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Attorney fees in post-settlement utilization review litigation: Where are they?

In August 1993, then-Governor Tom Ridge enacted the first of two amendments to the Pennsylvania Workers' Compensation Act that drastically changed the medical rights of injured Pennsylvania workers. With the Act 44 amendments to the Pennsylvania Workers' Compensation Act, Sec. 306(f.1) now for the first time contained utilization review procedures. 77 P.S. Sec. 531(5); Sec. 306(f.1)(5). In June 1996, a second amendment occurred, the so-called Act 57 amendment, which eliminated the intermediate utilization review level or "reconsideration." Now, after the initial decision on a Utilization Review Initial Request, processed by the Bureau of Workers' Compensation's Health Care Services Review Division, is issued by a Utilization Review Organization (URO) appointed by the Health Care Services Division, either party has the right to file an appeal in the form of a Petition to Review Utilization Review (UR) Determination within 30 days of the circulation of the UR reviewer's report or determination. 77 P.S. Sec. 531(5)(iv). While the legislative intent was purportedly a noble one—the elimination of fraudulent medical fee claims—a claim that workers' compensation insurers and self-insureds complained severely hampered the cost of doing business in the state—the result of the haphazardly constructed medical cost control provisions was to effectively eliminate the right to effective counsel with regard to post-settlement Utilization Review litigation, particularly once the Petition for Review of Utilization Review (UR) Determination is filed.

A Post-Settlement UR Dilemma:

The problem begins with Section 449, 77 P.S. Sec. 1000.5—the Compromise/Release provision that allows the parties to settle all aspects of the claim, both wage loss benefits and medical expenses. Under the pre-Act 57 amended workers' compensation statute, the parties could *not* settle their claims for wage loss and medical expenses, but only *commute* their wage loss benefits if paid as partial disability benefits. Sec. 316; 77 P.S. Sec. 604. The 1996 amendments changed dispute resolutions in this state to allow for termination of future medical treatment. However, in cases involving claimants with ongoing treatment and residual disability, while the wage loss portion of the claim may indeed be resolved, the necessity of an *open* Compromise/Release settlement, allowing claimant to receive ongoing medical treatment that is reasonable, necessary and related, results in future prospective utilization review issues that create the attorney fee dilemma. Most carriers on *open* Compromise/Release settlements review the future medical expenses closely and can subjectively decide when they believe claimant has undergone enough treatment by simply filing the Initial Request for Utilization Review Determination. 77 P.S. Sec. 531(6). This filing triggers a delay of the claimant's right to seek medical treatment and results in an immediate suspension of payment for treatment from the health-care provider under review. 77 P.S. Sec. 531(5). Many providers will reduce or suspend treatment while the utilization review commences. The bureau's regulations compel a deter-

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mination on the Initial Request no later than 65 days from the assignment of the UR initial request, or 30 days from the completed request for UR. 34 Pa. Code Sec. 127.465. If the result is favorable to claimant, his medical treatment continues and the challenged expenses are paid immediately, regardless of whether a Petition to Review UR Determination is filed. 34 Pa. Code Sec. 127.208(f). The insurer's relief, if successful on appeal, is against the Supersedeas Fund under Section 443(a), 77 P.S. Sec. 999.

The first steps, while usually not requiring the intervention of counsel, may require counsel's assistance, such as a chronic pain management case where claimant requires opioid medication treatment. Frequently, in these complex cases, claimants cannot wait for the sixty-five day determination period to expire and a potentially favorable decision to occur. Claimants require the immediate intercession of counsel to negotiate stipulations or repayment agreements so that chronic pain medication claimants can continue to receive treatment during UR. If the request is decided in their favor, there is still the prospect of an appeal by Petition to Review UR Determination and then the absolute necessity of counsel involvement in the litigation of this petition, which may require depositions, court testimony, and the filing of briefs and findings. If this is the first petition for this claimant, and claimant has not settled his wage loss claim, then there is a fund available for counsel to obtain an attorney fee.

