

IN THE  
COMMONWEALTH COURT OF PENNSYLVANIA

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NO. 647 C.D. 2004  
NO. 885 C.D. 2004

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BARBARA ORENICH  
Petitioner

v.

WORKERS' COMPENSATION APPEAL BOARD  
(GEISINGER WYOMING VALLEY MEDICAL CENTER)  
Respondent

and

BETH A. BRUTICO  
Petitioner

v.

WORKERS' COMPENSATION APPEAL BOARD  
(US AIRWAYS, INC.)  
Respondent

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BRIEF FOR AMICUS CURIAE, PENNSYLVANIA SELF-INSURERS'  
ASSOCIATION IN SUPPORT OF BRIEF OF RESPONDENT, GEISINGER  
WYOMING VALLEY MEDICAL CENTER

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On Petition for Review from the Opinion and Order of the  
Workers' Compensation Appeal Board dated February 26, 2004 Docketed at A03-  
0361, Affirming the January 24, 2003 Decision and Order of WCJ Mark A. Peleak,  
Denying, in Part, the Claim Petition of Barbara Orenich

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THE CHARTWELL LAW OFFICES, LLP

Andrew E. Greenberg, Esquire  
Attorney ID No.: 41334  
*Attorney for Amicus Curiae*  
*Pennsylvania Self-Insurers' Association*

Valley Forge Corporate Center  
2621 Van Buren Avenue  
Norristown, PA 19403  
(610) 666-7700

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**I. STATEMENT OF JURISDICTION**

This Honorable Court has jurisdiction over this Appeal of the final Order of the Workers' Compensation Appeal Board pursuant to Section 763 (a) (1) of the Judicial Code.

## **II. STATEMENT OF INTEREST OF AMICUS CURIAE**

The Pennsylvania Self-Insurers' Association ("PSIA") is a statewide organization of large and small employers who administer their workers' compensation programs on a self-insured basis. By establishing a forum through which self-insured employers can study and develop policy aimed at improving the efficiency and effectiveness of the administration of the Pennsylvania Workers' Compensation Act, the PSIA seeks to promote business growth and employment opportunity in the Commonwealth of Pennsylvania. Throughout the calendar year, the PSIA convenes workshops and seminars for members and non-members addressing all aspects of workers' compensation administration. In conjunction with its educational function, the PSIA represents its members and constituents in a variety of forums, including litigated matters that impact upon the goals and interests of all Pennsylvania employers.

### III. SCOPE OF REVIEW

This Honorable Court's scope of review on appeal from a decision of an administrative agency is limited to determining whether any constitutional rights have been violated, whether any errors of law have been committed or whether any necessary findings of fact are not supported by substantial evidence. See Section 704 of the Administrative Agency Law, 2 Pa. C.S. §704; Davis v. Workers' Compensation Appeal Board (Swarthmore Borough), 561 Pa. 462, 751 A.2d 168 (2000); Waugh v. Workers' Compensation Appeal Board, 558 Pa. 400, 737 A.2d 773 (1999).

In 2002, the Pennsylvania Supreme Court expanded the scope of appellate review in administrative cases such as this one to include "capricious disregard" analysis where, for example, the WCJ chooses not to consider uncontroverted evidence or chooses not to apply well-settled law. Leon E. Wintermeyer, Inc. Workers' Compensation Appeal Board (Marlowe), 571 Pa. 189, 812 A.2d 478 (2002); See also FOP Conference of Pennsylvania Liquor Control Board Lodges v. Pennsylvania Labor Relations Board, 557 Pa. 586, 735 A.2d 96 (1999).

In terms of its standard review, this Honorable Court, as an appellate tribunal, may not assess credibility or re-weigh evidence since the authority to do so rests exclusively with the WCJ. Taulton v Workmen's Compensation Appeal Board (USX Corp.), 713 A.2d 142 (Pa. Cmwlth. 1998). In examining questions of law, however, this Honorable Court's standard of review is plenary, Phillips, et. al. v. A-Best Products, et. al., 542 Pa. 124, 665 A.2d 167 (1995); Young v. Young, 507 Pa. 40, 488 A.2d 264 (1985) and, in the context of a statutory construction question, this Honorable Court's role is "to ascertain and effectuate the intention of the legislature; to the extent the legislative definition is not explicit, [to] also consider, among other matters, the occasion and necessity for the statute, the circumstances under which it was enacted, the mischief to be remedied, the object to be attained, the former law, if any, including

other statutes upon the same or similar subjects, the consequences of a particular interpretation, the contemporaneous legislative history, and the legislative and administrative interpretations of the statute.” Commonwealth of Pennsylvania, Higher Education Assistance Agency, et. al. v. Abington Memorial Hospital et. al., 478 Pa. 514, \_\_\_, 387 A.2d 440, \_\_\_ (1978) *citing* Statutory Construction Act of 1972, 1 Pa.C.S.A. §1921.

IV. ORDER IN QUESTION

ORDER

“The Decision of the Workers’ Compensation Judge is Affirmed. The Appeal of the Claimant is Dismissed.”

(Order of Workers’ Compensation Appeal Board dated 1/24/03)

V. COUNTERSTATEMENT OF QUESTION INVOLVED

1. Whether the WCJ below properly disallowed claimant's claim for *quantum meruit* counsel fees, asserted on the basis of defendant's initial informal administration of claimant's "medical only" work injury.

(Answered in the affirmative by the Workers' Compensation Appeal Board)

## VI. COUNTERSTATEMENT OF CASE

In November 2000, petitioner, Barbara Orenich ("claimant") was employed by respondent, Geisinger Wyoming Valley Medical Center ("defendant") as a full-time Registered Nurse assigned to the facility's "Medical/Surgical Intensive Care Unit." (R. 202a). Her job required her to undertake all activities associated with primary care nursing. (R. 202a).

On Wednesday, November 29, 2000, she sought to assist an obese patient who was suffering from the effects of an open bed sore. (R. 203a). While doing so, she attempted to pull the pad upon which the patient was lying, in order to permit the patient's health care providers access to the wound. (R. 203-04a). As she pulled the pad, she noticed a pinching sensation at the base of the right side of her neck. (R. 204a).

The sensation was of such insignificance that she soon "forgot about it" and continued to perform her regular work duties. (R. 205a).

A few days later - over the weekend - she sensed some discomfort in her neck, prompting her to so inform her nursing supervisor, who suggested that she consult the hospital's Emergency Room where she was given Flexeril, underwent x-rays, and apparently was instructed to return to work. (R. 205a).

She did not miss work time as a result of her symptoms, but continued to report to her regular job without wage loss. (R. 210a, 211a).

