

ClaimsBytes®

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Thanks for reading this edition of ClaimsBytes®. Please look for our Summer edition for more important claims news.

Sincerely,
The Graham Company Claims Services Department

Spring 2012 Claims Workshop

Mark your calendars! The Graham Company will conduct its Annual Spring Claims Workshop on Thursday, April 19, 2012, from 8:30 AM until 12:00 PM at The Graham Company's Conference Center, The Graham Building - 25th Floor, Philadelphia, PA 19102.

The program is entitled, "You've Been Sued! The Anatomy of a Bodily Injury Case from Accident to Trial". A. Peter Prinsen, Esq., The Graham Company General Counsel and Joseph R. Fowler, Esq., a Post & Schell Principal, will dissect an interesting liability claim that recently went to verdict. The Workshop will educate attendees on the stages of liability claim litigation, including all aspects of the pleadings, discovery, the trial, etc. More details to follow as the date approaches.



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EMERGENCY CLAIMS BYTES

The Graham Company recognizes that emergencies don't just happen during business hours. The Graham Company Claims Services Department stands ready to assist our clients 24 hours a day, 365 days a year. In the event of an emergency claim, please call The Graham Company at (215) 567-6300. If you are calling after hours, you will receive instructions on how to reach The Graham Company's On-Call Emergency Claims Coordinator.

The Graham Company will help you record the vital information concerning the loss and obtain the appropriate experts to help you. These experts could include an insurance adjuster, an attorney, cause and origin expert, restoration specialist, media consultant, and depending upon the severity of the loss, a public adjuster. These experts are important in documenting and controlling the evidence involved in the loss. Subrogation recovery may hinge upon the investigation and immediate attention is critical.

This is a service we hope you will never have to use, but rest assured, we are here to help.

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Winter Auto Bytes

Winter Weather Driving Hazards – Snow and Ice Accumulation

The fast approaching winter weather will undoubtedly challenge our ability to operate motor vehicles in a safe and consistent manner. Amongst the many recommendations that the Department of Transportation provides to motorists is to remove snow and ice from the hood and roof of your vehicle.

Many states now have laws which carry citable offenses if snow or ice from your commercial or private passenger vehicle strikes another vehicle or person and causes death or injury. In addition to avoiding possible costly citations, removal of snow and ice from tops of trailers and vehicles will directly contribute to a safer roadway for everyone by increasing visibility and allowing for more normalized safe and defensive driving protocols to be followed. For large commercial fleets, removal of snow and ice can also account for a significant improvement in fuel economy by reducing the overall weight of the accumulated snow and ice.

Clearing snow and ice off of private passenger vehicles is typically not a major hardship; it really just takes some extra time and possibly some simple snow removal tools to be used before you hit the road. For those that operate commercial motor vehicle fleets, the solution is not as clear cut. How safe is it to ask an operator to climb on the roof of his or her 13-foot high semi-trailer with a broom and shovel, to clear off accumulated snow and ice? The possible slip and fall potential alone during this type of task is tremendously risky. A study prepared by the American Transportation Research Institute (ATRI) identifies a trucking industry action plan which includes short-term, mid-term and long-term proposals to address the snow and ice removal problem.

Short-term controls suggest carrying appropriate equipment during winter months to help remove the snow and ice, and to do so at a safe location, such as a truck stop or rest area. Mid-term controls include the use of fixed or semi-portable snow removal devices such as scrapers, rotating brushes and catwalks where operators use specialized tools to remove snow and ice. Some examples of these fixed solutions can be found at www.durasweeper.com and www.scrapersystems.com. Long-term proposals call for the redesign of trailers to impede the formation of ice sheets and lessen the potential for falling snow and ice.

Awareness of this issue is the first step in moving towards a potential solution that will work for your fleet, so continue to talk to your drivers and operators about best practices and solicit their feedback for implementation of long-term controls. In addition, check your state's Department of Transportation website for more information. Some states also have cell phone call lines, such as call "511" in Pennsylvania, for traffic information, winter road conditions and weather forecasts.

Lastly, we recommend you follow these simple tips:

- Plan ahead and listen to weather forecasts and travel advisories
- Slow down and increase following distances
- Scan ahead and avoid sudden starts and stops

- Roadways that look wet may actually be frozen, AKA, “black ice”
- Do not use cruise control while driving in wet or wintry conditions
- Keep your gas tank at least half full and your vehicle properly serviced

Following these basic winter driving tips can help keep everyone on the roadway safe during inclement winter weather.

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Liability Bytes

NOT SO FAST- Don't give up on *Statutory Employer* and *Borrowed Servant* Defenses in Pennsylvania

The popular wisdom in some circles is that the doctrines of Statutory Employer and Borrowed Servant are no longer viable defenses in the courts of the Commonwealth of Pennsylvania. Recent experiences, however, belie this belief. Even in the Philadelphia Court of Common Pleas, properly supported motions for summary judgment seeking the protection of the defenses are being granted. The key, of course, is the phrase “properly supported.”

What is the Statutory Employer Status?

The Statutory Employer doctrine affords a party other than an injured party's actual employer to the immunity from the imposition of tort damages set forth in the Pennsylvania Worker's Compensation Act (hereinafter “the Act”). A Statutory Employer is entitled to the immunity normally afforded an injured party's actual employer because it is also obligated to the injured worker in the same manner as the actual employer.