However, what about the post-settlement UR Petition for Review, where wage loss benefits

have already been compromised and released and there is no available fund for payment of counsel fees and the parties cannot agree on a figure to settle the medical claim? For example, claimant's wage loss benefits have been paid out in a lump sum, which may include any remaining past, present, and future indemnity payments. The parties agree to allow the medical bills to remain open so long as claimant's treatment continues to be subject to Act 44 fee scheduling and utilization review procedures. A year later, the insurer's agent files the Utilization Review Initial Request that automatically allows the carrier to stop payment of the reviewed physician or health care provider's treatment. Sec. 306(f.1)(5); 77 P.S. Sec. 531(5). The Utilization Review Organization (URO) issues a report adverse to claimant declaring the treatment, or any future treatment from the request date, "unreasonable" and "unnecessary." Claimant files a Petition to Review Utilization Review Determination. Query how claimant's counsel perfects a claim for attorney fees on this UR petition? Sec. 440 of the Act, 77 P.S. Sec. 999, which allows the assessment of unreasonable contest counsel fees by quantum meruit submission would arguably not apply if there is a conflict between a UR reviewer's opinion and the treating health care provider's opinion? Further, Sec. 442 of the Act, 77 P.S. Sec. 998, which allows for the assessment of quantum meruit fees "where the efforts of counsel produce a result favorable to the claimant but where no immediate award of compensation is made," does not compel the employer's carrier to pay for such fees but imposes such an obligation on the claimant, upon agreement reached with his counsel "without regard to any per centum." *Id.*; See, *Wommer v. WCAB (Lycoming Cty.)*, 479 A.2d 661 (Pa. Cmwlth. 1984). Admittedly, the scenario this writer is contemplating is a narrow, but nonetheless, ubiquitous one. Many practitioners have open Compromise/Release cases, where indemnity has been settled but the medical treatment is still the subject matter of litigation. Some of the future medical cases can settle, but particularly in those cases with Medicare-eligible claimants concurrently receiving Social Security disability benefits, the settlement path is extremely dangerous and at best requires the approval of the third-party insurer, Medicare's Claims Management Services branch. Thus, in the litigated UR petition for review of UR determination, involving a claimant who previously settled his wage loss benefits by prior Compromise/Release agreement, the nagging question of counsel fees presents a problem that could effectively deny claimant proper representation of counsel.

At first blush, any practitioner in the field, judge, or insurance representative, may disagree

with this observation. The carriers will argue that the Act now mandates the participation of health-care providers and therefore counsel can be compensated by the providers who can participate as a party in a UR proceeding. Unfortunately, the reality of medical review litigation is that a) the treating providers frequently write-off the challenged medical expenses and simply discontinue treating injured workers or b) there is an insufficient fund or pool of outstanding medical fees to adequately compensate the claimant's attorney. Either way, any litigation by a Petition to Review Utilization Review Determination has frequently resulted with claimant's counsel sending their clients to community legal services for representation, recommending another non-reviewed provider to begin treatment, or attempting to plead with defense counsel for the self-insured employer or insurance carrier to allow the litigation to proceed on "medical reports only," thereby reducing the legal work to a single hearing for claimant's testimony and brief proposed findings, and the medical reports/records. Alternatively, the lack of any attorney fee for successful claimants forces their counsel to attempt ancillary penalty petitions and engage in imaginative lawyering to find some violation of the Act or its regulation so that claimants' counsel can submit unreasonable quantum meruit fees.

Suffice it to say that currently there is no fair remuneration for claimants' counsel litigating a UR Review Petition in Pennsylvania. Sec. 440, 77 P.S. Sec. 999, unreasonable contest fee claims are easily defeated with a UR reviewer report (statutorily admissible without even a deposition of the reviewer) since the report may state that all or some of claimant's treatment is "unreasonable," "excessive," or "unnecessary." While it may be tolerable if claimant is suffering from a relatively minor orthopedic injury that does not require chronic pain management, the game rules change when chronic pain management cases are involved, particularly when claimants are prescribed a regimen of opioids such as Methadone, Oxycodone, and Percoset. Many carriers target these cases because of the stigma attached to long-term opioid medication treatment of chronic pain patients. The automatic suspension provision of Sec. 306(f.1)(5), 77 P.S. Sec. 531(5), that operates immediately upon the filing of a Utilization Review Initial Request will create potentially life-threatening situations for claimants on a maintenance dosage of these powerful, addictive drugs.¹