On February 27, 2001, the Workers' Compensation Coordinator for Geisinger Health System Risk Management submitted correspondence to claimant advising that "[y]our injury is currently carried as a medical only claim. If circumstances change, or you anticipate or begin to lose time away from work due to this injury, please notify me immediately, so that we can implement Workers' Compensation lost wage benefits on your behalf." (R. 36a).

Four months later, despite having missed no time from work, claimant filed a Claim Petition on June 26, 2001 alleging that her November 29, 2000 work incident caused “burning pain base of right side of neck. Pain and stiffness right side of neck, weakness in right arm and hand with repetitive movements” thereby entitling her to total disability benefits from November 29, 2000 to “present and ongoing.” (R. 2a-3a)<sup>1</sup>.

At the first hearing conducted before the assigned WCJ, claimant amended her Petition to rescind her claim for wage loss benefits. (R. 211a).

In support of her Petition, claimant submitted of record a series of medical documents, including the August 26, 2002 report of Dr. Mitchell Gross, who diagnosed her with a right cervical radicular pain syndrome, a moderate cervical degenerative disease condition involving early arthritis and multi-level disc disease, which, he concluded, became symptomatic following the November 29, 2000 work incident.

In defending the nature and extent of claimant’s November 29, 2000 work injury, defendant presented the testimony of board-certified orthopedic surgeon, Dr. Thomas Allardyce (R. 159a) who, on the basis of his November 12, 2001 independent medical examination (R. 161a) and record review (R. 161a) , concluded that her work incident caused an

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<sup>1</sup> The facts in the companion case involving Beth A. Brutico are similar to those referenced above. In the Brutico matter, the claimant, a lead distribution representative assigned to the US Airways office services department slipped and fell on a van that she was loading while in the course of her employment on January 5, 2001. Although she did not immediately experience pain, she developed back spasms later that evening at home, prompting her to report the incident to her supervisor the following day. She thereafter sought treatment at WorkWell and continued to work on a light-duty basis without wage loss. She soon returned to her regular job duties, although she continued to experience symptoms and continued to treat with various health care providers. Ms. Brutico eventually filed a Claim Petition seeking formal recognition of what she alleged was a work-related lumbar disc herniation, and filed a Penalty Petition alleging US Airways’ failure to issue a timely Notice of Compensation Denial form – US Airways filed the form seven months following Ms. Brutico’s work incident, acknowledging the work injury, but denying any resulting wage loss. By Decision and Order circulated May 12, 2003, the assigned WCJ disallowed claimant’s Claim Petition, finding that she had failed to prove that her work injury resulted in a lumbar disc herniation and disallowed her Penalty Petition, ruling that she had failed to prove that US Airways violated the Act. By Opinion and Order dated April 2, 2004, the Workers’ Compensation Appeal Board affirmed the WCJ’s ruling below.

aggravation of her pre-existing degenerative cervical condition and a cervical strain (R. 167a) both of which had fully resolved by the time he saw her on November 12, 2001. (R. 168a).

By Decision and Order circulated January 24, 2003, the WCJ granted claimant's Claim Petition in accordance with the following pertinent Findings of Fact: (1) he found that claimant's work incident caused a cervical or paracervical strain/sprain and an aggravation of an underlying degenerative process (R. 13a); (2) he found that claimant "has not lost any time from work" as a result of her November 29, 2000 work incident (R. 12a); and (3) he found credible the testimony of defendant's expert medical witness, Dr. Allardyce that by November 12, 2001, claimant had fully recovered from her November 29, 2000 work incident. (R. 12a).

On February 11, 2003, claimant filed an Appeal from Judge's Findings of Fact and Conclusions of Law with the Pennsylvania Workers' Compensation Appeal Board, assigning as error, the WCJ's failure to impose penalties<sup>2</sup> against defendant and failure to award *quantum meruit* counsel fees for defendant's supposed unreasonable contest of her Claim Petition. (R. 23a).

By Opinion and Order dated February 26, 2004, the Appeal Board affirmed the WCJ's Decision and Order, concluding that defendant's contest of claimant's Claim Petition was reasonable since there was a "genuine issue as to duration of the Claimant's disability as alleged as well as the Claimant's entitlement to ongoing medical benefits." (R. 29a).

On March 26, 2004, claimant filed the instant Petition for Review with this Honorable Court, challenging the Appeal Board's ruling, urging, in essence, that WCJs must, as a matter of

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<sup>2</sup> Claimant did not request penalties before the WCJ. Yet she continues to insist that penalties be assessed: "[u]nless this Court rules in favor of the Claimant and remands for the imposition of counsel fees and/or penalties, Employers and insurance carriers will continue to not only disregard their obligations and responsibilities under the Act and case law, but to unfairly and illegally handicap Claimants even more to their physical and financial detriment." (See Brief of Petitioner, at p. 13). Since a request for penalties was not made before the WCJ it must be deemed waived for appellate purposes. See Rox Coal Company v. Workers' Compensation Appeal Board (Snizaski), 570 Pa. 60, 807 A.2d 906 (2002). The PSIA is mindful, however, that the claim for penalties made before the WCJ in the companion Brutico matter remains at issue before this Honorable Court.

law, award *quantum meruit* counsel fees and/or penalties to any injured employee whose employer does not file a timely Notice form with the Bureau of Workers' Compensation formally acknowledging the work injury even in those instances when the injury does not cause the employee to miss a run, shift or single day of work.

## **VII. SUMMARY OF ARGUMENT**

The drafters of the Pennsylvania Workers' Compensation Act were mindful of the distinction between significant and minor work injuries. In drawing such a distinction, the Legislature established separate administrative regimes for work injuries not resulting in the disruption of the injured employee's normal work schedule i.e. "non-disabling" injuries and for work injuries causing the employee to become physically incapable of continuing to work i.e. "disabling injuries."

Although it has been suggested that all Pennsylvania work injuries should be administered equally - that all should trigger formal state supervision - the PSIA respectfully submits that such a perspective is not consistent with the plain language of the Act or the Regulations interpreting the Act and ignores the overwhelming practical and financial ramifications that such an approach would engender.

## VIII. ARGUMENT

### A. THE APPEAL BOARD'S AFFIRMANCE OF THE WCJ'S ADJUDICATION BELOW WAS APPROPRIATE SINCE THE DEFENDANT PROPERLY ADMINISTERED CLAIMANT'S MEDICAL ONLY CLAIM.

The essence of claimant's Petition for Review in this case is a mechanical one - in every instance where an employee suffers a work injury - serious or minor - the employer or insurer must file a formal Notice either accepting the work injury as compensable or, apparently, acknowledging the occurrence of the work injury, but denying any resulting loss of earnings.

