Kupchinsky, John

From: Larry Chaban [lchaban@rjslegal.com]
Sent: Monday, August 08, 2005 2:54 PM
To: jkupchinsk@state.pa.us
Subject: Chapter 121 Regulations - Comments

Dear Director Kupchinsky:

On behalf of the Pennsylvania Trial Lawyers Association I am submitting Comments on the proposed rulemaking for 34 Pa. Code Chapter 121 that were published in the July 9, 2005 Pennsylvania Bulletin. These are attached to the email. I will also be sending a copy of the comments by first class mail today.

Lawrence R. Chaban, Esquire

Chair, Workers' Compesnation Section

Pennsylvania Trial Lawyers Association

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COMMENTS REGARDING PROPOSED REGULATIONS FOR TITLE 34 PA CODE CHAPTER 121 ON BEHALF OF THE WORKERS' COMPENSATION SECTION OF THE PENNSLYVANIA TRIAL LAWYERS ASSOCIATION

34 Pa. Code §123.3(d): The regulation addresses the filing date when mail is used. However, it does not specify the filing date when electronic means are used. While common sense should tell one that filing is complete upon electronic transmission, it should be made clear in the regulation that this is so. Otherwise, it can potentially lead to arguments over when a form is actually filed electronically.

The current electronic forms have an option to print confirmation upon submission. Other than that, the public does not know how the electronic submissions are logged at the Bureau. To prevent unwanted litigation, this should be made clear in the regulations with regard to electronic filing.

34 Pa. Code §123.3b(b)(3): It remains a significant problem that employers or their representatives are selecting health care providers for injured employees, whether there is a panel or not. This was recognized as a problem in the Fall 2004 Bureau of Workers' Compensation newsletter. Injured workers are not adequately informed of their rights with regard to the selection of the health care provider. Injured workers, therefore, do not realize the employer is violating the WC Act when the employer selects the provider. As the Department is mandating adequate notice to injured workers of rights with regard to panel providers this protection should be included.

This section should include the following statement, "The injured worker, and not the employer, is the only one permitted to select the health care provider with which to treat."

34 Pa. Code §121.5(c): This proposed regulation should be eliminated. There is no statutory or regulatory authority to allow a Notice of Compensation to be amended, except as provided by 34 Pa. Code §121.7(d) and (e), or by Supplemental Agreement (Form LIBC-377). The Employer should have no greater right to amend a Notice of Temporary Compensation Payable (NTCP) than it does a Notice of Compensation Payable.

An NTCP is a document that is unilaterally issued by the employer, insurance carrier or TPA. The injured worker has no input regarding the information included in it. Allowing the amending of a NTCP will permit significant, unilateral changes in the terms of the form. This is particularly true where the amendment would relate to the "Description of Injury." As the WC Act and regulations now stand, only a Supplemental Agreement or petition to a workers' compensation judge is the allowable method to amend an NCP or NTCP.

There was no statement in the "Purpose" section of the proposed regulations with regard to the reason for the substantial expansion of the rights of an employer,

carrier or TPA to unilaterally amend the NTCP. It is not possible, therefore, to comment directly on the reasons for this beyond what was stated above.

34 Pa. Code §121.7(f): The regulation on medical only cases should be mandatory and not merely optional. The word "may" should be changed to "shall."

Commonwealth Court has made clear that in medical only cases an NCP is required. *Orenich v. Workers' Compensation Appeal Board (Geisinger Wyoming Valley Medical Center)*, 863 A.2d 165, 168 (Pa. Cmwlth. 2004). The court showed that there are an extremely important reasons for this requirement.

> Under the usual practice of workers' compensation when an employee is injured, the employer issues an NCP to identify the nature of the injury and specify the amount of money being paid to the employee. It also places the burden of proof on the proper party who wishes to make a challenge to either the medical bills or the compensation being paid. Regarding the medical bills, based on that NCP, the employer is able to question medical bills for treatment that it believes is not reasonable nor necessary. It may do so by requesting a utilization review of the medical bills, which it would not be able to do without the NCP, as there would be no record of any injury to question. As to compensation being paid, the NCP is also important where the employer decides that it wants to terminate paying the employee's medical bills or benefits. In such a case, the burden is properly on the employer to prove that the medical bills or benefits are no longer warranted rather than on the injured employee who would otherwise have to prove they were to be continued if the NCP did not exist. In the converse situation, the burden would be on the employee, by filing a claim petition, who believes that he or she is entitled to compensation because the injury has resolved into a disability causing loss of earning power or to add additional injuries to the NCP, which the employer disputes. Having an NCP acknowledging the injury fixes the nature of the injury for both the employer and the claimant, allows for utilization review of treatment, and keeps the burden of proof on the proper party to prove what otherwise would not be possible without an NCP.