The concept of Statutory Employer was initially used to ensure that injured workers would have a source from which they could obtain compensation benefits should the actual employer be unable to pay the required benefits. For the status to attach, the injured party was required to prove that the putative Statutory Employer controlled a property under a contract with the actual owner of the property, retained the actual employer to perform part of the work it had promised to perform for the owner and that the injured party was an *employee* of the actual employer. Once these elements were proven, the Statutory Employer was liable to the injured worker as if it was his actual employer.

Because the language of the Act imposes the *obligations* of the injured party's actual employer upon the Statutory Employer, it also confers the actual employer's *immunity* from tort liability to the Statutory Employer. This is because the Act makes the workers' compensation system the exclusive remedy for an injured employee seeking redress for an on-the-job injury. By placing the statutory employer in the same position as the “contractual” or “common law” employer of the injured worker as to potential tort liability, the Act entitles the statutory employer to the same immunity from suit that would be enjoyed by the “contractual” or “common law” employer.

In 1930, the Pennsylvania Supreme Court set forth what is known as the *McDonald* test to determine whether a party is entitled to the status of Statutory Employer. The court held that the Statutory Employer status will be conferred only if all of the following requirements are met:

1. The employer [party seeking status] is under contract with an owner or one in the position of an owner;
2. The premises must be occupied or under the control of such employer;
3. A subcontract made by such employer;
4. Part of the employer's regular business entrusted to said subcontractor;
5. The injured party is an employee of such subcontractor.

Despite the passage of time, and the efforts of those who wish to limit its reach, in the eighty years since it was established, no additional elements have been added to the *McDonald* test.

So, how does one “properly support” a motion invoking the status? Simply, the lawyer defending the case must know the law and be focused on its potential applicability from day one. This is true because the proper support of a statutory employer motion begins at the time the first defensive pleading is filed. The easiest way to preclude the determination that the status exists is to create a question of fact in one’s own pleadings. Having a plaintiff’s cause of action dismissed at the motion stage is difficult enough without creating the factual conflict which dooms it to failure.

The Borrowed Servant Doctrine - Statutory Employer’s Lesser Known Stepsister

Because the first element of the *McDonald* test requires that the party seeking the status to have a contract with the owner of the property where the injury occurred, an owner cannot be a Statutory Employer. This, however, does not mean that an owner in control of work on its property cannot be subject to the obligations of the Act or enjoy the immunity it provides. To the contrary, owners, under the correct facts, can take advantage of the immunities afforded an actual employer under the Borrowed Servant doctrine.

The test for determining whether an employee furnished by his/her actual employer to another party becomes the employee of the person to whom he is loaned is whether the loaned worker is subject to the latter’s right of control with regard not only to the work to be done, but also to the manner of performing it. Thus, if the party seeking the status controls the manner of the work being performed by the injured party, sets the hours worked, sets forth the assignments given at the site and establishes the rules and regulations of the workplace, he/she meets the definition of a borrowing employer and thus should be immune from tort damages.

If sufficient control over the injured party has been established, the status will be conferred even though the payment of wages, issuance of W-2s, and other administrative issues were performed by a party other than the putative borrowing employer. Other relevant factors courts consider include the right to select and discharge the employee and the skill or expertise required for the performance of the work, but ultimately, control of the worker at the borrowing employer’s facility is the most important factor in the analysis.

Like the cases involving the Statutory Employer status, setting up a motion for summary judgment based on the Borrowed Servant doctrine begins with the defense lawyer’s knowledge of the relevant law. Knowing the law permits counsel to properly respond to pleadings in a manner which will not doom the defense from the beginning. When utilizing defenses of these types, the use of blanket, “standard” pleadings are often a mistake and can doom a potential motion from the beginning of the case.

As with anything else, the devil is in the details. Therefore, early identification of the cases to which these defenses apply is critical. Although not a sure thing, properly supported motions for summary judgment invoking these defenses are being granted.

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Workers' Compensation Bytes

If You Tell Them Not to Do It and They Do It Anyway, Do They Get Workers' Compensation for their Injuries?

A recent Commonwealth Court of PA Opinion, Habib vs. John Roth Paving Pavemasters, 2011 WL 4986079 (Pa. Cmwlth.) found that the violation of a positive work order defense is alive and well in the Commonwealth of Pennsylvania.

The Habib case involved an employee, who while awaiting a delivery of asphalt, found a bowling ball next to the parking lot they were paving. He and others first used the bowling ball as a shot-put and, looking for further excitement, chose to swing at the bowling ball with a sledge hammer to see if anyone could break it. Testimony from the foreman on the job revealed that before striking the bowling ball a second time, the foreman told the worker to "knock it off or stop". After striking the bowling ball a second time, a piece broke off and struck the claimant in the eye, which resulted in the loss of his eye.

The workers' compensation judge initially granted benefits to the injured employee, finding that he was "merely careless" and that the employee did not deviate from his employment during this short interval of leisure during work time.

The Workers' Compensation Appeal Board, on the other hand, disagreed with the workers' compensation judge and found that the employee had in fact violated a positive work order and was not entitled to workers' compensation benefits. In reaching this conclusion, the Workers' Compensation Appeal Board addressed the criteria for establishing this defense. The employer must prove that: 1) the injury was, in fact, caused by the violation of the order or rule; 2) the employee actually knew of the order or rule; and 3) the order or rule implicated an activity not connected with the employee's work duties. The Commonwealth Court agreed with the Workers' Compensation Appeal Board that no benefits should be awarded and simply ran down the elements of the defense and concluded that all of them were met in this case.

