determine whether or not they have mistakenly offered "FMLA" coverage to their employees.

The Pennsylvania Superior Court expands common law wrongful discharge to include retaliation pursuant to the Prohibition of Excessive Overtime in Healthcare Act.
Roman v. McGuire Hospital, 2015 Pa.

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Super. 232 (Pa. Super. Ct. Nov. 9, 2015)

The Pennsylvania Superior Court affirmed a judgment in favor of a former hospital employee who was awarded more than $120,000 following a bench trial. The employee was a direct care worker at the hospital and was terminated after she refused to work mandatory overtime on three occasions. Following her termination, she filed a lawsuit asserting a claim for wrongful termination, alleging that she was terminated in retaliation for refusing to work overtime and that her termination "offended the public policy of the Commonwealth of Pennsylvania," as articulated in the Prohibition of Excessive Overtime in Healthcare Act (Act 102). On appeal, the hospital argued that the court did not have subject matter over the plaintiff's claim as the Department of Labor would be the exclusive agency where the plaintiff could seek relief for an alleged violation of Act 102. Although the court recognized that the Department of Labor was tasked to promulgate regulations to implement the Act and proposed rules were proposed and published for comment (which would include a procedure to provide a complaint and hearing process), the rules had not yet been adopted. From this the court noted that "Act 102 contains nothing that allows for an employee in [plaintiff's] position to seek any remedy or even what administrative procedure [plaintiff] should follow to recover from [the hospital's] for its actions."

Based upon this decision, employers should expect additional attempts from plaintiffs' attorneys to further expand the theories of public policy violation in support of wrongful discharge claims in Pennsylvania.

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