Claimant maintains that where the employer or insurer fails to issue a formal Notice within 21 days of the work injury at issue, the employee must be awarded penalties and/or any *quantum meruit* counsel fees incurred during the prosecution of a Claim Petition.

In advancing her position, claimant has relied upon a series of decisions issued by this Honorable Court in Lemansky v. Workers' Compensation Appeal Board (Hagan Ice Cream), 738 A.2d 498 (Pa. Cmwlth. 1999), Waldameer Park, Inc. v. Workers' Compensation Appeal Board (Morrison), 819 A.2d 164 (Pa. Cmwlth. 2003) and Williams v. Workmen's Compensation Appeal Board (AT&T Technologies, Inc.), 601 A.2d 473 (Pa. Cmwlth. 1991).

The PSIA respectfully urges this Honorable Court to reject the bright line rule sought by claimant since it has no statutory or regulatory support and since the mechanical regime it would impose will not advance the policy concerns upon which claimant has based her Petition for Review.

The PSIA recognizes that the Pennsylvania Workers' Compensation Act is a humanitarian statute designed to provide expedited medical and/or wage loss coverage to employees injured in the course of their employment. The statutory displacement of employer civil liability for work injuries represents a fundamental compromise between the employee and the employer - the employee is assured of immediate compensation in nearly every case

involving a work injury and the employer is immunized against the substantial consequences of civil litigation.

The PSIA recognizes, however, that not all work injuries have serious ramifications – most work injuries require either no formal treatment or at best some minor first aid. Moreover, most work injuries do not cause the employee to miss a run, shift or day of work, but rather generate what are commonly referred to as “medical only” claims.

The PSIA respectfully submits that there are three categories of “medical only” claims: (1) the pure “no lost time” claim, where the work injury does not impact upon the employee’s work duties; (2) the “modified duty” claim, where the injury does not result in wage loss but forces the employee to undertake modified work; and (3) the “7 days or less of disability” claim, where the work injury prevents the employee from working for seven days or less, but permits him or her to return to work without wage loss on the eighth day.

The claim in this case involves a “no lost time” medical only claim – although claimant experienced a pinching sensation while working on November 29, 2000 she continued to perform her regular job without wage loss<sup>3</sup>. (R. 210a).

In advancing her claim for *quantum meruit* counsel fees, claimant has challenged the manner in which defendant administered her no lost time claim – she maintains that defendant’s failure to issue a formal Notice within 21 days of her work incident inappropriately required her to file a Claim Petition in order to guarantee her coverage under the Act: “[T]he Employer is required by law to take some action and its failure to do so require the unnecessary filing of this Claim Petition.” (See Brief of Petitioner, at pp. 13-14) (emphasis supplied).

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<sup>3</sup> The Brutico case also involves a “no lost time” medical only claim.

Claimant further maintains that defendant's failure to take "some action" jeopardized her entitlement to medical benefits because in such instances "if the statute of limitations runs before Claimant has completed treatment, the employer [who has not issued either a Notice of Compensation Payable or Notice of Compensation Denial] is then off the hook for any future payments as a result of the injury." (See Brief of Petitioner, at p. 12).

The PSIA respectfully submits that claimant's Petition for Review raises concerns that were fully contemplated and resolved by the drafters of the Act.<sup>4</sup>

### **Statutory Distinction Between Minor Injuries and Serious Injuries**

The pertinent sections of the Act reveal the Pennsylvania Legislature's determination to distinguish between serious work injuries - where the employee becomes unable to work - and minor work injuries - where the employee is able to continue to work without wage loss.

Section 438(a) of the Act, for example, requires that "**all**" work injuries - whether they prompt wage loss or not - be reported either to the employer's workers' compensation insurer or the self-insured's workers' compensation administrator:

"An employer shall report **all injuries** received by employees in the course of or resulting from their employment immediately to the employer's insurer. If the employer is self-insured such injury shall be reported to the person responsible for management of the employer's compensation program" (emphasis supplied).

In addition, Section 439 of the Act requires that employers document the nature and occurrence of **all** work injuries regardless of their severity:

"Every employer shall keep a record of **each injury** to any of his employees as reported to him or of which he otherwise has knowledge. Such record shall include a description of the **injury**, a statement of any time during which the injured person was unable to work because of the injury, and a description of the manner in which the **injury** occurred. These records shall be available for inspection by the department or by any governmental agency at reasonable times." (emphasis supplied).

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<sup>4</sup> Indeed, the PSIA respectfully submits that at best, the policy considerations prompting this Appeal call for a Legislative, not a judicial, response.

Section 438(b), however, draws a distinction between serious and minor work injuries by specifying that where the injury **does not result in a lost day or shift or run**, the employer has no legal obligation to file an *Employer's Report of Occupational Injury or Disease* with the Bureau, meaning that for the "no lost time" claim and the "modified duty" claim, the Act does not require formal state supervision:

"An employer shall report such injuries to the Department of Labor and Industry by filing directly with the department on the form it prescribes a report of injury within forty-eight hours for every injury resulting in death, and mailing within seven days after the date of injury for all other injuries **except those resulting in disability continuing less than the day, shift, or turn in which the injury was received**. A copy of this report to the department shall be mailed to the employer's insurer forthwith." (emphasis supplied).

The Pennsylvania Legislature further distinguished between serious and minor work injuries when it enacted Section 406.1(a) of the Act, which instructs that formal acceptance of a work injury through notification to the state - by way of Notice of Compensation Payable - is only necessary where the employer learns that the employee's work injury has resulted in a **"disability"**:

"The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in subsection (d), on forms prescribed by the department and furnished by the insurer. **The first installment of compensation** shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employee's **disability**..." (emphasis supplied)<sup>5</sup>.

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<sup>5</sup>As the statute itself makes clear, Section 406.1 must be read in conjunction with Section 407, which instructs that where the payment of disability benefits is to be made without an Agreement between the parties, the defending party must issue the Notice and the payment simultaneously. In other words, that the simultaneous issuance of the Notice of Compensation and the payment of disability benefits constitutes a single action that represents the acceptance of the wage loss claim.

As discussed below, the word "disability" is a workers' compensation term of art that does not measure "physical impairment", but measures "wage loss" arising out of the work injury. Dillon v. Workmen's Compensation Appeal Board (Greenwich Collieries), 536 Pa. 490, 640 A.2d 386 (1994) *citing* Kachinski v. Workmen's Compensation Appeal Board (Vepco Construction), 516 Pa. 240, 532 A.2d 374 (1987).

Construed most strictly, one might be tempted to conclude that Section 406.1 requires the issuance of a Notice of Compensation Payable where the work injury causes the employee to suffer wage loss for at least one day, one shift or one run.