One of the critical issues in applying this defense is that ***it will not apply to an activity directly connected with the employee's work duties.*** Hitting a bowling ball with a sledge hammer is so outside of a paving company employee's normal duties, that the court easily concluded that this element of the defense was met. On the other hand, for example, if an employee is told not to lift things over his or her head (assuming that the employee is doing this in the course of performing their job), the defense would very likely not work.

If you have an activity not connected with the employee's work duties which could cause injury, consider a strong directive to the employees to not engage in that activity. Directing this in writing is preferred. Consistent enforcement of violations of that directive will also help greatly.

If employees engage in that unsafe behavior contrary to your directive, it is very likely that their workers' compensation benefits would be denied.

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Workers' Compensation Bytes

Addressing The Social Security Disability And Medicare Concerns In Resolving A Pennsylvania Workers' Compensation Injury Claim

If a worker in Pennsylvania is injured in the course of his/her employment, he/she is entitled to reasonable medical care for the treatment of the work injury as long as necessary and, if disabled from work, he/she may also be entitled to wage loss/indemnity benefits. Following the occurrence of a work injury, a workers' compensation carrier/self-insurer in Pennsylvania establishes indemnity and medical treatment financial reserves based upon statistical data as to the type of injury and wage loss sustained by the injured worker/Claimant. The ultimate goal of a carrier/self-insurer is cost containment, i.e., an end to future wage loss and an end to future medical expenses. Oftentimes, this cost containment goal can be achieved through negotiations and is implemented under a Compromise and Release Agreement as provided for by Section 449 of the PA Workers' Compensation Act, as amended. This article attempts to explore how a seriously injured workers' compensation Claimant's receipt of Social Security Disability benefits and Medicare coverage impacts upon any negotiated resolution implemented by means of a Compromise and Release Agreement, which must be approved by a Workers' Compensation Judge after a hearing.

If a workers' compensation Claimant is seriously injured, his/her attorney must be prepared to address Social Security Disability, as well as Medicare issues that may arise in any workers' compensation resolution. Therefore, it is helpful to review basic concepts to explain how they are interrelated.

Social Security Disability

Initially, it should be noted that workers' compensation disability differs from the criteria used by Social Security:

(a) Workers' compensation disability is synonymous with a loss of earning power which results from a medical condition/injury related to a workers' employment. Davis v. WCAB (USX Corp), 567 A.2d 782 (Pa. Cmwlth. 1989);

(b) Social Security Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last continuous periods of not less than 12 months. See 20 CFR 404.1520 and 20 CFR 416.920 for sequential analysis (for SSD information or to apply 1-800-772-1213).

Once applied for and awarded, a workers' compensation Claimant's SSD benefits may be reduced so that the combined amount of the SSD benefits that a Claimant and his/her family receive plus workers' compensation benefits and/or public disability benefits do not exceed 80% of the average current earnings (ACE). ACE is calculated by either averaging Claimant's five highest gross earning years, or, more commonly, by taking the highest earning year and multiplying the net result by a factor of .8 (80%). The easiest method for determining Claimant's ACE number is to find it in the lower left hand corner of the Claimant's earning statement from the Social Security Administration. Once you

calculate 80% of the ACE number, subtract the monthly SSD benefits, the remaining amount is how much the disabled worker/Claimant can receive in monthly workers' compensation benefits before the offset rule is triggered.¹ Any reduction will last until age 65 (Social Security Retirement conversion) or the month that the workers' compensation benefits stop, whichever comes first.

The practical consequences of a workers' compensation resolution ending future wage loss claims/indemnity benefits is a Win:Win situation for the disabled worker/Claimant. He/she receives a lump sum amount and the monthly SSD benefits will likely increase as well. This is accomplished by prorating the lump sum over the number of months the workers' compensation would have normally been payable had the lump sum not been paid. Therefore, it is recommended that Claimant's life expectancy be utilized for proration purposes by including the appropriate language in the Compromise and Release Agreement. As the lump sum is prorated, the monthly amount subject to the potential offset is reduced thereby most likely increasing the monthly SSD benefit.

It is important to note that the net amount paid to the Claimant is used in the proration language because amounts allocated to current or future medical, legal fees or related expenses incurred are excluded from the offset calculation. This means allocating a sum for the payment of future medical (in consideration of Medicare's interest) in connection with a lump sum compensation resolution will have the favorable effect of reducing the sum prorated over Claimant's life expectancy which is subject to the offset of SSD, thereby likely increasing the amount of the SSD benefit to an injured worker/Claimant.

Medicare and Considering Medicare's Interest in a Workers' Compensation Settlement

The Medicare program was enacted into law in 1965, as a Federal Health Insurance Program designed to provide medical benefits to individuals age 65 or older. In 1972, the program was expanded to provide coverage for individuals under 65 who were awarded Social Security Disability (SSD) benefits. Immediate Medicare coverage is provided for individuals with end stage renal disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS). The Medicare secondary payer statute (MSP) is codified at 42 USC Section 1395Y, et. Seq. In addition, pertinent provisions are contained in subparts (B, C & D) are titled 42 of the code of Federal Regulations (42 C.F.R. Sections 411.20 through 411.50, et.).