Apparently, the United States Supreme Court did not contemplate that scenario when it affirmed the 3rd Circuit Court of Appeals in its 1999 landmark decision, *American Mfrs. Mutual Ins. v. Sullivan*, 526 U.S. 40 (1999), thus placing its imprimatur of unabashed immediate and auto-

matic stoppage of all challenged medical treatment to a Pennsylvania claimant—whether narcotic, surgical or otherwise—simply by filing a piece of paper. Months may go by before the Bureau of Workers' Compensation's appointed Utilization Review Organization issues a determination. In the meantime, claimants are entitled to mail in a statement and their providers are required to submit the entire medical chart and, on occasion, confer with the URO reviewer by telephone. All along, the unrepresented claimant may have his or her rights supremely violated without competent counsel. Does this make any sense?

Any careful lawyer, whether a workers' compensation practitioner or not, who has even scintilla of knowledge about Pennsylvania workers' compensation, realizes that our statute is complex—much too complex for the occasional practitioner. The utilization review provisions are some of the most complex provisions in the Act, setting forth formulae for fee scheduling, designated physicians, examinations, medical review procedures, fee application review, the competency of the health care providers and potential illegal practices of providers. Sec. 306(f.1), 77 P.S. Sec. 531, is a medical expense section and does not address or reference attorney fees. Barring an attempt of extracting a fee from an ancillary penalty petition (assuming the WCJ exercises her discretion to even award a violation of the Act), the claimant counsel that applied her years of experience, sometimes cross-examining several physicians, obtaining and reviewing copious medical records, presenting careful summaries of evidence, argument via proposed findings of fact and briefs, performs these specialized services for Pennsylvania claimants *pro bono*. Alternatively, the claimant's attorney must advise his client that he will require an hourly attorney fee, paid for by the client at the conclusion of the litigation, assuming judicial approval pursuant to a proper fee petition submitted in compliance with Sec. 442 of the Act. 77 P.S. Sec. 999(b). These are harsh situations, punishing not only to diligent counsel that strive to adequately represent their clients, but more importantly, to injured Pennsylvania workers, who in many cases, require ongoing medical treatment that is every bit as vital to their claim as the bi-weekly indemnity checks.

While the 1984 decision in *Baksalary v. Smith, et. al.*, 579 F.Supp. 218 (E.D. Pa. 1984), aff'd *Allstate Ins. Co. v. Baksalary*, 469 U.S. 1146 (1985), has withstood scrutiny from any challenge against an automatic stoppage of claimants' wage loss or indemnity benefits, not so for claimants' medical entitlement in light of the Supreme Court's decision in *Sullivan, et. al.* What

remedies exist to compensate the claimant representation by counsel who sought to protect their clients' rights when participating in utilization review litigation.

B. Remedies

The "Advisory Opinion" Challenge

One remedy that surfaced in a recent WCJ decision is attacking the UR reviewer report as an incompetent "advisory opinion" in violation of the Bureau's medical cost containment regulations. *Greg Brown v. Folsom Fence Co.*, Bur. Claim No. 362394(3/05/02, Liebau, WCJ); 34 Pa. Code Sec. 127.471 (Duties of reviewer—issues reviewed), Sec. 127.471 mandates that utilization review reports not be merely "advisory opinions" but must adequately explain the reasons for declaring a claimant's treatment "unreasonable" and "unnecessary." The section states, in pertinent part:

Reviewers shall decide only the issue of whether the treatment under review is reasonable or necessary for the medical condition of the employe. Reviewers shall assume the existence of a causal relationship between the treatment under review and the employe's work-related injury. Reviewers may not consider or decide issues such as whether the employe is still disabled, whether maximum medical improvement has been obtained, quality of care, or the reasonableness of fees. Id.