It is respectfully submitted that the better view is that Section 406.1 requires the issuance of a Notice of Compensation Payable only where the work injury prompts a **payable wage loss** i.e. where the employee suffers wage loss for at least eight days.

It will be recalled that Section 306(e) of the Act provides, in pertinent part, that "no compensation shall be allowed for the first seven days after disability begins, except as provided in this clause (e) and clause (f) of this section. If the period of disability lasts fourteen days or more, the employee shall also receive compensation for the first seven days of disability."

When read together, Sections 306(e) and 406.1 instruct that where the work injury does not result in a period of disability for a period in excess of seven days, "no compensation shall be allowed" i.e. that a Notice of Compensation Payable should only be issued where, under Section 306(e) of the Act "compensation shall be allowed."

Claimant's Petition for Review maintains that the Act requires employers or insurers to issue either a Notice of Compensation Payable or Notice of Compensation Denial form in every instance - whether or not the work injury results in wage loss.

In other words claimant would have this Honorable Court construe the Act as meaning that following a “no lost time” or “modified duty” medical only claim, the employer has **no obligation to officially notify** the Bureau of the occurrence of the work incident - through the filing of an *Employers Report of Occupational Injury or Disease* under Section 438 of the Act -but must, nevertheless, file a formal Notice with the Bureau **accepting** the injury arising out of the work incident.

Such an interpretation of the Act would appear to engender the kind of “absurd” result that Section 1921(1) of the Statutory Construction Act proscribes. Boettger v. Loverro, 526 Pa. 510, A.2d 712 (1991).

Indeed, it logically follows that where an *Employer’s Report of Occupational Injury or Disease* need not be filed, the subsequent form contemplating formal Notice **accepting** the work injury as compensable need not be filed.

As noted, the distinction between “injury” and “disability” is a subtle, but significant one in the context of Pennsylvania workers’ compensation claims administration, that would seem to lay to rest the ruling claimant is seeking in this case.

Once again, the word “disability” is a workers’ compensation term of art that does not measure the employee’s physical impairment, but refers to the sum of two distinct events - work injury + wage loss. See Harbison-Walker v. Workmen’s Compensation Appeal Board, 40 Pa. Cmwlth. 556, 397 A.2d 1284 (1979). While the meaning of the word “disability” is often misused in the context of the Act by lay persons and health care providers, the law is clear that the word is not a measure of the injured employee’s physical impairment, but instead represents the method under the Act for gauging the extent of wage loss arising out of the work injury at issue, so that “total disability” refers to a work injury that has prompted total wage

loss and “partial disability” refers to a work injury that has prompted partial wage loss. See Dillon v. Workmen’s Compensation Appeal Board (Greenwich Collieries), *supra*.

This Honorable Court has declared on numerous occasions that “disability” is synonymous with “loss of earning power”. See Eljer Industries v. Workers’ Compensation Appeal Board (Evans), 707 A.2d 564 (Pa. Cmwlth. 1998); Ginyard v. Workers’ Compensation Appeal Board (City of Philadelphia), 733 A.2d 674, (Pa. Cmwlth. (1999)); Borough of Catawissa v. Frank Schultz, 9 Pa. Cmwlth. 546, 308 A.2d 663 (1973); See also Unora v. Glen Alden Coal Company, 377 Pa. 7, 104 A.2d 104 (1954).

Proper use of the terms “injury” and “disability” necessarily presumes that the drafters of the Pennsylvania Workers’ Compensation Act intended to distinguish between the two, by requiring employers and insurers to take certain action in the context of all “injuries” and certain action only in the context of those “injuries” resulting in a loss of earning power.

The PSIA respectfully submits that the Legislature’s determination not to engage the state workers’ compensation system for work “injuries” not resulting in “disability” was quite pragmatic.

Indeed, the Legislature must have recognized that the sheer number of minor and non-disabling work injuries that occur every Pennsylvania work day would render it impossible for business owners and insurance carriers to administer all claims equally.

#### **Customary Claims Administration of Minor Work Injuries**

A survey of self-insured employers and third-party administrators undertaken by the PSIA reveals that customary claims administration tracks quite well what the drafters of the Act clearly envisioned in the context of medical only cases such as this one.

The claims administrators interviewed by the PSIA report the following state of the medical only claim: (1) most “no lost time” and “modified duty” medical only claims do not

prompt the filing of an *Employer's Report of Occupational Injury or Disease*; (2) most medical only claims warrant either no file reserve or a minimal file reserve – a standard amount of between \$300.00 and \$500.00 is typically set aside; (3) most “no lost time,” “modified work” and “7 days or less of disability” medical only claims do not result in the filing of Notice of Compensation Payable forms but have increasingly resulted in the filing of Notice of Compensation Denial forms, admitting that a work injury occurred, but denying a resulting compensable period of disability; (4) very few claims administrators have chosen to issue the new “Medical Only Notice of Compensation Payable” form issued by the Bureau on March 29, 2004<sup>6</sup>; and (5) most claims administrators do not use the Notice of Compensation Denial form when administering medical only claims and (6) most important, manpower considerations make it impossible to administer medical only claims in the same manner as lost time claims<sup>7</sup>.

Perhaps the most compelling anecdotal information obtained by the PSIA reveals that most Pennsylvania work injuries are not reported to the Bureau.

In its recently published “Annual Report Fiscal Year 2002-2003”, the Bureau of Workers’ Compensation confirmed that only 9.2% of the work injuries reported<sup>8</sup> in the fiscal year of 2002-2003 involved cuts, lacerations and puncture wounds – meaning that the business community is proceeding in the manner the Legislature envisioned – it is not burdening the state system with minor, non-disabling work injuries.

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<sup>6</sup> The new form was not available at the time the Orenich and Brutico claims were filed in 2000 and 2001 respectively.

<sup>7</sup> Interviews with author – Carol Spayd Madigan, Senior Claims Manager, Tower Associates, Ltd.; Cheryl M. LaPotin, Executive Director and Marie E. Wallace, Claims Manager, School District Insurance Consortium; Thomas Crompton, Risk Manager, Thomas Jefferson University Hospital; Patricia Raskauskas, Workers’ Compensation Manager, Pennsylvania Turnpike Commission.

<sup>8</sup> See Pennsylvania Workers’ Compensation and Workplace Safety Annual Report – Fiscal Year 2002/03, Pennsylvania Department of Labor & Industry, Bureau of Workers’ Compensation at p. 45. In fiscal year 2002-03 a total of 98,042 work injuries were reported to the Bureau, meaning that only 9,020 incidents involving cuts, lacerations or punctures were reported. One could reasonably speculate that hundreds to thousands of work-related cuts, lacerations and punctures occur in Pennsylvania every day.

