

Jaeger v. Bureau of Workers' Compensation Fee Review Hearing Office (American Casualty of Reading c/o CNA), No. 2205 C.D. 2010, filed June 22, 2011.

Issue: Whether the insurer complied with the Bureau's regulations when it changed a doctor's billing code to calculate his fee reimbursement.

Answer: The insurer properly complied with the Bureau's regulations when it provided the doctor notice of the proposed change to the billing code, explained the reason for such change and provided the doctor ten days to dispute the downcoding decision.

Analysis: Dr. Jaeger provided VAX-D treatment to claimant. Accordingly, he submitted three invoices for the treatment rendered that assigned a Medicare Billing Code of 97799, which is a "miscellaneous physical therapy" billing code. In return, the insurer, CNA, sent Dr. Jaeger three letters informing Dr. Jaeger that it was downcoding the VAX-D treatments to code 97012, which is a "mechanical traction" procedure code. Each of the letters sent by CNA included an explanation for the downcoding and informed Dr. Jaeger that if he disagreed with the downcoding, that he had ten days to respond in writing. When CNA did not receive a timely written response, it downcoded the treatment in accordance with the letters sent.

Dr. Jaeger filed an Application for Fee Review and the Bureau ruled in favor of Dr. Jaeger. CNA then requested a de novo hearing. At the hearing, CNA presented the testimony of an insurer representative who testified that the letters were sent in accordance with Section 306(f.1)(3)(viii). CNA also submitted the letters into evidence. Dr. Jaeger did not present any evidence. As a result, the Hearing Officer reversed the Bureau's Decision. In doing so, the Hearing Officer credited the insurer representative's testimony and concluded that the insurer's business records showed that the ten-day notices had been sent to Dr. Jaeger.

On appeal, Dr. Jaeger argued that CNA did not prove that Dr. Jaeger was provided notice of its intent to downcode the treatment and, in the alternative, that CNA improperly paid for claimant's treatment before Dr. Jaeger had the opportunity to respond to the notice of downcoding.

34 Pa. Code § 127.207 provides that an insurer may change a provider's code so long as:

1. The provider has been notified in writing of the proposed changes and the reasons in support of the changes;
2. The provider has been given an opportunity to discuss the proposed changes and support the original coding decisions;
3. The insurer has sufficient information to make the change; and
4. The changes are consistent with Medicare guidelines, the Act and this subchapter.

Furthermore, it is the insurer's burden to prove by a preponderance of evidence that it acted properly in downcoding or reimbursing the provider.

Moreover, it is sufficient for the insurer to submit copies of the notices sent, even if they are not signed by the insurer, to establish that notice was given, as the Court is able to infer that the notices would not be in the insurer's system had they not been sent. In addition, the

copies of the notices are admissible into evidence under the hearsay exception for business records as specified in the Pennsylvania Rules of Evidence Section 803(6).

Thus, the notices were sufficient in establishing that the insurer acted in accordance with the Bureau regulations in downcoding Dr. Jaeger's treatment rendered to claimant.

Lastly, the Court held that the insurer did provide payment to Dr. Jaeger during the period upon which Dr. Jaeger was able to challenge the downcoding. However, the payment was for treatment other than the disputed and thus, was proper.

Conclusion and Practical Advice: Insurers are able to downcode a doctor's billing. However, the insurer must provide notice to the doctor, in writing, specifying the proposed downcoding, reason for same and specify that the doctor has ten days to dispute the change in writing. During the ten day period upon which the doctor can challenge the downcoding, payment should not be made. Only after the ten day period has expired should the insurer issue payment in accordance with the proposed downcoding.

*Vaughn v. Workers' Compensation Appeal Board (Carrara Steel Erectors), No. 1790 C.D. 2010, filed March 11, 2011*¹.

Issue: Whether a job offer letter sent to claimant offering claimant his pre-injury position with restrictions was sufficient when it failed to specify the job requirements.

Answer: The employer's job offer letter was sufficient because claimant was asked to return to his pre-injury position, a position for which he was already familiar with the duties associated with its performance. However, if the job offer letter was for a position that claimant had never held, then it would not have provided sufficient notice.

Analysis: Claimant was working as a union ironworker for the employer on July 23, 2005 when he suffered a back injury. He filed a Claim Petition, which the WCJ granted.

On January 3, 2008, claimant underwent an Independent Medical Examination (IME) performed by Dr. Daniel Altman. Based upon his review of records and examination of claimant, Dr. Altman opined that claimant was capable of returning to work in a modified, medium-duty capacity. In addition, Dr. Altman completed a Work Capability Chart to reflect the restrictions that he would place on claimant's ability to lift, stand, walk and drive, among other things.