The interaction of Medicare has become an increasingly important issue that must be addressed. Essentially, the underlying concept is that it is improper to cost shift the treatment of the work injury from the workers' compensation carrier/self insurer to Medicare. MSP, 42 USC Section 1394Y(b). All parties to such a transaction that improperly cost shifts future medical treatment for a work injury to Medicare are potentially liable, including the disabled worker/Claimant, his/her attorney, the carrier/self-insurer and their attorney.

¹Generally, workers' compensation benefits are not taxable. 26 USC Section 104 (a)(1). However, when the injured worker is receiving workers' compensation benefits and his/her Social Security Disability benefits are offset, then this offset amount (workers' compensation) becomes taxable.

The requisite starting point for any analysis is to determine when the interests of Medicare must be considered. First, if the Claimant is a current Medicare beneficiary either because of age 65 retirement or an SSD award, pre-approval must be obtained from the Center for Medicare Services (CMS) before any workers' compensation resolution is approved by a Workers' Compensation Judge. This creates an important safety net to ensure future medical coverage by Medicare for a Claimant once the Medicare set aside funds are depleted for the treatment of the work injury. It is suggested that the injured worker/Claimant be asked if he/she possesses a red, white and blue Medicare beneficiary card at the start of any negotiations.

After a disabled worker/Claimant receives SSD benefits for 24 months, he/she becomes automatically enrolled for Medicare A and eligible for B coverage. Certain disabilities such as chronic kidney disease requiring regular dialysis or transplant may qualify for Medicare immediately. The SSD decision should be reviewed to ascertain the onset date then count an additional 29 months (5 full months SSD waiting period plus the additional 24 months) to determine Medicare's enrollment date. Because the processing of an SSD application is time consuming and may require a hearing and decision from an Administrative Law Judge, it is important to track the time sequence based upon the alleged onset of disability. As a practice tip to Claimant's counsel, the timing of the SSD application as well as the choice of the disability dates therein and the potential amendment of the disability date are important considerations that may afford much needed flexibility.

Secondly, even if the Claimant is not a Medicare beneficiary, pre-approval must be obtained from CMS if it is reasonably anticipated that the Claimant will become a Medicare beneficiary within 30 months and the total settlement exceeds \$250,000.00. Pre-approval by CMS is not required if the Claimant is currently a Medicare beneficiary but the total settlement amount is less than \$25,000.00. However, the parties are still obligated to consider the interest of Medicare in any resolution. (See advisory memos 4/25/2006 and 5/11/2011). In recognition of the Federal mandate contained in the Medicare Secondary Payer Act (MSP) as of January 2011, the PA Bureau of Worker' Compensation has revised its Compromise and Release Agreement not only to specifically inquire into all benefits received or available to a Claimant including Social Security (Disability or Retirement) and Medicare but also to address the interest of Medicare as follows:

No. 14

- (a) Matter in which Medicare interests have been addressed;
- (b) Amount allocated: \$_____
- (c) Matter in which conditional payments have been addressed;

In order to successfully implement a negotiated resolution by Compromise and Release Agreement reached through an arms length negotiation between the parties, there must be a promise to cooperate and exchange important information in working towards the mutual goal of achieving a Medicare compliant Compromise and Release Agreement.

Conditional Medical Payment Inquiry

Once the attorney has ascertained that his/her client (a Medicare beneficiary) must obtain pre-approval from CMS of their Compromise and Release Agreement which will end or limit the future

medical obligations of the workers' compensation carrier/self insurer, then steps must be undertaken with the joint cooperation of defense counsel which are not only time consuming but filled with pitfalls. First, an attorney must determine if past conditional medical payments have been made by Medicare for the treatment of the work injury that is the subject of the Compromise and Release Agreement.

A conditional payment is a Medicare payment for services where another payer may be responsible. These situations usually arise where the workers' compensation carrier initially denies the injury claim and does not pay for the incurred medical services but later accepts responsibility or conversely the medical provider mistakenly bills Medicare instead of the responsible workers' compensation carrier. It is advisable for an attorney to recommend to his injured worker/client to segregate, if possible, his/her work related medical treatment with specific providers separate from other physicians, such as a family physician who may treat their other non work related ailments. Essentially, Medicare has a statutory right for a conditional payment reimbursement when a settlement or an award is made. 42 USC 1395(y)(b)(2)(b)(ii). Obtaining conditional payment information can be a time consuming process. In general, this process is initiated by notifying the coordination of benefits contractor (COBC) and providing this COBC with identifying information related to the injured worker/Claimant and the injury claim (CMS c/o Coordination of Benefits Contractor, P.O. Box 33847, Detroit, MI 48232; 1-800-999-1118; <http://www.cms.hhs.gov/cobgeneralinformation/>).