In *Brown*, claimant suffered a crushed left hand injury that became gangrenous and resulted in several amputations and development of painful neuromas until claimant was at the below-elbow level amputation on his left arm. He is a chronic pain management patient, at that time, taking seven medications and various opioids (including Methadone and Oxycontin) to quell the pain from the neuromas. The UR reviewer determined that all narcotic and some of the other medications were unreasonable and unnecessary and only allowed ongoing prescriptions for Wellbutrin, an anti-anxiety drug. Claimant's indemnity claim was settled nearly ten years prior, under the old commutation provision of Sec. 316, 77 P.S. Sec. 604, albeit the employer agreed to pay for all future "reasonable and necessary medical treatment." Claimant retained its prior counsel to appeal the adverse UR Determination and protect his right to chronic pain treatment via a Petition to Review UR Determination. Claimant succeeded before the WCJ not only on the merits of the petition to allow him to continue to receive his pain medication but also as to attorney fee payment as unreasonable contest fees because of the "advisory

opinion" nature of the UR reviewer's decision.

If counsel can successfully argue that the UR reviewer's report is basically a sham statement with no logical rationale or adequate explanation for declaring a claimant's medical treatment unreasonable or unnecessary, or to use the WCJ's words "no legally valid reason as to why claimant's ongoing treatment should be stopped," then there is the possibility of juxtaposing this regulation with a Sec. 440 unreasonable contest fee allegation and successfully arguing for quantum meruit counsel fees assessed against the employer.

The workers' compensation judges give claimants' counsel's unreasonable contest arguments and quantum meruit fee petitions very careful scrutiny on UR Petitions for Review and, occasionally award at least a partial unreasonable contest fee to compensate claimants' counsel. The question remains: will it withstand scrutiny on appeal before the Workers' Compensation Board, the appellate tribunal that suspends the payment of any unreasonable contest counsel fees on supersedeas petition filed by the employer pending a decision on the merits of the appeal. Unfortunately for claimant's counsel in the *Brown* case, the Board agreed with the employer's arguments that the UR reviewer "expressed concern over the addictive nature of claimant's narcotic medication" and thus provided a reasonable basis to contest the treating physician's course of treatment irrespective of the fact that the WCJ found the UR reviewer not credible. *Greg Brown v. Folsom Fence Co.*, A02-0770 (4/08/03).

The Penalty Petition Challenge

The essence of a penalty petition is to demonstrate an illegality committed by the employer pertaining to the Act's provisions or a Bureau regulation. However, a penalty is not guaranteed, particularly if the Judge exercises her discretion not to award a penalty even if counsel proves a violation of the Act. *Department of Labor & Industry v. WCAB (Robinson)*, 407 A.2d 139 (Pa. Cmwlth. 1979). However, if the penalty is sufficient and patent, this approach can elicit a fee for counsel and at the same time enshrine the aggressive conduct of an employer to stamp the imprimatur of skepticism on future employer-challenges to a claimant's rights in a specific case. Moreover, unreasonable contest counsel fees can be assessed as costs in a penalty petition proceeding, and for efforts to enforce the employer's compliance with the Act. *Thomas v. WCAB (Delaware Cty.)*, 746 A.2d 1202 (Pa. Cmwlth. 2000).

If possible, counsel may consider deposing a claims adjuster or self-insured risk manager. Unless properly prepared by defense counsel,

claims representatives may simply recite their computerized claims annotations, frequently without thinking about the consequences of their recitations on record. A skilled claimant's counsel can take computerized claims log entries and cross-reference the reviewed or challenged treatment with the non-challenged medical treatment. If the carrier or self-insured is violating a claimant's rights on non-reviewed treatment, such as arbitrarily stopping payment, partially paying, late payments that result in the providers' refusal to adhere to the treatment schedule or dismissal of a patient, or interference with a claimant's attempt to replenish his prescription medication, this can be a fertile area to explore and prosecute penalties against the employer or self-insured. The claimant need prove that the cessation of payments was unwarranted because the treating physician was not under review and therefore the basis for the penalty may be the employer's attempt to unilaterally stop payments on causation grounds—a wholly inappropriate defense where treatment is rendered for a compensable injury. *See, Listino v. WCAB (Germantown Sav. Bank)*, 687 A.2d 16 (Pa. Cmwlth. 1996).