While the PSIA recognizes that Lemansky<sup>9</sup> ostensibly provides support for the result claimant is seeking in this case, it remains mindful that the statutory analysis underlying the ruling seemingly rests upon an interchangeable application of the terms “disability” and “injury.”

“Employer’s argument [that a formal response to a medical only claim is not mandated by the Act] ignores §406.1 of the Act, which provides that an employer shall promptly investigate each injury reported or known to the employer, and shall commence payment of compensation due no later than the twenty-first day after the employer has notice or knowledge of the employee’s **disability**. If an employer believes that the claim is not compensable, it must issue a notice of denial within twenty-one days...Our reading of the Act indicates that indeed Employer does have an affirmative obligation to accept or deny the **injury** as work-related within twenty-one days of notice.” (emphasis supplied).

It is respectfully submitted that the operative text of Section 406.1 does not refer to “injury” but mandates affirmative state notification on the part of the employer or insurer only after the work incident at issue precipitates “disability” or wage loss occasioned by a work injury<sup>10</sup>.

### Regulatory Treatment of Minor Work Injuries

It is important to consider that the Bureau of Workers’ Compensation, pursuant to its administrative responsibility under Section 435(a) of the Act, promulgated Section 121.5 of its

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<sup>9</sup> In affirming its apparent application of Section 406.1 to medical only claims in Waldameer Park, Inc. v. Workers’ Compensation Appeal Board (Morrison), 819 A.2d 164 (Pa. Cmwlth. 2003), this Honorable Court urged workers’ compensation practitioners to administer such claims through the issuance of what it described as “Medical Only Notices of Compensation Payable.” On March 29, 2004 the Bureau of Workers’ Compensation issued a revised Notice of Compensation Payable form which includes a check box permitting the employer or insurer to characterize the alleged work injury as involving a medical only claim. Whether the use of the “Medical Only Notice of Compensation Payable” which arguably represents nothing more than a reconstructed Notice of Compensation Denial form, constitutes a formal acceptance of the claim remains an open question.

<sup>10</sup> It is again respectfully submitted that the use of the word “disability” in the context of Section 406.1 refers to any compensable disability or a disability in excess of seven days under Section 306(e) of the Act and Section 121.5 of the Bureau Rules and Regulations.

Rules and Regulations, which makes clear that the term “disability”<sup>11</sup> is a subset of “injury” under the Act:

“(b) It shall be mandatory that the employer report to the Department all occupational injury and disease **resulting in disability continuing more than the day, shift, or turn in which the employe was injured**. It shall also be mandatory that the employe receive, as soon as practicable, a copy of this report to be completed at least through item 30.

(c) For purposes of reporting injuries, a variance is granted under Section 438 of the act (77 P.S. § 994) to allow submission of the reports as late as 10 days but no sooner than seven days from the date **disability** begins.

(d) The report shall be filed with the Department as follows:

- (1) Within 48 hours for every injury resulting in death.
- (2) Not before seven days but no later than 10 days after the date of disability begins for all other injuries covered by Section 435 of the act (77 P.S. § 991).
- (3) If there **is no disability**, a copy of the report **should not be sent** to the Department.

**(e) Disability for the purposes of reporting to the Bureau shall be defined as loss of time or wages beyond the day, shift, or turn in which the injury was received or the loss of a member, loss of use of a member or disfigurement which may qualify for**

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<sup>11</sup> The PSIA acknowledges that Section 121.7(b) of the Bureau Regulations instructs that Notices of Compensation Payable should be submitted within “21 days from the date employer knew of injuries.” The PSIA notes, however, that Subsections (a) and (d) of the Regulation contemplate the payment of disability benefits, suggesting that the Bureau’s use of the word “injuries” was inadvertent. In addition, Section 121.13 of the Bureau Regulations instructs that in those cases where the employer disputes the injured worker’s claim for “compensation” benefits, a Notice of Compensation Denial must be filed “no later than 21 days after notice or knowledge to the employer of [f] employee’s disability or death.” It is respectfully submitted that the Bureau’s use of “disability” in Section 121.13 of its Regulations confirms its inadvertent use of the word “injuries” in Section 121. 7(b), *supra*. Consistent with such a conclusion is the fact that Section 121.5 of the Bureau Regulations instructs that a formal Report of Occupational Injury or Disease need only be filed with the Bureau where the work injury at issued results in a “disability continuing more than the day, shift, or turn in which the employee was injured.” The notion that the Bureau would not require the filing of a formal Report of Injury but would require the filing of a Notice of Compensation Payable form following the occurrence of a work injury not resulting in disability is simply not logical.

**a specific loss payment under Section 306(c) of the act** (77 P.S. § 513).” (emphasis supplied)

The Bureau’s interpretation of “disability” is not a benign matter of historical fact that carries little or no weight in this judicial proceeding. Quite the contrary, as the Pennsylvania Supreme Court has explained, the interpretation of a statute, advanced by the administrative agency charged with the responsibility of explaining its meaning, cannot and should not be regarded lightly.

Indeed, in the context of a variety of disputes arising out of the interpretation of legislative pronouncements, the Supreme Court has instructed that “the contemporaneous construction of a statute by those charged with its execution and application, especially when it has long prevailed, is entitled to great weight and should not be disregarded or overturned except for cogent reasons, and unless it is clear that such construction is erroneous.”

Commonwealth of Pennsylvania, Pennsylvania Higher Education Assistance Agency, et. al. v. Abington Memorial Hospital, et. al., 478 Pa. 514, \_\_\_, 387 A.2d 440, \_\_\_ (1978) *quoting* Federal Deposit Insurance Corp. v. Board of Finance and Revenue of Commonwealth, 368 Pa. 463, 471, 84 A.2d 495, 499 (1951).

In addressing the meaning of a regulation issued by the Pennsylvania Department of Revenue the Supreme Court observed in Philadelphia Suburban Corporation v. Commonwealth of Pennsylvania, Board of Finance and Revenue, 535 Pa. 298, 635 A.2d 116 (1993) that “in a case such as this, where the subject matter is within the agency’s area of expertise and beyond general judicial competence, we give great weight to the agency’s interpretation.” 535 Pa. at \_\_\_, 635 A.2d at \_\_\_, *citing* Uniontown Area School District, 455 Pa. 52, 78, n26, 313 A.2d 156, 169 n26 (1973); SmithKline Beckman Corp. v. Commonwealth, 85 Pa. Cmwlth. 437, 458, 482 A.2d 1344, 1353 (1984), *affirmed* 508 Pa. 359, 498 A.2d 374 (1985).