Orenich, 863 A.2d at 169-170. By making the medical only NCP optional, the Department is taking a position contrary to the settled case law in this area. PaTLA believes that only the General Assembly can make such a significant change in the interpretation of the statute. The Department does not, even under Section 435 of the WC Act, have the ability to make such a significant change in what the WC Act requires.

Further, PaTLA believes that making the medical only NCP optional will continue to encourage employers, carriers and TPAs to use what are called "medical only Notice of Compensation Denial." Use of such forms, where medical is paid, is contrary to the

precedent of Commonwealth Court. As noted above in *Orenich*, use of an NCD misplaces the burden of proof in compensation cases where compensation, by way of medical benefits, has been paid. PaTLA believes that the regulations should not encourage employers, carriers and TPAs to act contrary to the law as stated by Commonwealth Court.

34 Pa. Code §121.17: In our initial proposal, we recommended that a termination not be permitted by using a Supplemental Agreement, Form LIBC-337. The reason for this is that Form LIBC-377 does not have the express warnings that an Agreement to Stop Weekly Workers' Compensation Payments (Final Receipt), Form LIBC-340, does.

The Final Receipt lets the injured worker know that the agreement means the worker is fully recovered. The Final Receipt also tells the worker that it should not be signed if he or she has returned to work earning less or the employer is holding the final check for signature.

Form LIBC-337 contains no such warnings. The employer, compensation carrier or TPA is the sophisticated party in such situations having training and/or advice on the procedures under the WC Act. The unrepresented, injured worker does not have the legal sophistication to be aware of the significance of signing a Supplemental Agreement with termination language. The warnings on Form LIBC-340 have no effect if Form LICB-337 is allowed to be used for a termination (final receipt).

Form LIBC-340 also contains a warning about having three (3) years to reopen the claim from the date of last payment. Form LIBC-337 contains no such warning. Significantly, where Form LIBC-337 is used for suspension or modification, the injured worker will have up to 500 weeks to reopen a claim, the period of partial disability. The unrepresented, injured worker will not be aware of the significant difference between a suspension verses final receipt where Form LIBC-337 is allowed to be used for a termination.

The workers' compensation statute is remedial and to be applied in the manner most favorable to the injured employee. *Sporio v. Workmen's Compensation Appeal Bd. (Songer Const.)*, 717 A.2d 525 (Pa. 1998). Allowing the use of Form LIBC-337 in place of Form LIBC-340 is contrary to that principle. Subsection (b) should make it clear that Form LIBC-337 cannot be used in place of Form LIBC-340 where the employer or carrier is seeking a final receipt/termination.

ORIGINAL: #2484

-----Original Message-----
From: Cicola, David
Sent: Wednesday, May 17, 2006 10:50 AM
To: Kupchinsky, John
Subject: Proposed Bureau Reg 121.25

Kindly allow me to comment on the following proposed regulation:

Section 121.25(b)(1) of the Proposed Regulations amending Chpt. 121. This section states in pertinent part that:

(b) The claimant's compensation checks shall be mailed by first-class mail to the claimant's last known address, unless the claimant has authorized another method of delivery on a form to be prescribed by the Bureau. In no event shall a claimant or his representative be required to appear at a specific place designated by the employer or insurer in order to receive his compensation payments.] Compensation payments shall be issued according to the following:

(1) Unless the claimant and the employer have executed an Authorization for Alternative Delivery of Compensation Payments, Form LIBC-10, or a court orders payment, a claimant's payment for workers' compensation or occupational disease compensation may not be made payable to, or delivered to, an attorney unless the attorney is the administrator or executor of the claimant's estate, a court-appointed trustee, a court-appointed guardian or acting in some other fiduciary capacity.

I recommend that subparagraph (b)(1) be amended to read as follows:

(1) Unless the claimant and the employer have executed an Authorization for Alternative Delivery of Compensation Payments, Form LIBC-10, or a Workers' Compensation Judge, the Workers' Compensation Appeal Board or a court orders payment, a claimant's payment for workers' compensation or occupational disease compensation may not be made payable to, or delivered to, an attorney unless the attorney is the administrator or executor of the claimant's estate, a court-appointed trustee, a court-appointed guardian or acting in some other fiduciary capacity.

The word "court" in the proposed regulation does not clearly encompass the compensation authorities. I have encountered requests for alternative delivery in connection with Compromise and Release Agreements. These agreements are frequently time-sensitive. If WCJs did not have clear authority to authorize alternative delivery, the parties would be inconvenienced and settlements delayed as they obtain orders from the judicial system. The LIBC-10 is an imperfect alternative, as parties sometimes neglect such details (again delaying hearings or decisions) and the WCJ factinding process reduces the odds of misunderstanding among parties and counsel.

The WCAB should have the same authority. The Board might have occasion to order alternative delivery in a remand/reversal order. Also, since it retains the authority to hear commutations, the Board requires the power to order alternative payment in connection with them.