As a result of Dr. Altman's release of claimant to return to modified duty work, the employer sent claimant a job offer letter that stated as follows:

We are pleased to hear that you are capable of returning to work with some restrictions. Your activities at work will be modified to

¹ A subsequent Order was issued on June 3, 2011 that ordered that the Memorandum Opinion filed on March 11, 2011 be designated as Opinion.

accommodate the restrictions identified in the 1/3/08 Work Capabilities Chart signed by Dr. Altman. A copy of this chart is enclosed.

Please report to Kevin Litz on May 19, 2008 at 7:00 a.m. You will, of course, be paid at your regular rate of pay.

Claimant failed to return to work or respond to the job offer letter in any manner. Thus, employer filed a Petition to Modify/Suspend claimant's benefits.

The WCJ granted the Petition to Suspend and claimant appealed to the WCAB, which affirmed the WCJ's Decision.

On appeal, the claimant argued that the WCAB erred in affirming the WCJ's Decision because the employer did not sustain its burden of proving that the job offer letter sufficiently notified him of an available job.

Job referrals are to be reviewed in a common sense manner to determine whether a suitable position has been made available to claimant. In addition, if the job is for a position that claimant has not previously held, then the employer must provide additional information regarding the job duties and classifications so that the claimant can make an informed decision on whether the position offered is within their capabilities.

Here, the job offered to claimant was his pre-injury position rather than alternative employment. In addition, the job offer letter attached the Work Capability Chart to assure claimant that the accommodations would be made in accordance with the release of Dr. Altman. Thus, while the letter does not specifically state claimant's duties, the claimant was aware of the portions of his job that he could do within the restrictions since it was his pre-injury position. Therefore, the job offer letter was sufficient and the WCAB's Order was affirmed.

Conclusion and Practical Advice: When issuing a job offer letter, one must first determine if the job is claimant's pre-injury position or whether it is a job that claimant has not previously held. If the job is claimant's pre-injury position, then the job offer letter does not need to list the job requirements. However, if the job is one that claimant has not previously held, the job offer letter must state the specific requirements so that claimant can make an informed decision as to whether he/she is able to perform the job.

Horner v. Workers' Compensation Appeal Board (Liquor Control Board), No. 2155 C.D. 2010, filed June 14, 2011.

Issue: Whether the employer presented sufficient evidence to establish that it was entitled to a pension offset when the employer did not present any documentation as to its actual contribution.

Answer: The employer met its burden of establishing its entitlement to a pension offset when it presented the actuarial testimony that established that the employer contributed to the pension plan.

Analysis: Employer sent claimant a notice of pension benefit offset and, as a result, claimant filed a Petition to Review Benefit Offset.

In support of an offset, employer presented the testimony of Linda Miller, the Director of SERS Benefits Determination Division. She testified that the pension was a defined benefit plan that consisted of regular deductions from claimant's gross salary, contributions from the employer and investment income. Furthermore, Ms. Miller testified that the employer's monthly contribution to claimant's pension was \$1,881.81 per month.

Employer also presented the testimony of John Wolford who testified that his office processed employer's payroll and made the necessary retirement deductions from each employee's gross earnings.

Lastly, employer presented the testimony of actuary, Brent Mowery, who testified that the employer's contribution varied from year to year. In addition, Mr. Mowery testified as to the calculation utilized to determine the amount contributed by the employer.

The WCJ found the testimony of the employer's witnesses to be credible and concluded that the employer was entitled to an offset. However, noting that there was a lack of evidence with regard to the rate of return prior to 1996, the WCJ concluded that the amount of the offset could not be determined from the record and ordered that the record be reopened in order to present additional evidence with regard to those rates and the amount of the employer's offset.

Both parties appealed and the Board affirmed the WCJ's Decision, remanding the matter to the WCJ.

On remand, the claimant presented the testimony of actuary, Nathan Kolbes, who testified that neither Ms. Miller nor Mr. Wolford presented any documentation of the actual contributions that the employer made to the pension plan or the time of year such contributions were made. Mr. Kolbes testified that additional information was needed to determine the employer's contribution.

The employer presented additional testimony from Mr. Mowery who acknowledged the rate of return for the years prior to 1996.

The WCJ credited Mr. Mowery's testimony and rejected the testimony of Mr. Kolbes as not credible. Claimant appealed to the WCAB, which affirmed the WCJ's Decision.

On appeal, claimant argued that the Board erred in affirming the WCJ's Decision because the present case is distinguishable from precedent set forth in Harvey, Hensal and Cato. Specifically, claimant argued that there is no factual information on which the actuary can

make a proper actuarial calculation. However, the Court rejected claimant's assertion as the evidence presented in this case closely mirrors the evidence presented in the precedent.

Furthermore, the precedent states that actuarial testimony can be used to establish claimant's burden of proof of its entitlement to a pension offset. Thus, the Board's Order was affirmed.