The United States Supreme Court has instructed that even where the administrative interpretation at issue has **not** long prevailed – arguably it has in the context of Section 438(b) –

the statutory construction advanced by the agency responsible for explaining and enforcing the legislation at issue, must be afforded substantial deference: “[u]ndoubtedly questions of statutory interpretation, especially when arising in the first instance in judicial proceedings, are for the courts to resolve, giving appropriate weight to the judgment of those whose special duty is to administer the questioned statute.” *Id. quoting National Labor Relations Board v. Hearst Publications, Inc.*, 322 U. S. 111, 130-31, 64 S. Ct. 851, 860, 88 L. Ed. 1170 (1944).

It is respectfully submitted that the Bureau’s distinction between “injury” and “disability” is perfectly in accordance with the plain language of the Act and certainly deserving of judicial deference.

Indeed, the distinction drawn by the Legislature and the agency charged with the responsibility of administering the Act is one that explains quite well the customary manner in which employers and insurers have traditionally administered medical only claims in Pennsylvania.

An example of the practical impact the legislative/administrative distinction between lost time claims and medical only claims has had on workers’ compensation claims handling is provided by the rulemaking process that followed a noteworthy legislative effort made ten years ago to reform the Pennsylvania Act.

On July 2, 1993, when legislation commonly referred to as “Act 44” was signed into law by Acting Governor Mark Singel, the concept of “Medical Cost Containment” was introduced to Pennsylvania workers’ compensation practice.

Two fundamental changes brought about by the “Medical Cost Containment” provisions of Act 44 were Section 306(f.1)(3) of the new law, which imposed for the first time maximum allowances for reimbursement of health care services based upon Medicare Fee Schedules, and Section 306(f.1)(6) which established, for the first time, an administrative

Utilization Review mechanism allowing for prospective, concurrent or retrospective review of the reasonableness and necessity of treatment arising out of the subject work injury.

During the rulemaking process that followed the enactment of Act 44, one issue that caused much interaction between the workers' compensation community and the Bureau was whether the Cost Containment provisions of the new law would apply to those minor work injuries that had not been formally accepted under the Act.

Initially, Section 127.405 of the proposed Regulations instructed that an employer or insurer could only invoke the new Utilization Review regime – and the defending party's attendant right to unilateral supersedeas for the medical bills at issue – where it had already formally accepted liability. Proposed Section 127.405(b) further provided that **“if the insurer is paying for an injured workers' medical treatment at the capped rates...the insurer will be deemed to have admitted liability even if no document admitting liability has been filed with the Bureau.”** (emphasis supplied).

The proposed rule drew criticism from the workers' compensation community, prompting the Bureau, in its Final Rulemaking to permit employers and insurers access to the Cost Containment/Utilization Review without having to formally accept the work injury under the Act.

**§127.405. UR of medical treatment in medical only cases.**

**(a) In medical only cases, where an insurer is paying for an injured workers' medical treatment but has not either filed documents with the Bureau admitting liability for a work-related injury nor has there been a determination to the effect,** the insurer may still seek review of the reasonableness or necessity of the treatment by filing a request for UR. (emphasis supplied).

**(b) If the insurer files a request for UR in a medical only case, then the insurer shall be responsible for paying for the costs of the UR.**

**(c) If the insurer files a request for UR in a medical only case, then the insurer shall be liable to pay for treatment found to be reasonable or necessary by an uncontested UR Determination.**

The Bureau explained its decision to expand the scope of the Cost Containment regime as follows:

**Numerous commentators including attorneys for both claimant's and insurers objected that such an admission was overbroad, and inconsistent with the statute and case law. The Department was persuaded to alter its position, especially in light of commentators who expressed a concern that the proposed regulation might discourage the voluntary payments for medical bills in medical only cases<sup>12</sup>. . . [T]he Department has...attempted to clarify the consequences of an insurer's request for UR in medical only cases. The Department wishes to encourage insurers' use of UR in these cases, finding this alternative preferable to an insurer simply discontinuing payments or medical bills and forcing the injured workers into litigation.** Unfortunately, there have been instances when insurers who lost URs in medical only cases still refused to pay for treatment on the grounds that they had not accepted liability for a work injury. **To prevent this scenario, and to also avoid regulating an admission, the Department's most recent versions completely eliminate reference to admission of liability for a work-related injury or admissions of a causal relationship between the injury and the treatment to be reviewed.** This rulemaking simply states that if an insurer files a request for UR in a medical only case, the insurer will be obligated to pay for the initial UR and will be obligated to pay for the treatment if it loses the UR."<sup>13</sup> (emphasis supplied).

It is respectfully submitted that the final version of Section 127.405 was inspired by the customary approach to workers' compensation claims handling that itself was prompted by the Legislature's distinct treatment of no lost time injuries.

#### **The Convergence of Legislative, Regulatory and Traditional Claims Handling Views of Minor Work Injuries**

In assessing the customary approach to medical only claims handling in Pennsylvania, it is important to consider that the Pennsylvania judiciary – just like the Legislature - has

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<sup>12</sup> See 25 Pennsylvania Bulletin 4873, 4882 (No. 45, November 11, 1995). Among the organizations who submitted comments to the Bureau were the Pennsylvania Trial Lawyers Association and the Pennsylvania AFL-CIO.

<sup>13</sup> Pennsylvania Workers' Compensation Law and Practice, (West/Thomson), §14.112, at p. 238, *quoting* 25 Pennsylvania Bulletin 4873, 4882 (No. 45, November 11, 1995).

traditionally encouraged employers and insurers to voluntarily pay for medical expenses of injured employees, in various factual circumstances, without having to fear the subsequent imposition of penalties arising out of the decision to do so. See Bailey v. Workers' Compensation Appeal Board (Abex Corp.), 717 A.2d 17 (Pa. Cmwlth. 1998) *citing* Bellefonte Area School District v. Workmen's Compensation Appeal Board (Morgan), 156 Pa. Cmwlth. 304, 627 A.2d 250 (Pa. Cmwlth. 1993), *allocatur granted*, Workmen's Compensation Appeal Board (Morgan) v. Bellefonte Area School District, 538 Pa. 618, 645 A.2d 1321 (1994), *affirmed*, Workmen's Compensation Appeal Board (Morgan) v. Bellefonte Area School District, 545 Pa. 70, 680 A.2d 823 (1994); see also Dennis v. E.J. Lavino & Company, 203 Pa. Super. 357, 201 A.2d 276 (Pa. Super. 1964)). Reasoning that penalizing an insurer or an employer for informally paying for medical and hospital costs would discourage the practice of voluntarily payment for treatment incurred by injured workers - that the injured workers themselves would suffer most from an abandonment of the voluntary practice - this Honorable Court has ruled that the mere payment of a medical bill does not constitute a formal acceptance of the work injury as compensable under the Act.