Thank you for considering my views.

David A. Cicola
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Original: 2484

Kupchinsky, John

From: Seelig, Todd
Sent: Friday, August 05, 2005 5:12 PM
To: Kupchinsky, John; Wunsch, Eileen
Cc: Cicola, David
Subject: Comments of Proposed Rulemaking, Chapter 123 and 121

Dear John and Eileen:

As you may know, the Pennsylvania Workers' Compensation Judges have an Association known as the Pennsylvania Workers' Compensation Judges' Association (PWCJPA). A majority of the approximate 90 WCJs are members. We have polled our members to see if there were any comments on these regulations. Pursuant to the Pennsylvania Bulletin, I am submitting written comments to the proposed regulations.

34 Pa. Code 123:

Proposed Regulation 123.203. This proposed regulation received the most comments from our members. Several judges were concerned whether there was statutory authority to support the Regulation, specifically 123.203(c).

Proposed Regulation 123.204(a). There was a comment expressed that the regulation did not specify "when" the disclosure must be made to allow the WCJ to determine if the regulation has been complied with. Perhaps Proposed regulation 123.204(a) should begin with the word, "Before", as does 123.205(b).

Proposed Regulation 123.204(b). There was a comment that this section should also contain a provision as to when a copy of the report must be sent to the employee. At this point, the Rules of Administrative Practice and Procedure before WCJs would seem to be the only source for this information which apply after litigation has already started. The WCJ Rules require disclosure at the first hearing in a litigated modification or suspension petition. The Commonwealth Court has seemed concerned with when the Claimant receives this information to allow Claimant to actually "follow up" on the job. Perhaps a regulation would be useful to the WCJs and Appellate Courts on this issue.

34 Pa. Code 121

Proposed Regulation 121.3b(b)(3). There was a comment made that the proposed regulation should include in the "posted information" when the employer must provide this notice (i.e., both at the time of hire and at the time of injury). This would hopefully aid in giving both employers and employees more information of what is required. This is often an issue in litigation.

Thank you for your attention to these comments.

Judge Todd B. Seelig
President, PWCJPA

Original: 2484

The Insurance Federation of Pennsylvania, Inc.

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Samuel R. Marshall
President & CEO

August 4, 2005

John Kupchinsky, Director
Bureau of Workers Compensation
Department of Labor and Industry
P.O. Box 15121
Harrisburg, PA 17105

Re: Chapter 121 - proposed regulation

Dear John:

On behalf of our member companies and several national trade associations with overlapping membership, we offer the following comments on the Bureau's proposed revisions to Title 34, Chapter 121, the General Provisions chapter for the Bureau.

As a general comment, we appreciate the Bureau's attempt to update an old regulation to reflect changes in the law and implement improvements.

We are concerned, however, that the proposed regulation creates rather than resolves confusion in various filing requirements, and that it imposes significant - but needless - paperwork in the proposed Annual Claims Status Report. Our comments are intended to point out the areas of confusion, what we believe (and, we think, the Bureau's experience proves) to be needless filings, the areas where we question the statutory authority behind a proposed change, and to recommend revisions that will address those concerns.

Section 121.3 - Filing of forms

Subsection (b): We recommend the 10 day period for filing a corrected version of a form be extended to **21 days**, consistent with the 21 day deadlines in other sections. Ten days - especially assuming these are calendar, not business, days - is too short in instances where new information may need to be gathered. Further, we recommend the timing on this - "10 days of (from?) the written notice of the return of the form" - be clarified to match the timing in subsection (d): It should be ten days from the postmark on the return.

Subsection (c): We favor greater acceptance of electronic filings by the Bureau, but this goes in a different direction: The better focus is on requiring the Bureau to accept electronic filings, not allowing it to require these filings. We recommend the subsection be redrafted to state, **"The Bureau shall accept the filing of forms or data through electronic means."**

Section 121.3b - Posting workers' compensation information

Subsection (a): Requiring the posting of this information at all sites, not just the employer's primary place of business, is an impractical expansion of the current requirement. The problem is with what constitutes a "site of employment" in a temporary or moving workplace with roving contractors, where the employer may not have a trailer or building (e.g., a home renovation site).

We recommend this refer to **"fixed sites of employment"**; otherwise, the ambiguity in what is a "site of employment" invites needless arguments of improper postings at temporary worksites, and jeopardizes such things as the required use of a physician panel because of questions of adequately displayed notice.

Section 121.5 - Reporting injuries to the Bureau

Subsection (c): This should clarify that the "definition" of disability applies only to reports under this section, not reports generally.