Once the COBC is placed on notice it in turn notifies another contractor, the Medicare Secondary Payer Recovery Contractor (MSPRC, WC, P.O. Box 33831, Detroit, MI 48232-3831, 1-866-MSPRC-20) which in turn issues a rights and responsibilities letter to the parties advising of Medicare's reimbursement rights. Within 65 days, a conditional payment letter (CPL) will be issued. Since a conditional payment may continue to accrue, it is often necessary to request updated information. Often times in practice the parties cannot obtain the exact reimbursable conditional payment amount until after the injury claim settles and the Compromise and Release Agreement is sent to the MSPRC which then issues CMS's final demand letter requesting reimbursement within 60 days.²

Notice and Reporting Statute

The tracking of conditional Medicare payments is also monitored by a separate means by CMS. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (42 USC Section 1395(y)(b) (8) This notice and reporting statute directs a workers' compensation carrier/self insurer (also liability and no fault carriers) classified as a responsible reporting entity (RREs) to determine when an injury claim involving a Medicare beneficiary needs to be reported to CMS via an Internet reporting system. There are two reporting triggers referred to as total payment obligations to the Claimant (TPOC) and/or ongoing responsibility for medicals (ORM). Essentially, reporting is triggered when an RRE either accepts responsibility for medical payments, or settles or concludes a disputed claim such that there is an award involving a Claimant entitled to Medicare. When a trigger is met, the RRE must report the claim electronically to Medicare and submit certain required claim data information. This is

²On June 27, 2011 CMS has issued a new revised conditional payment final demand letters presumably in response to the recent case of Haro v. Sebelius, No. CV 09-134, TCU DCV, 2011 WL 2046219 (D.Ariz., May 9, 2011).

a road map to track and monitor the settlement and awards to a Medicare eligible Claimant. CMS has released its mandatory insurer reporting (MIR) guidelines to implement Section 111 Notice and Reporting mandates. The clear threat of a civil penalty of \$1,000.00 for each day of non-compliance has heightened the insurance industry's awareness to scrutinize their work injury claims and to ensure that all Compromise and Release Agreements must be Medicare compliant.³

Medicare Set Aside Arrangement Proposal

In addition to addressing the conditional medical payments made by Medicare that may be reimbursable at the time of a Compromise and Release Agreement the parties through joint cooperation must submit a proposed workers' compensation Medicare set aside arrangement (MSA) to CMS for review and pre-approval. This MSA is a mechanism for recognizing Medicare's interest with respect to anticipated future Medicare covered expenses. All Medicare set aside arrangements proposals must be submitted for review and sent to CMS c/o Coordination of Benefits Contractor, P.O. Box 33849, Detroit, MI 48232-5849, Attention: WCMSA Proposal. The COBC's contractor's recommendation is then transmitted to CMS which pre-approves the requisite set aside amount. It is important to understand the purpose of the Medicare set aside amount (MSA) is to require sufficient funds be available for the payment of those future medical expenses (possibly for an injured worker/Claimant's lifetime) that would otherwise be covered by Medicare. Once such a fund is depleted, the safety net of Medicare becomes available to the Claimant who can look to Medicare to pay future work injury treatment. CMS ultimately decides what sum is adequate for the MSA. This includes deciding what medical conditions are causally related to the injury claim unless there is a judicial decision on the subject. (CMS policy memo, April 22, 2003, question 5). The creation and submission of a proposed MSA can be a daunting task especially in a litigated case where the outcome is uncertain and which may reduce or possibly end a Claimant's workers' compensation entitlement for wage loss and future medicals. It is important to realize that CMS relies heavily upon the opinions of the treating physician regardless of qualifications. Therefore, as a practice tip it is helpful for Claimant's counsel to obtain a medical note from the treating physician providing a prognosis and commenting on the need for future medical care as part of any submission of a proposed MSA. The approval by CMS provides a safe harbor for all parties who will not be subject to further claims for non compliance. Common medical treatment covered by Medicare includes: doctors visits; diagnostic tests; steroid injections; hospitalization; surgeries; morphine pumps; tens unit; physical therapy and prescription drugs. Common medical services not currently covered by Medicare includes: dentures; glasses; hearing aides; travel to medical appointments; custodial care; alternative medicine (i.e. acupuncture, aqua therapy, biofeedback, etc.).

Once approval from CMS is obtained in writing (often used as an exhibit and attached to a C & R Agreement) the parties can proceed to a hearing before a workers' compensation Judge for approval of a Compromise and Release Agreement that specifies a Medicare set aside arrangement and ends future medical treatment of a work injury. Often times a Compromise and Release Agreement will provide for the injured worker/Claimant to self administer the Medicare set aside funds. Written guidelines for the self administration of an approved MSA is contained in CMS's approval letter.

³Many insurers, TPA's and self insurers are in fact utilizing the software/services of vendors who typically perform Medicare set aside analysis and obtain pre-approvals from CMS of worker's compensation settlements.

Essentially, Claimant may utilize a poor man's trust by establishing a separate interest earning checking account from which he/she will pay only for those work injuries/Medicare covered medical bills.

Current and Future Trends

Because of the increasing complexity and delays in obtaining CMS's pre-approval for a workers' compensation resolution to be implemented with a Compromise and Release where the injured worker/Claimant is also a Medicare beneficiary, it is anticipated the carrier/self insurer's wishing to ensure the certainty of the transaction will more and more insist on undertaking the Medicare set aside approval process with the consent of the injured worker/Claimant. A number of vendor/organizations are actively marketing such services to the insurance industry as well as to Claimant's attorneys. Naturally, if the carrier/self insurer insist on handling the Medicare set aside pre-approval process then it is advisable that Claimant's counsel request this written analysis before agreeing to the Compromise and Release of future medical treatment. To do otherwise is to risk disappointing your client/Claimant who may envision a significant amount of the C & R settlement going into his/her pocket, only to become dissatisfied upon learning of the strings attached by a Medicare set aside proposal. Often times during active negotiations the parties will find themselves conducting an arms length negotiation where a Claimant's attorney will endeavor to inflate the value of the claim with the prospect of future medical costs only to in turn seek to cooperate in obtaining pre-approval of a proposed MSA that is both reasonable and defensible but at a lower amount. Over funding by CMS of MSAs remains a legitimate concern. For instance, CMS will likely require an MSA allocation for future surgery if surgery is mentioned in the treating physicians records, even if the injured worker/Claimant does not desire such an operation. CMS focuses its review on medical records for the last two years of treatment before the submission date of the MSA and on the cost of the treatment in that interval in making its approval decisions.