Some key observations before filing a Penalty Petition: 1) are the challenged medical bills for which payment was suspended all within the 30 day window allowable under Sec. 306(f.1)(5) for a proper UR challenge; 2) did the challenged provider previously submit the bills in question with the proper HCFA forms attached and periodic reports as required by the statute; 3) did the claims representative who filed the UR Initial Request stop payments of non-reviewed providers; 4) did the claims representative deny treatment to the work-related body part from non-reviewed providers on causation grounds, as opposed to challenging the bills under a proper UR Initial Request for reasonableness and necessity of treatment; 5) did the claims representative refuse to certify treatment or cooperate with a hospital or preadmission claims representatives for a surgical procedure scheduled by claimant's treating physician, alleging that the carrier does not "preauthorize" treatment. If any of these situations exist, consideration should be given to a penalty petition to support your client's UR petition to review.

The McLaughlin Challenge

A recent Commonwealth Court of Pennsylvania decision called *McLaughlin v. WCAB (St. Francis Homes)* 808 A.2d 285 (Pa. Cmwlth. 2002) sheds some light for claimants' counsel to assist with providing grounds for prosecuting penalty petitions, particularly where injured workers' physicians recommend surgery during an open claim and the employer or carrier

has not filed for prospective utilization review of the surgical treatment.

In *McLaughlin*, employer's claims representative unilaterally refused to pay for claimant's low back surgical care declaring that Pennsylvania law did not require "preauthorization" of surgical treatment. Pending before the WCJ was employer's petitions for medical treatment and termination, suspension, modification alleging claimant was recovered and could return to work. Employer did *not* obtain a supersedeas pending the petitions. Claimant's treating neurologist recommended a lumbar laminectomy and referred claimant to a neurosurgeon for surgery. The surgery was scheduled and claimant thereafter underwent various preadmission tests. The hospital personnel contacted employer's claims service representative to obtain pre-approval of surgery. The adjuster refused to authorize the surgery and stated that because claimant's work injury "resolved," based on the IME physician report, claimant's ongoing medical condition is pre-existing and degenerative. Therefore, the petitions were filed and because the case was in litigation, surgery was denied. The adjuster went further by reducing her fallacious interpretation of the Act to a letter and mailed it to the injured worker. *Id.* at 286.

Claimant filed a Petition for Utilization Review of treatment rendered by the treating physician, and also a Penalty Petition alleging a violation of the Act because the employer's carrier refused to pay for medical benefits and "intentionally engaged in a course of conduct effectively preventing (claimant) from being admitted to the hospital for surgery recommended by the treating physician." *Id.* The employer's defense was contained in Sec. 306(f.1)(2) and (5)—essentially that employer had no obligation to pay absent periodic reports from the treating physician and that the obligation to pay does not arise until bills and records are submitted in accordance with the Act. This circular argument was not effective, particularly since records could not be procured, a medical bill generated, nor a periodic report issued if the surgery could not occur. The WCJ agreed with claimant that except for a judicial order, Supplemental Agreement or utilization review filing, the employer cannot simply stop paying for a claimant's medical treatment to the body part(s) of an ongoing, compensable injury. *McLaughlin at* ___, 808 A.2d at 288. Such an action will result in the assessment of penalties and quantum meruit counsel fees, irrespective of the Act's declaration that the employer or its claims representative need not "pre-approve" medical treatment. *Sheridan v. Workers' Compensation Appeal Board (Anzon, Inc.)*, 713 A.2d 182, 187 (Pa. Cmwlt. 1998)(the propriety

of a penalty award is determined by evaluating the conduct of the employer as it relates to whether a legally recognized event occurred that suspended the employer's pre-existing and ongoing obligation to pay benefits.). Clearly, here, the employer's deplorable conduct could not legally support the unilateral cessation of authorizing and allowing claimant to have surgical treatment to a compensable injury as recommended by his treating doctor.