Section 121.7 - Notice of compensation payable and notice of temporary compensation payable

Subsection (a): With Section 121.1 now defining an "employer" as including an insurer, this creates some confusion. An insurer cannot require an employer to notify it of a disability, or punish it for failing to do so, so an insurer cannot necessarily file within 21 days of when the insured employer knew of the disability - since the insured employer may not have told the insurer. This can be corrected by stating that the employer shall do all the obligations set forth in this subsection within 21 days from the date **"that"** (not "the") employer knew of the disability.

Subsection (b): As drafted, this creates confusion with subsections (d) and (f), since it arguably calls for conflicting reporting requirements. We recommend this be clarified by adding to this subsection the phrase, **"except as provided in the following subsections."**

Section 121.16 - Updating claims status

Subsection (a): This implements a new form and new reporting requirement. We have not seen the form, and we do not understand the requirement - but it seems an expensive, expansive and needless amount of paperwork on all sides, and we recommend this be deleted.

We are not sure what the Bureau is seeking in the Report - is it aggregate information on all claims, or information on each claim, or somewhere in between? What information

is required? Depending on what is sought in this new Report, this could go well beyond other required forms and reports - and for what reason, and based on what statutory authority?

This creates the potential for a significant - and needless - increase in cost to insurers, employers and the Bureau. In the preamble, the Bureau claims the regulation should have no significant fiscal impact, and that the regulation imposes no significant additional reporting - in large part suggesting that this new Report is neutralized by the Bureau's deletion of the annual filing of a Statement of Account of Compensation, Form LIBC-392.

That is misleading. First, the Bureau has not sought, and insurers have not filed, Statements of Accounts of Compensation for some time, so this is really a new requirement, not a neutral replacement of an existing one. Second, it appears this new form may require significantly more information than in the Statement of Account of Compensation, or at least information that is significantly harder and more expensive to produce.

Further, the Bureau should explain the purpose of the proposed Report as well as the statutory authority behind it. The preamble suggests this report is to verify information the Bureau already has on claims; does that information really need separate verification, or is this merely an expensive way of making insurers and employers say the same thing twice? The history of the Statements of Account of Compensation shows that some filings, whatever their theoretical merit, are irrelevant in practice; this regulation provides a chance to correct that, not extend it through a new and just as needless filing requirement.

Finally, the enforcement provisions in subsections (a)(3) and (4) need to be reconciled with the provisions in the proposed Section 121.27. These subsections suggest referral by the Bureau to the Insurance Department is the exclusive remedy for failing to file this new report; but Section 121.27 envisions the alternative enforcement tool of an Order to Show Cause within the Department (as distinct from the Bureau?). Which is it?

Subsection (b): The Bureau has not required, and many insurers have not always filed, this Final Statement of Account of Compensation Paid. Rather than proposing the continuation of this filing, why not delete it - or at least explain why the Bureau wants to require this in the proposed regulation even though it has not required it in practice in the past?

Further, we recommend this subsection's reference to "compensation" be clarified to refer only to indemnity payments, not medical bills. Courts at times lump both into the term "compensation", but we assume the Bureau does not intend this to apply to "medical only" claims.

Section 121.18 - Subrogation

Subsection (a): We recommend this be corrected to state that it applies **"if an employer obtains a recovery from a third party."**

Subsection (b): We recommend this subsection be deleted. Supplemental agreements are rare and, in any event, the information envisioned here is already in the Third Party Settlement Agreements in subsection (a). This seems another instance of a form that amounts to needless paperwork.

Section 121.25 - Issuance of compensation payable

Subsection (a)(2): So as to avoid confusion and arguments on what constitutes proper notice, we recommend this be clarified to state, **"Such notice shall be satisfied by sending a copy of the Notice of Compensation Payable or Notice of Temporary Compensation Payable."**

Section 121.27 - Orders to show cause

We believe the old language in this section was, although rarely used, lacking in clarity or statutory authority in many instances; but we think the new language suffers the same defect.

We recommend this section be revised to simply incorporate the rules of administrative practice and procedure controlling Orders to Show Cause as set forth in Part II of Title 1 of the Pennsylvania Code. An example is in the Insurance Department's regulations, set forth in Section 56.1 of Title 31 of the Pennsylvania Code.

Absent this, the regulation implements seemingly minor, but potentially crucial, differences without explanation. For instance:

- **Subsection (b)** and its provisions for an Answer vary from Section 35.37 of Part II, Title 1, but with no explanation of the reasons for the variances;

- **Subsection (c)** refers to the appointment of a "hearing officer", presumably as distinct from the presiding officers (and the rules related to them) in Part II of Title 1, again with no explanation of the differences;

- **Subsection (d)** provides that hearings will be conducted under this section and, when applicable, Part II of Title 1, but without explanation of when Part II would not be applicable.

- This section generally refers to the Department, whereas the rest of the regulation refers to the Bureau, and the regulation itself is for a chapter within Part VIII of Title 34, referring only to the Bureau. That could create unintended consequences - as with subsection (a) and its reference to this section applying to the Department and any violations of the "regulations," possibly a broader scope than Part VIII.