In other words, all of the forces that impact upon workers' compensation administration - the intent of the Pennsylvania Legislature, the interpretation of the Act by the Bureau and the policy considerations traditionally encouraged by the Pennsylvania courts - agree that informal administration of minor work injuries is appropriate because it ultimately inures to the benefit of the injured worker.

### **Claimant's Policy Arguments**

The PSIA is mindful that central to claimant's Appeal is her concern that the manner in which defendant administered her medical only claim "require[d] the unnecessary filing of this Claim Petition." (See Brief of Petitioner, at pp. 13-14).

It is respectfully submitted that the administrative “action” contemplated by claimant will not ameliorate the foregoing concern since it will not relieve the injured worker from having to file a Claim Petition where the parties dispute the nature and extent of the subject work injury.

It will be recalled that in Darrall v. Workers’ Compensation Appeal Board (H.J. Heinz Company), 792 A.2d 706 (Pa. Cmwlth. 2002) this Honorable court ruled, in the context of a “7 days of disability” medical only claim, that an employer or insurer can satisfy Section 406.1 of the Act by issuing a Notice of Compensation Denial form acknowledging the work injury, but denying that the injury resulted in a compensable period of disability, without having to absorb the kind of sanctions sought by claimant in this proceeding – the imposition of penalties or *quantum meruit* counsel fees:

“Employer and Claimant did not agree as to whether compensation was payable and **employer issued a Notice of Compensation Denial Pursuant to Section 401.1** disagreeing as to the length of Claimant’s disability but agreeing to pay medical benefits. Then, Claimant filed a Claim Petition and this case proceeded to litigation before the WCJ pursuant to Section 410. **We fail to see how the Employer acted improperly.**” (emphasis supplied).

This Honorable Court issued a similar ruling in Ginyard v. Workers’ Compensation Appeal Board (City of Philadelphia), 733 A.2d 674 (Pa. Cmwlth. 1999), a case involving a social worker employed by the City of Philadelphia, who suffered injury when a woman she was investigating for possible child abuse struck her in the face with a telephone. After seeking medical attention the day following the work incident, the employee was instructed by her treating physician that she was capable of returning to work on a full-duty basis. On that basis, the employer issued a Notice of Compensation Denial form admitting that a work injury had occurred but denying that it had resulted in a compensable period of disability.

The employee filed a Claim Petition on March 8, 1995, that was eventually granted by the assigned WCJ who, in conjunction with his award of disability benefits for a closed period, awarded the employee counsel fees totaling \$13,400.00 for an unreasonable contest. In affirming the Appeal Board's reversal of the *quantum meruit* award, this Honorable Court sanctioned defendant's use of the Notice of Compensation Denial form that acknowledged claimant's work injury, but still required her to file a Claim Petition in order to recover the additional benefits she was seeking under the Act.

In other words, this Honorable Court has endorsed the notion that a Notice of Compensation Denial form acknowledging the occurrence of a work injury, but denying any subsequent wage loss, does not constitute a formal acceptance of the work injury as compensable under the Act - does not relieve the injured worker from having to file a *de novo* Claim Petition in order to extract formal acceptance of the work injury, but immunizes the employer or insurer against the kind of sanctions claimant is seeking in this case.

In suggesting that the defendant in this case could have avoided the imposition of penalties and *quantum meruit* counsel fees had it simply issued a timely Notice of Compensation Denial form admitting that claimant suffered a work injury on November 29, 2000, but denying that the work injury prompted a compensable period of disability (See Brief of Petitioner, at pp. 7, 11), claimant presumes that once such a document is filed, the injured employee is relieved from having to file a Claim Petition at some later date - that the employer or insurer must "file a petition to stop or refuse payment of medical benefits." (See Brief of Petitioner, at p. 12).

The ruling in Darrall makes clear that such a presumption is not accurate.

Since the Bureau's new "Medical Only Notice of Compensation Payable" form issued on March 29, 2004 is really nothing more than a reconstructed Notice of Compensation Denial form, that acknowledges the work injury at issue, but denies any resulting wage loss, the

employer's use of the new form will presumably have no impact upon cases such as Ginyard or Darrall<sup>14</sup>.

In other words, the mechanical regime that claimant is advancing in this proceeding does not relieve the employee, who has suffered a "medical only" work injury, from having to file a *de novo* Claim Petition where he or she requires additional relief under the Act.

As noted above, claimant further maintains that defendant's failure to take "some action" jeopardized her entitlement to medical benefits because in such instances "if the statute of limitations runs before Claimant has completed treatment, the employer [who has not issued either a Notice of Compensation Payable or Notice of Compensation Denial] is then off the hook for any future payments as a result of the injury. (See Brief of Petitioner, at p. 12).

The PSIA respectfully submits that the presumption underlying claimant's expressed policy concern - that an employer's failure to formally "take some action" creates some unique predicament for the employee who has suffered a minor work injury - though appealing, perhaps, on some visceral level, fails to articulate an actual deficiency.

Rather, it would appear more accurate to observe that the occurrence of a minor work injury that prompts the employer or insurer to make voluntary medical payments on behalf of the injured employee actually enhances the employee's opportunity to seek additional benefits under the Act.

It will be recalled that Section 315 of the Act provides, in pertinent part, as follows:

**"In cases of personal injury all claims for compensation shall be forever barred, unless, within three years after the injury, the parties shall have agreed upon the compensation payable under this article; or unless within three years after the injury, one of the parties shall have filed a petition as provided in article 4 hereof...Where, however, payments of compensation have been made in any case, said limitations shall not take effect until the**

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<sup>14</sup> And, if the courts ultimately rule that an employer's issuance of a "Medical Only Notice of Compensation Payable" form constitutes a full acceptance of the work injury under Section 407 of the Act, there can be little doubt that the form will be abandoned by cautious claims administrators.

**expiration of three years from the time of the making of the most recent payment prior to date of filing such petition;**

Provided, That any payment made under an established plan or policy of insurance for the payment of benefits on account of non-occupational illness or injury and which payment is identified as not being workmen's compensation shall not be considered to be payment in lieu of workmen's compensation, and such payment shall not toll the running of the Statute of Limitations." (emphasis supplied).

Consistent with the foregoing statutory provision, this Honorable Court has ruled that where the employer or insurer does not formally accept a work injury under the Act, but voluntarily covers medical bills incurred by the employee following the occurrence of a work injury, the employee will be protected against any subsequent effort by the employer or insurer to avoid full liability under the Act.

Under such circumstances a tolling the three-year statute of limitations under Section 315 of the Act will result, thereby extending the time during which the employee can file a Claim Petition seeking indemnity benefits or additional medical benefits that his employer refuses to provide. See Scheffler v. Workers' Compensation Appeal Board (Kocher Coal, Inc.), 745 A.2d 697 (2000); Levine v. Workers' Compensation Appeal Board (Newell Corp.), 760 A.2d 1209 (Pa. Cmwlth. 2000); Golley v. Workers' Compensation Appeal Board (AAA Mid-Atlantic, Inc.), 747 A.2d 1253 (2000)<sup>15</sup>.