Conclusion and Practical Advice: The presentation of actuarial testimony is crucial in establishing the entitlement of a benefits offset as it can be used to establish the employer's burden of proof, even if other documents of actual contributions are not submitted into evidence by the employer.

*Upper Darby Township v. Workers' Compensation Appeal Board (Nicastro), No. 1285 C.D. 2010, filed March 17, 2010*².

Issue: Whether claimant's evidence was sufficient in establishing an entitlement to a reinstatement of benefits when claimant's medical doctor testified in direct contradiction to a Stipulation of Facts previously adopted by the WCJ and claimant testified that he was capable of performing his pre-injury position.

Answer: The claimant failed to meet his burden of establishing a change or worsening condition and thus, was not entitled to a reinstatement of total disability benefits.

Analysis: Claimant was employed as a laborer for employer when, on April 23, 2002, claimant injured his low back. Claimant's injury was recognized as compensable via a converted Notice of Temporary Compensation Payable (NTCP) in the nature of a low back strain. On March 22, 2004, claimant return to work with no restriction and thus, employer suspended claimant's disability payments by issuing a Notification of Suspension.

On June 8, 2004, claimant alleged that he again hurt his low back. As a result, claimant filed a Claim Petition. Ultimately, the parties resolved the matter by entering into a Stipulation of Facts that was adopted by the WCJ. The Stipulation stated that the parties agreed that claimant's work-related injury resulted in a limited period of disability from June 8, 2004 through October 7, 2004, and that claimant returned to work without a wage loss or restrictions as of October 8, 2004. The parties further agreed that any time that claimant missed from working after October 8, 2004 was not attributed to his work injury and that claimant ultimately left his job with the employer in December of 2004 because of injuries unrelated to his back.

In January of 2008, claimant filed a Petition to Reinstate his benefits alleging that his condition had worsened, causing him a loss of earnings as of January 24, 2008. During the course of litigation, it became apparent that claimant was seeking a reinstatement of benefits as of December 5, 2004, the date when he stopped working for the employer.

² A subsequent Order was issued on June 21, 2011 that ordered that the Memorandum Opinion filed on March 17, 2011 be designated as Opinion.

Claimant testified in support of his Petition, stating that no specific incident prompted him to seek reinstatement and that he would "love to try" to return to work but his doctor will not permit him to do so. Claimant also testified that since December 2004, he has been capable of performing his pre-injury job without restrictions.

In further support of his Petition, claimant presented the testimony of Dr. Swamy who first saw claimant on November 1, 2006. Dr. Swamy testified that claimant has permanent medical restrictions and cannot perform his pre-injury job. Furthermore, Dr. Swamy testified that claimant was unable to perform his pre-injury position at any time between December 2004 and November 2006 because claimant had returned to work after his second work injury but could not do the job and thus, stopped working for the employer.

The employer presented the testimony of Dr. Trabulsi, who testified that claimant's condition remained unchanged since he examined claimant in February of 2004. Furthermore, Dr. Trabulsi testified that the medical records do not support a worsening of claimant's condition.

The WCJ granted claimant's Petition, crediting claimant's and Dr. Swamy's testimonies as credible. Furthermore, the WCJ granted claimant's Claim Petition as of November 1, 2006, the date that Dr. Swamy first evaluated claimant. The employer appealed and the Board affirmed. The employer then filed a Petition for Review.

On appeal, the employer argued that the reinstatement as of November 1, 2006 was contrary to claimant's testimony and the Stipulation of Facts. In claimant's prior litigation, claimant stipulated that after he returned to his pre-injury job in October 2004, he missed no time from work because of his work injury and left work in December of 2004 for reasons unrelated to the work injury. Thus, to reinstate his benefits, claimant had to show that the reason for the suspension of his benefits in December of 2004 no longer existed. However, claimant was unable to meet his burden as he testified that he could do his regular job as of December of 2004 and as of February of 2008.

Furthermore, Dr. Swamy's testimony did not support a reinstatement as it had two fatal flaws. First, Dr. Swamy's opinions were contradicted by claimant's statement that he could perform his regular job at all times. Second, Dr. Swamy's opinions were based upon incorrect information as Dr. Swamy testified that claimant was disabled because he had an earlier attempt to return to work but could not do it. However, Dr. Swamy's testimony was in direct contradiction with the Stipulation of Facts, thus rendering her opinion as incompetent.

As a result, because claimant failed to show a change in his condition or circumstances after the WCJ's previous decision that adopted the Stipulation of Facts, the WCAB's Decision affirming the decision of the WCJ was reversed.

Conclusion and Practical Advice: An expert opinion is incompetent if it is based upon an assumption that is contrary to the established facts of the case. Thus, if a dispute was previously involved in litigation, it is crucial that the expert testifies consistent to the established facts or will be deemed incompetent.