Curiously, subsection (c) has the appointment of a hearing officer being made by the Bureau Director, whereas the rest of the section refers to the Department - raising the questions of why the appointment would not come from the Secretary, and whether appeals would go to the agency head or directly to Commonwealth Court;

The Administrative Agency Law and Part II of Title 1 of the Pennsylvania Code set forth a detailed and well-established framework for Orders to Show Cause that has long applied to all Commonwealth agencies. This regulation should follow them, or at least better explain its proposed differences.

Section 121.27a - Bureau intervention and penalties

This section raises the same questions as with Section 121.27. Part II of Title 1, at Section 35.27 **et seq.**, has provisions controlling intervention generally; to what extent, and why, does this regulation vary?

Further, this section continues the possible confusion of the Bureau and the Department. Under Section 121.27, it is the Department that files an Order to Show Cause for violations of the act or regulations (albeit with the question of the scope of the regulations - Part VIII or beyond?); and the hearings on alleged violations would be before an officer serving on behalf of the Bureau Director (albeit with the question of whether it should be the Secretary). Here, the Bureau, not the Department, intervenes to pursue the same alleged violations; and the hearing is before a workers compensation judge, not a hearing officer appointed by either the Bureau Director or the Secretary.

Agencies should be consistent in determinations of what constitute violations of the act or the regulations; that means consistent in the hearings to determine violations, too, and that should mean one forum, not multiple ones, for resolving disputes.

Thank you for the opportunity to comment on this proposed regulation. We are happy to discuss any questions or concerns, and we look forward to a true dialogue with the Bureau, the standing committees, the IRRC and other interested parties in the effort to revise Chapter 121.

Sincerely,

Samuel R. Marshall

C: Kim Kaufman, Executive Director
Independent Regulatory Review Commission

Honorable Joseph B. Scarnatti, III
Honorable Christine M. Tartaglione
Honorable Robert Allen
Honorable Robert E. Belfonti, Jr.

Original: 2404

Kupchinsky, John

From: Matthew Welch [matthew.welch@uug.com]
Sent: Thursday, August 04, 2005 11:19 AM
To: jkupchinsk@state.pa.us
Subject: Proposed Rules

I'm not sure if this is the appropriate time or not but I think a proposed rule change should be the requirement of the claimant to sign and return all 3 LIBC forms 750, 756 & 760. Right now, only 760 has to be signed and returned. However, it is more crucial for them to return and sign LIBC 756 since this is the form that lists Unemployment Benefits, Social Security, Severance & Pension benefits because it is these benefits the carrier might be able to take a credit for against ongoing benefits. I never understood why they are only required to return 760? Can you respond?

Matt Welch
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Matthew.Welch@UUG.com

Kupchinsky, John

From: Samuel R.. Marshall [smarshall@ifpenn.org]
Sent: Thursday, August 04, 2005 2:56 PM
To: jkupchinsk@state.pa.us
Subject: Chapter 121 comments

John:

Attached is our comment letter on Chapter 121. Largely editorial points on areas of confusion, but we are very concerned about rhe proposed new Annual Claims Status Report - that's a first, and nobdy"s seen the proposed form, so we're wondering just what you want insurers to file.

Hope we can have some real discussions on this, and look forward to working with you on it.

Sam

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Samuel R. Marshall
President & CEO

August 4, 2005

John Kupchinsky, Director
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- **Subsection (c)** refers to the appointment of a "hearing officer", presumably as distinct from the presiding officers (and the rules related to them) in Part II of Title 1, again with no explanation of the differences;

- **Subsection (d)** provides that hearings will be conducted under this section and, when applicable, Part II of Title 1, but without explanation of when Part II would not be applicable.

- This section generally refers to the Department, whereas the rest of the regulation refers to the Bureau, and the regulation itself is for a chapter within Part VIII of Title 34, referring only to the Bureau. That could create unintended consequences - as with subsection (a) and its reference to this section applying to the Department and any violations of the "regulations," possibly a broader scope than Part VIII.

Curiously, subsection (c) has the appointment of a hearing officer being made by the Bureau Director, whereas the rest of the section refers to the Department - raising the questions of why the appointment would not come from the Secretary, and whether appeals would go to the agency head or directly to Commonwealth Court;

The Administrative Agency Law and Part II of Title 1 of the Pennsylvania Code set forth a detailed and well-established framework for Orders to Show Cause that has long applied to all Commonwealth agencies. This regulation should follow them, or at least better explain its proposed differences.

Section 121.27a - Bureau intervention and penalties

This section raises the same questions as with Section 121.27. Part II of Title 1, at Section 35.27 **et seq.**, has provisions controlling intervention generally; to what extent, and why, does this regulation vary?