Accordingly, where, in the context of a "medical only" claim, the employer or insurer does not formally administer the work injury at issue but continues to provide the employee with medical benefits on the basis of an acknowledged work injury, the three-year statute of limitations period set forth in Section 315 of the Act will toll. If at some point, the employer or insurer chooses, for whatever reason, to stop providing medical coverage, the claimant will be

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<sup>15</sup> If, however, the claimant does not treat for three years and does not require additional benefits under the Act during that time period, there would appear to be no reason why the limitations period set forth in Section 315 would not dispose of the claim by operation of law.

afforded the benefit of an extended limitations period to file a Claim Petition seeking whatever relief the defending party has refused to provide.

It is a reality of workers' compensation life that in certain instances, disputes between the employer or insurer and the injured employee will necessarily arise, requiring the employee to file a Claim Petition seeking whatever relief he or she, the employer or insurer refuses to provide.

In other words the scenario presented in this litigation is not particularly unique, but rather involves the kind of dispute that the Legislature envisioned when it drafted Section 315 of the Act.

What the PSIA recognizes quite well, is that when the injured employee feels compelled to file a Claim Petition – similar to what transpired in the Ginyard and Darrall cases – the defending party must be prepared to explain its refusal to provide the benefits requested, since if the presiding WCJ determines that the defending party unreasonably contested the claim, it faces the imposition of *quantum meruit* counsel fees.

The PSIA respectfully submits, however, that any claim for such fees should be assessed by the WCJ on a case-by-case basis.

If the employer fails to prove that its refusal to provide the claimed benefits was reasonable, the WCJ should award *quantum meruit* counsel fees. If the employer proves that its refusal was reasonable, the WCJ should deny the claim for counsel fees.

Such a sanction, should not, however, be imposed automatically, where the employer or insurer administers a minor medical only claim in the informal manner envisioned by the Legislature, the Bureau and the courts.

In both the Orenich and Brutico cases, the informal administration of the medical only claims at issue did not compromise the rights or needs of either claimant. Rather, in each case,

the injured employee filed a Claim Petition in order to expand the nature of the work injury and perhaps to obtain additional benefits from the employer. Because in each case, the employer reasonably contested the claimant's effort, the WCJ properly refused to impose sanctions, either in the form of counsel fees or penalties.

In terms of the substantive dispute between the parties, and the procedural burden placed upon the injured worker, there is no factual distinction between the Orenich and Brutico cases and the Darrall case reviewed above.

The PSIA, therefore, respectfully urges that this Honorable Court advance the policy envisioned by the drafters of the Act by continuing to encourage informal claims administration for minor work injuries and by resisting claimant's effort to establish a mechanical regime that will encourage litigation, discourage voluntary payment of medical bills for injured workers and ultimately compromise the interests of Pennsylvania workers.

**IX. CONCLUSION**

The Pennsylvania Self-Insurers' Association wishes to thank this Honorable Court for considering the views and concerns it has respectfully submitted in this important appellate proceeding. With the goal of advancing the fundamental distinction drawn by the Pennsylvania Legislature between serious work injuries and minor work injuries, the Pennsylvania Self-Insurers' Association respectfully urges this Honorable Court affirm the ruling of the Workers' Compensation Appeal Board below.

Respectfully submitted,

**THE CHARTWELL LAW OFFICES, LLP**

By: \_\_\_\_\_  
Andrew E. Greenberg, Esquire  
Attorney ID No.: 41334  
*Attorneys for Amicus Curiae*  
*Pennsylvania Self-Insurers' Association*

Valley Forge Corporate Center  
2621 Van Buren Avenue  
Norristown, PA 19403  
(610) 666-7700

Dated: October 14, 2004

**CERTIFICATE OF SERVICE**

I, Andrew E. Greenberg, Esquire, do hereby certify that fifteen (15) copies of the Brief for Amicus Curiae, Pennsylvania Self-Insurers' Association in Support of Brief of Respondent, Geisinger Wyoming Valley Medical Center were served upon the Commonwealth Court of Pennsylvania at the address noted below, and that true and correct copies were served on the following on **October 14, 2004**, via first-class U.S. Mail, postage pre-paid, at the following addresses:

Office of the Chief Clerk  
Commonwealth Court of Pennsylvania  
South Office Building, Room 624  
Commonwealth & Walnut Streets  
Harrisburg, PA 17120

John A. Bednarz, Jr., Esquire  
Attorney ID No. 28094  
Suite 405 - 15 Public Square  
Wilkes-Barre, PA 19103  
(570) 821-0480  
*Attorneys for Petitioner, Barbara Orenich*

Kimberly A. Zabroski, Esquire  
Attorney ID No. 70515  
Littler Mendelson  
Dominion Tower  
625 Liberty Avenue, 26<sup>th</sup> Floor  
Pittsburgh, PA 15222-3110  
*Attorney for Respondent, US Airways*

Lawrence R. Chaban, Esquire  
Attorney I.D. No. 32506  
310 Grant Street, Suite 825  
Pittsburgh, PA 15219  
(412) 434-7790  
*Attorney for Amicus Curiae, Pennsylvania Trial Lawyers Association*

Alexander J. Palutis, Esquire  
Marta J. Guhl, Esquire  
Post & Schell  
1600 JFK Boulevard  
Philadelphia, PA 19103  
(215) 587-1101

*Attorneys for Respondent, Geisinger Wyoming Valley Medical Center*

Edward J. Abes, Esquire  
Abes Bauman, P.C.  
810 Penn Street  
Pittsburgh, PA 15222

*Attorney for Petitioner, Beth Brunico*

Thomas J. Kuzma, Esquire  
Deputy Chief Counsel  
Bureau of Workers' Compensation  
Department of Labor & Industry  
1171 South Cameron Street  
Harrisburg, PA 17104-2501

Gerald J. Pappert, Esquire  
Office of the Attorney General  
Strawberry Square, 16<sup>th</sup> Floor  
Harrisburg, PA 17120

*Acting Attorney General for the Commonwealth of Pennsylvania*

THE CHARTWELL LAW OFFICES, LLP

By: \_\_\_\_\_

Andrew E. Greenberg, Esquire  
Attorney ID No. 41334  
*Attorney for Amicus Curiae*  
*Pennsylvania Self-Insurers' Association*

Valley Forge Corporate Center  
2621 Van Buren Avenue  
Norristown, PA 19403  
(610) 666-7700