This has lead to two divergent trends, two step shuffle and the one and done approaches to Compromise and Release Agreements. First, the developing trend is to negotiate a two step compromise and release process with the first compromise and release agreement ending the wage loss indemnity benefits with the Claimant, who then receives the bulk of the settlement, while the second compromise and release is held in abeyance pending CMS pre-approval. Once again, timing is important since the curative effect of a large sum of money paid at the time of the indemnity benefit Compromise and Release Agreement may reduce the frequency of future medical treatment since the prospect of litigation has ended. By delaying the attempt to end the future medical treatment for such an injured worker/Claimant, the carrier may ultimately benefit by approaching the Claimant for a second Compromise and Release of its future medical obligations, several years later when a pattern of less frequent treatment can be used as a basis to seek a lower proposed MSA. It is important for both parties to retain sufficient funds for the second Compromise and Release Agreement to offset the escalating CMS set aside amount. To avoid future misunderstandings it is important that the parties, as part of their negotiations, predetermine what occurs in the event that the CMS Medicare set aside amounts is higher than anticipated. It may also be possible that the workers' compensation carrier/self insurer will agree to cover any additional funds required by CMS for its medicare set aside amount.

The second approach of one and done involves a single full Compromise and Release Agreement with contingency language designed to provide greater flexibility in the future. This one and done approach involves a Compromise and Release Agreement in which the indemnity/wage loss portion of the injury claim is resolved by a specific amount and in the same document the Claimant agrees to compromise and release future medical based on contingencies. Additional language is provided so that all the parties to the Compromise and Release Agreement acknowledge that in cases where CMS approved MSA allocation is significantly higher than the allocation recommended by an MSA vendor, the carrier may have the right to negotiate with CMS on the final allocation amount before the medical portion becomes final or in the alternative, the carrier has the sole elective right to rescind the medical portion of the Compromise and Release since the CMS approved allocation amount was significantly higher than what the parties had contemplated, while acknowledging the carrier's responsibility to continue to pay for causally related medical treatment for the injured worker/Claimant's work injury. In the latter event, the interest of Medicare would be protected since the resolution of the indemnity/wage loss injury claim has the legal effect of keeping the medical portion of the injury claim left open. The attempt to resolve the future medical portion of the injury claim can be revisited at some future time. If so, it is important to also include language that both parties retain their respective rights under the PA Workers' Compensation Act so as not to preclude the filing of a Termination Petition or seeking to attain cost containment through Utilization Review challenges. It is advisable that at the time of the Compromise and Release hearing that a record be made establishing Claimant's knowledge and understanding and ultimate agreement to these possible scenarios.

This area of law remains a fast evolving and challenging one with periodic advisory memos and updates from CMS that has placed the workers' compensation practitioner in the vanguard of implementing complex settlements now that CMS has actively sought to protect Medicare's interest in liability cases and no fault motor vehicle accident claims.

Remember, you must always consider the interests of the Center for Medicare Services in any negotiated workers' compensation resolution implemented by Compromise and Release in Pennsylvania.

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Workers' Compensation Bytes

Paying Partial Disability? Don't Pay Too Much!

There is a silver lining in the economy's dark cloud

There is a useful tool in the world of Pennsylvania Workers' Compensation defense that is not known very well. It can help employers limit the amount of partial disability benefits they have to pay to injured workers who have returned to work with a loss of earnings. Particularly in this weak economy, the tool that is known as the "fellow worker rule" is more available than otherwise. The rule is that an injured worker (a claimant) is not allowed to receive more in wages and benefits combined than what his fellow workers receive in wages alone. *Section 306(b)(1) of the Pennsylvania Workers' Compensation Act, 77 P.S. 512(1).*

At White and Williams, we recently litigated a case using this rule and obtained a Judge's decision that granted the Employer a complete suspension of wage loss benefits. The Employer is an electronics manufacturer who no longer has to pay partial disability benefits to a mechanical inspector who returned to work with a loss of earnings because he was limited by his work injury from performing overtime. We established that the other mechanical inspectors were also not performing overtime because it was no longer available given the existing economic circumstances. With that set of facts, the Judge concluded that the mechanical inspector's loss of earnings was not due to his work injury, and therefore partial disability benefits were not payable.

There are some key elements that need to be met in order to have the "fellow worker rule" apply, and these are set forth in the Commonwealth Court's decision in *Verizon v. WCAB (Baun)*, 863 A.2d 1247 (Pa. Cmwlth. 2004). In *Verizon*, the claimant had a low back injury, went out from work, and returned to work at his pre-injury position as a splicing technician. However, he was not allowed to climb poles or work overtime because of his work injury, according to his physicians. When he returned to work, he had a loss of earnings in comparison to his pre-injury average weekly wage.