Further, this section continues the possible confusion of the Bureau and the Department. Under Section 121.27, it is the Department that files an Order to Show Cause for violations of the act or regulations (albeit with the question of the scope of the regulations - Part VIII or beyond?); and the hearings on alleged violations would be before an officer serving on behalf of the Bureau Director (albeit with the question of whether it should be the Secretary). Here, the Bureau, not the Department, intervenes to pursue the same alleged violations; and the hearing is before a workers compensation judge, not a hearing officer appointed by either the Bureau Director or the Secretary.

Agencies should be consistent in determinations of what constitute violations of the act or the regulations; that means consistent in the hearings to determine violations, too, and that should mean one forum, not multiple ones, for resolving disputes.

Thank you for the opportunity to comment on this proposed regulation. We are happy to discuss any questions or concerns, and we look forward to a true dialogue with the Bureau, the standing committees, the IRRC and other interested parties in the effort to revise Chapter 121.

Sincerely,

Samuel R. Marshall

C: Kim Kaufman, Executive Director
Independent Regulatory Review Commission

Honorable Joseph B. Scarnatti, III
Honorable Christine M. Tartaglione
Honorable Robert Allen
Honorable Robert E. Belfonti, Jr.

Original: 2484

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FAX

TO: John Kupchinsky, Director
Bureau of Workers' Compensation

FAX NO: 1-717-772-0342

DATE: July 25, 2005

FROM: Thomas C. Lowry, Esq.

TOTAL PAGES: 5
(including cover sheet)

MESSAGE: **Chapter 121 Regulations - Comments**

If you do not receive this facsimile document in its entirety, please call Sue at the number listed above.

NOTICE

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July 25, 2005

John Kupchinsky
Bureau Director, Bureau of Workers' Compensation
Department of Labor and Industry
Chapter 121 Regulations – Comments
P. O. Box 15121
Harrisburg, PA 17105

Re: Chapter 121 Regulations – Comments

Dear Bureau Director Kupchinsky:

I am writing to you to provide my enclosed analysis and comments, as well as suggestions, regarding the proposed rule making/regulations. Please accept my letter as an attempt to provide constructive criticism from someone who is an experienced workers' compensation litigator.

Section 121.3b Posting Workers' Compensation Information

It is commendable that the proposed regulations will require that an employer, at its primary place of business and at its sites of employment, post the proposed workers' compensation information. However, I would suggest additional language to Section 121.3b (3) as follows:

> "If your employer has posted a list of six or more healthcare providers in your work place, you are required to visit one of them for your initial treatment, except for an emergency. Your employer is required to give you a notice of your rights and responsibilities for using the list of providers."

It is suggested that the underlined language be revised by the following:

> "You will be asked to sign a written acknowledgment form by your employer that you have been informed of your rights and responsibilities for using the list of providers."

This suggested change would bring the regulation in better conformity with Section 306 (f.1)(1)(i), which requires that an employer shall ensure that the employee has been informed and that he understands these rights and duties as evidenced by the employee's written acknowledgment.

Section 125.5 Reporting Injuries to the Bureau and Section 121.7 Notice of Compensation Payable and Notice of Temporary Compensation Payable

It is commendable that the Bureau seeks to require an employer to timely report the occurrence of an injury by the submission of the requisite Employer's Report of Occupational Injury or Disease, Form LIBC-344. However, by deleting references to the seven day waiting period, so to redefine disability as an injury resulting in disability continuing the entire day, shift or turn, or longer in which the injury was received, I am concerned that an employer will be forced to file a Notice of Compensation Payable or a Notice of Temporary Compensation Payable where there is no legal requirement to do so. In the past, under the existing regulations, it was not necessary to file an Employer's Report of Occupational Injury or Disease until the expiration of the seven day waiting period occurred (thus rendering it a compensable injury). Therefore, the proposed change at Section 121.5 (d)(2), which deletes the words "not before" and replaces it with "within seven days" will have far reaching consequences with unintended results. While it will encourage employers to timely report a disabling injury under Regulation 121.7, an employer is then required to file either a Notice of Compensation Payable, Notice of Temporary Compensation Payable, or a Notice of Denial no later than 21 days from the date the employer has notice or knowledge of disability. Without the reference to the waiting period previously contained in Section 121.5 (d)(2), an employer would be forced to file the NCP, NTCP or ND if an injured worker is disabled for less than seven days. Therefore, I would oppose the elimination of the seven day waiting period as contrary to law. A suggested correction would be to redraft the proposed rule of Section 121.7 (a) to include a reference that only upon the expiration of the statutory waiting period does an employer's obligation arise to file an NCP, NTCP or Notice of Denial.

In response to developing case law spearheaded by the PA Commonwealth Court in Lamansky v. WCAB (Hagan Ice Cream Company), 738 A.2d 498 (Pa. Cmwlth. 1999) and Waldameer Park v. WCAB (Morrison), 819 A.2d 164 (Pa. Cmwlth. 2003), the Bureau created a Medical Only Notice of Compensation Payable on March 29, 2004. Prior thereto, the

practice by many insurers and self-insurers has been to attempt to put a square peg in a round hole by utilizing a Notice of Denial (LIBC-496) disputing disability, but agreeing to pay medical benefits. See Darrall v. WCAB (H.J. Heinz Company), 729 A.2d 706 (Pa. Cmwlth. 2002).

Therefore, in recognition of the importance that an injured worker who is not disabled be assured of ongoing medical treatment for an acknowledged work injury, I would recommend that additional proposed language be set forth in Section 121.7 (f) that indicates that this form should be utilized when there is a need for ongoing medical treatment after any initial treatment is received for a non-disabling injury. Once again, the language contained in the proposed regulation is imprecise and lacks internal consistency, since it indicates in medical only cases when an employee's injury has not resulted in lost time from work, an employer may file a Notice of Compensation Payable (Form LIBC-495). There is no explanation of the seven day waiting period that renders the injury compensable on the eighth day of disability. The current language would suggest that it be limited in its use only for injuries that did not result in lost time from work which improperly restricts the use of this valuable document.

Section 121.16 Statement of Compensation Paid Updating Claims Status

The apparent intent of this proposed regulation is to replace the Statement of Compensation Paid, which pertained to a specific final payment report that permitted the Bureau to review to ensure that proper payment was received before a claim was closed, with a much broader obligation to report all insurers' and self-insurers' open claims. I am concerned with the need to safeguard such important information including the non-discoverable posting of reserves for each and every open claim. There is a further need to safeguard such information that may lead to the improper solicitation of unrepresented claimants who are receiving compensation benefits. Clearly, the filing of a Notice of Compensation Payable, Notice of Temporary Compensation Payable and the filing of a Claim Petition already permits the Bureau of Workers' Compensation to track the number of open cases. Therefore, because of the aforementioned legitimate concerns, I would recommend that this proposed regulation be deleted and not adopted. It would further appear to place undue burden upon insurers and self-insurers to provide on an annual basis updated claim status information on each open claim.

Section 121.18 Subrogation Procedure

The proposed new regs merely contain clarifying language. However, I believe the Bureau is missing the opportunity to clearly set forth the procedure and calculation method to complete a Third Party Settlement Agreement. The Bureau's form itself, as written (and as interpreted by insurance companies), is contrary to controlling case law. The Bureau misses the opportunity to remedy this problem, although the redrafting of the Third Party Settlement Agreement, Form LIBC-380, would be a satisfactory remedy.

I welcome further discussions and dialogue on my written comments.

Respectfully submitted,

Thomas C. Lowry
Attorney at Law

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July 29, 2005

John Kupchinsky, Bureau Director
Bureau of Workers' Compensation
Department of Labor and Industry
Chapter 121 Regulations - Comments
P.O. Box 15121
Harrisburg, PA 17105

RE: Proposed Rules on Workers' Compensation

Dear Director Kupchinsky:

I reviewed the proposed rules. I have the following comments:

Rule 121.1(b)(ii) – The Proposed Amendment expands the definition of "employer" to include the insurer. I believe such a definition conflicts with the Commonwealth Court decision in Kramer v. WCAB (Rite Aid) 2002 Pa.WCLR Lexis 51(February 2002). In Kramer the Court specifically limited the right to take a credit for severance payments only to those employers which were also making payment of compensation benefits. By incorporating the insurer into the definition of employer the Rule either invalidates or unnecessarily complicates the issue of whether the carrier can take a credit without actually being the employer.

Rule 121.17(d) – This Rule indicates the employer may stop payment of Temporary compensation within five days of the last payment ... I believe it should be made more clear that under Section 406.1(d)(2)(ii) stopping payment of compensation is proper only if such notice is given within five days and assuming the payment of compensation has not extended beyond ninety days. If payment is made for more than ninety days the employer does not have the right to stop payment of compensation even if such notice is given within five days from the date of last payment.

I hope you find these suggestions/comments useful.

Very truly yours,

MARC S. JACOBS

MSJ/db

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Kupchinsky, John

From: AMannSr@donsco.com
Sent: Sunday, July 17, 2005 10:39 AM
To: JKupchinsk@state.pa.us
Subject: New worker compensation regulations

In response to a request for comments on proposed rule changes.

First, I am curious as to what problems the new regulations are designed to solve. Adding more forms to the over 100 now in play is the wrong approach and signifies a lack of hard thinking about the entire system. The proposal adds cost and complexity and achieves what?

Shouldn't we be simplifying the process?

Second, our governor and his staff are working hard to attract industry to Pennsylvania faster than it is leaving. How does this change help Donsco or any other manufacturer become more competitive in a global marketplace?