The employer in the *Verizon* decision was not able to convince the Workers' Compensation Judge, the Appeal Board, or the Court that it was entitled to an application of the fellow worker rule. The Court set forth four elements that are essential to an application of the rule.

In our case, we were able to meet all four elements by presenting testimony from the Claimant's supervisor, the payroll supervisor, and the human resource manager. The four elements needed to reduce benefits with the rule are as follows:

"Similar Employment at Time of Injury"

In *Verizon*, the Judge had incorrectly looked at the claimant's job when he returned to work with his restrictions, which included the inability to work overtime or to climb poles. The Court held that this was not the proper basis to define the class of workers for comparison. Instead, the other workers needed to be comparable to the Claimant's position *at the time of his work injury*, which was a splicing technician, working regular duty and able to work overtime.

In our case, we provided a class of fellow workers who were all mechanical inspectors on the injury date in 2003, with the ability to work overtime.

“Similar Employment-Comparison of Individuals or Averages”

In *Verizon*, the employer had presented the averages of fellow workers’ earnings, rather than the individual earnings for each worker. The Court held that averages or individual earnings will depend on the number of fellow workers that are available for comparison, and what the Judge considers to be persuasive enough.

In our case, we provided the individual earnings of the fellow workers and the averages already calculated for the Judge’s comparison.

“Comparison-Economic Distress”

In *Verizon*, it was undisputed that overtime was less available after the claimant’s injury. However, the Workers’ Compensation Judge and the Board had erred in concluding that it was necessary for the lack of overtime to result from economic distress. The Court held that economic circumstances were not a necessary element. It just needs to be established that there are wage reductions among other workers for any reason.

In our case, we showed that the loss of overtime for workers was the result of economic circumstances, even though we were not required to do so. It is generally helpful to show the Judge the reason for the reduction in earnings, and it supports another basis for a suspension if the claimant has returned to his pre-injury, regular duty job.

“Comparison-Current Compensation and Wages Combined”

In *Verizon*, the Court held that the employer failed to compare the correct class of workers, so this last element about their wages was not addressed. The rule requires that the current wages of the claimant, combined with his partial disability benefits, be compared with the current wages of the fellow workers.

In our case, we presented the details of the Claimant’s partial disability benefits combined with his earnings at the time he returned to work in 2010. We compared those figures to the 2010 earnings of his fellow workers (with figures for each individual and with the averages, on a weekly basis). We demonstrated that the Claimant was receiving an unfair windfall compared to his fellow workers.

In summary, our advice to Employers is to NOT let your injured workers receive any windfalls. Keep an eye on their earnings and partial disability benefits combined, in comparison with their fellow workers. There may be an opportunity to limit the benefits paid. This not only avoids an unnecessary expense, but it applies common sense and fairness for the Employer's work force as a whole.

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This alert should not be construed as legal advice or legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult a lawyer concerning your own situation with any specific legal question you may have.



Risk Management Bytes

Developing and Maintaining a Strong Partnership with Your Claims Management Team

Developing and maintaining a strong business relationship with your claims management team is critical to the success of your claims management program. By clearly identifying the roles and responsibilities of all team members, you will avoid miscommunication among the team members, which often can lead to poor claims results. Our professional Claims Consultants work hard to assist you in developing and maintaining a strong business partnership with your claims management team by learning and understanding your business, clearly identifying the roles and responsibilities of all team members and custom tailoring a claims management program to meet your unique claims servicing needs.

Some basic key activities with your Claims Management Team should include:

Develop and Implement Special Claims Handling Procedures. Special Claims Handling Procedures are the agreed upon service commitments that serve as the roadmap for your Insurance Carrier or Third Party Administrator to follow when communicating relevant claims information. Some of the more notable provisions included in the Special Claims Handling Procedures are establishing the team members and developing key contact information, defining dollar thresholds and contact procedures prior to settling claims, setting guidelines for establishing and changing reserves, and outlining the frequency of Claims Review Meetings and loss run distribution.

Conduct a Claims Kick-Off Meeting. Your Claims Kick-Off Meeting is the first official meeting to start or “kick-off” your claims management program and serves as your introductory meeting for the entire Claims Management Team. At this meeting, you will review your unique claims reporting procedures and confirm the agreed upon Special Claims Handling Procedures. This meeting provides an exceptional opportunity for the entire claims management team to meet and describe their role in the claims management process to ensure you are maximizing your resources and tapping into everyone’s valuable experience. Most importantly, this is a great opportunity for you to educate the claims management team about your business and establish your expectations.

Establish Emergency Claims Procedures. Don’t wait for a claims emergency to occur after hours to establish a plan for responding to claims emergencies. In the event of a claims emergency, The Graham Company is available 24 hours a day, seven days a week. Simply call our main number at (215) 567-6300.

Conduct Regularly Scheduled Claims Services Review Meetings. You should meet periodically with the entire Claims Management Team to review the amounts paid and reserved, discuss the current status, and more importantly, develop a future strategy and action plan to bring claims to a cost-effective and quick resolution.

Provide Prompt Praise and Constructive Feedback. When your Insurance Carrier or Third Party Administrator is doing a great job, it is important to let them know! Conversely, it is important to provide prompt constructive feedback if your expectations are not being met. Open communication ensures that everyone is continually focused on raising the bar to exceed your claims servicing expectations.