If you want to deal with a known problem within the WC system, work on improving the competence of the WC hearing judges.

Art Mann

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Samuel R. Marshall
President & CEO

May 31, 2006

ORIGINAL: #2484 & #2485

To: Elizabeth Crum
John Kupchinsky
Tom Kuzma

From: Sam Marshall

Re: Chapters 121 and 123

First, our thanks to the Bureau for the May 19 meeting. It helped us better understand the Bureau's thinking, and I hope gave you a better understanding of ours. In that vein, the following sets forth our comments on the specific sections we discussed, based on insights from the meeting and some follow-up within the industry (as last week was a vacation week for many, comments are still coming in, and I'll share them as they arrive).

Chapter 121 - General provisions

Section 121.3 - Filing of forms

Subsection (b): We appreciate your willingness to consider extending the 10 day period in which to send corrective forms to 14 days, and to consider adopting subsection (d)'s timing of 14 days from the postmark on the return.

Subsection (c): We remain troubled by the regulation's allowing the Bureau to "require the filing of forms or data through electronic means." As we said in earlier comments on this subsection, we hope electronic filings will be used more often.

Nonetheless, the technical concerns in converting systems - yours and ours - make us concerned with the possibility of unilateral requirements. Our reasoning really is the same as when you objected to our recommendation that you be required to accept electronic filings: You noted that "the Department must first have the capability in place in order to receive and accept an electronic filing, and simply is not able to accept certain types of electronic filings."

That holds true on our end, too. Accordingly, we recommend the Bureau revise this subsection to allow it to require electronic filings by regulation. That can be a painful process from both sides, but it generally leads to a practical solution for both sides.

Section 121.3b - Posting

This section highlights the concern of including, in the definition section, insurers as part of employers: The general posting is not something an insurer could do or monitor. That is a concern throughout this Chapter; you might consider carving out within the definition of "employer" those sections where the inclusion of an insurer makes no sense.

We also recommend you delete the requirement that the general workers compensation information be given to each new employee at the time of hire and annually thereafter. This is not required in Section 305(e) or elsewhere in the Act, would be unworkable (especially on the "annually thereafter" end), and would be incapable of monitoring and enforcement.

We also recommend the notice be revised to keep separate the physician panel notice in Section 306(f.1)(1)(i) of the Act. Under the act, that is a separate notice, with an employee acknowledgement requirement; it should remain separate in the regulation, too.

Sections 121.7 and 121.7A - Notices of compensation and temporary compensation payable

We note the practical problem of an insurer having to file the forms in these sections within 21 days of the insured employer having notice of a disability - namely, those situations where the employer doesn't tell the insurer in time for us to comply with the 21-day rule.

We appreciate this problem is created by the Act. Nonetheless, a regulation should solve, not perpetuate, impossible compliance requirements, and triggering the 21 day obligation from when the insurer knows makes sense. This can be done by changing, in subsection (a) of both sections, the phrase "no later than 21 days from the date the employer had notice or knowledge" to "that" employer.

Section 121.16 - Annual Claims Status Report

We appreciate your willingness to have this apply to claims opened between three and four years before a given calendar year - as opposed to between two and three years. We reiterate that the instructions be written into the regulation, perhaps by incorporating Form LIBC-774 into the regulation.

Chapter 123 - Vocational experts

Section 123.202a: For all the reasons we raised in April, we recommend the Bureau drop its requirement that a vocational expert be both a Licensed Professional Counselor under Pennsylvania's Social Workers, Marriage and Family Therapists and Professional Counselors Act, and certified by one of the nationally recognized organizations.

We appreciate your concern that the state be given the chance to take action against a bad expert. Our understanding is that the national organizations already have a process in place to do that (and I'll bet it is more focused that the state licensing agency; my experience is that proceedings in those agencies are rare and slow).

Section 123.204(b): We appreciate your clarification that you really did mean this to apply to the vocational expert's report of the interview, as opposed to his report of the earning power assessment itself.

We recommend you revise this to require that a vocational expert send the earning power assessment report to the injured worker at the same time he sends it to the employer; you may want to expressly require that the earning power report include a report and or the case notes from the interview as required under the Code of Ethics for vocational experts. That should satisfy both our concerns, since the injured worker would get the case notes or report of the interview, but would get this as part of getting a copy of the earning power assessment itself.

The earning power assessment report, not the interview, is the key element and, I think, was at the heart of the IRRC's comment that "an employee who undergoes **this assessment** (my emphasis, but the IRRC didn't refer to the undergoing the interview) has a vested outcome in the outcome regardless of whether the outcome was in the employee's favor of the insurer's favor." Ironically, the regulation as currently drafted would require timely sharing of an interim report but not the final assessment report.

Again, thank you for the meeting. Give me a call with any comments or questions, and I'll keep you abreast of ours.

C: John McTiernan