There are significant claims dollars at stake. You can make a positive impact on your bottom line by taking a few key actions to develop and maintain a strong business relationship with your claims management team.

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Bedbugs Bytes

Pulling Back the Sheets on Bedbugs: Not Just a Hospitality Issue

Bedbugs have aroused more attention – and proven more insidious and challenging – than any other urban pest in 2011.

The New York City Department of Housing reports an increase from 536 to 12,768 cases in 2004-2010. Five out of nine New Jersey housing authorities reported an increase in bedbug infestation since 2008. Alarmingly, bedbugs are appearing more frequently in nursing homes, offices, schools, theatres, stores, dormitories, thrift stores, and other public places.

The greatest challenge in Bedbug control is detection. Bedbugs are difficult to find; they often hide in inaccessible areas. An effective bedbug monitor is badly needed. Unfortunately, the pest industry's bedbug monitoring tools have not advanced as rapidly as lawsuits surrounding bedbugs.

The best protection against costly lawsuits is a comprehensive program in conjunction with your pest control company. This program must be sensitive to the needs of the consumer as well as employees, since lawsuits can arise from either.

Bedbugs are primarily nocturnal insects and feed exclusively on human blood. This food source, or host, is required in order to develop and reproduce. Bedbugs lead a cryptic life style. As a result, bedbugs are often present for weeks, even months, before a single bug is ever seen. They live in the cracks and crevices of bed frames, mattresses and box springs. They will also disperse away from the bed and live between and beneath floor boards, carpeting, decorative molding, picture frames, inside wall voids, even inside a smoke detector. There is virtually no crack too small for this insect to occupy.

When conditions are right and there is a host, the bedbugs will emerge and feed. Bites are typically painless and often go undetected. Once fed, the bedbug returns to its hidden resting place. In the absence of a host, bedbugs will continue to survive for many months without a meal. There are some extreme cases in which a bedbug can survive up to 18 months between meals.

A nymph, or early stages of bedbugs, can be the size of the letter on a penny; even adults are thinner than a business card. This makes detection difficult.

A female will lay 3-5 eggs daily with a 7-10 day hatching period. A low infestation can become a severe infestation shortly.

The epidemic of bedbugs has recently resurged in cities throughout the United States. Although no residence is safe, certain areas are particularly prone to bedbug infestation. A troubling high number of bedbug infestations have been reported in nursing homes and other facilities throughout the country. Because bedbugs are natural hitchhikers, the infestation can easily spread to employees' homes and beyond.

Bedbugs do not carry disease; however, they become a harbor for other injuries. Dr. Michael Potter, an expert in this field, advises that one is just a scratch away from an infection when dealing with bedbugs. Emotional distresses, significant discarding of property, loss of sleep, impaired responses to home/school/work are all common reactions to an infestation. Experts in the field have diagnosed victims with acute stress disorder, post-traumatic stress disorder, and entomophobia (fear of insects), to name just a few. There have also been rare cases where individuals suffer from Wells Syndrome and other allergic reactions from insect bites that would cause severe reaction.

Despite the still-to-be-proven method of detection, lawsuits are springing up. Many attorneys now focus on class action lawsuits where apartment buildings and nursing home residents are involved. These class action lawsuits will likely become more common as industry standards are developed.¹

Many methods are used to increase overall damages beyond compensatory and injuries. New Jersey and other states have a liberal Consumer Fraud Statute that allows for compensatory damages to be tripled if there is a violation. New Jersey also provides for payment of the suing attorneys' fees and costs for evaluation.

Additionally, as we learn from the seminal cases involving bedbugs, punitive damages are a significant component. Specifically, if it is proven that a facility knew of a bedbug infestation and it did nothing to eradicate and/or attempted to hide the issue from the tenants/customers, punitive damages have been granted providing not only compensation to the injured party, but a monetary value to punish the facility.

In addition to the large monetary awards, punitive damages and/or fraud and/or consumer fraud are generally not covered by liability insurance policies, exposing the facility to significant out of pocket awards.

Once a lawsuit is filed, the media coverage can truly create irreparable damage to a company's reputation.

The epidemic is expected to continue to spread. A proactive approach is essential for a facility to protect itself from the dangers and costs associated with bedbugs and lawsuits.

There are many good products on the market today to assist, including mattress encasements, anti-bedbug laundry bags, and interceptors. However, a plan should be developed with a professional pest control company for several reasons: to help avoid those products that claim to be bedbug resistant when they are not; to formulate an effective plan; and to serve as the primary defense in a lawsuit that all actions were taken in anticipation of the infestation and for the protection of the residence. Additionally, protocols need to be in place once bedbug detection is made. Much like the H1N1 protocols that have been in place, both the residents, employees, and those originating the infestation must all be protected.

¹As of this date, the only country that has developed a bedbug industry standard is Australia. England is close behind in formulating its standard for bedbug best practices. There has been no such effort initiated here in the United States.

It is doubtful that this epidemic will be alleviated in the next five (5) years. While it is hoped that detection methods will improve, there is no silver bullet expected on the horizon. As such, in order to protect both the residents of your facility, as well as your bottom line, working in conjunction with your pest control providers, as well as legal and insurance representatives, may help take a bite out of this pest.

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