Unfortunately for employers, the reality is that most hospital or surgical centers will not even begin preadmission procedures without some guarantee of payment. Query why an employer's claims representative would risk a penalty petition here. Why would "preauthorizing" certain allegedly work-related surgical treatment necessarily conflict with the employer's obligation to only pay for reasonable and necessary medical treatment? Employers still have the statutory right to file utilization review requests upon receipt of the medical bill from the hospital or surgical center. Again, one can only presume that the claims representative in *McLaughlin* was on corporate auto-pilot mode instead of thinking through the consequences of the responses in that case. Regardless, the recitation of "no preauthorization" to claimant-patients on a gurney preparing for surgical remedy to their work-related injuries is simply intolerable and, quite frankly, a most barbarous interpretation of the statute.

The *McLaughlin* rule allows claimants' counsel to argue that the bogus "preauthorization" excuse for unilaterally stopping a claimant's right to surgical treatment is akin to cruel and unusual punishment and not only a mandatory penalty assessment but the surcharge of unreasonable contest quantum meruit counsel fees. *Thomas, supra*. Pursuant to the *Thomas* decision, there is no question that counsel fees may be assessed during the litigation of a penalty petition as a cost against the employer to force compliance with the Act. Compliance with the Act Sec. 306(f.1) requirement to provide surgical treatment to injured workers would appear to be a perfect allegation to assert *McLaughlin's* costly sanctions.

The Subrogation Method

Another less effective method for procuring a counsel fee while litigating a Petition to Review UR Determination is by arguing that counsel is entitled to 20% or more of the health care provider's outstanding bills. Usually, this method is insufficient for two reasons: 1) what if the fund of outstanding bills is de minimis; 2) whatever the gross bills are, as long as a third-party carrier has not issued payment, they are still subject to fee schedule, which will reduce the bills substantially; 3) the providers are hesitant to enter into a fee

agreement with claimants' counsel. Many WCJs demand a "provider fee agreement"² before an attorney fee is awarded out of the provider's net medical payment. If the provider refuses to enter an agreement and simply stops treating the claimant-patient, counsel can still argue it is entitled to a fee regardless of whether the provider assents to the fee or not because counsel created a subrogation fund. *LTV Steel Co. v. WCAB (Morrow)*, 690 A.2d 1316 (Pa. Cmwlt. 1997). However, counsel is *not* entitled to a fee on an amount credited to a self-insured employer who also funded a disability plan that paid the sickness and accident benefits to claimant that were the subject of a credit. *Acme Mkts., Inc. v. WCAB (Chisom)*, 644 A.2d 259 (Pa. Cmwlt. 1994). Arguably, the same holding would apply to the medical treatment paid by the self-insured's group carrier on claimant's behalf. Here, the problem most often is the insufficiency of the fund, whether the provider assents or not. In cases with chronic pain management claimants, not only the past and present medication is the subject matter, but any future treatment.

Sec. 442 Counsel fees from claimant:

There is statute and case law that allows a quantum meruit counsel fee chargeable to claimant "in cases where claimant's counsel produce a result favorable to the claimant but where no immediate award of compensation is made...". 77 P.S. Sec. 998, Sec. 442. The judge may approve a fee greater than 20 percent of the award, *but only upon cause shown*. 77 P.S. Sec. 998; *Cardwell v. WCAB (Illumex Corp.)*, ___A.2d___, No. 941 C.D. 2001 (Pa. Cmwlt. Nov. 1, 2001). Further, the statute allows for "reasonable counsel fees agreed upon by claimant and his attorneys, *without regard to any per centum*." *Id.* However, this writer suggests that the Sec. 442 reimbursement from your client, whether by retainer later approved by a WCJ, or a post-litigation hourly fee bill, is unsatisfactory for most clients. The ability to pay for a substantial litigation fee that could be several thousand dollars is simply unrealistic for claimants that are not situated in affluent professional practices. Most workers' compensation clients barely receive enough indemnity and medical treatment to compensate their injuries let alone the ability to pay for their attorney's representation. Nevertheless, where the WCJ will not find an unreasonable contest to impute a quantum meruit fee against the employer, and where the provider will not enter a fee agreement or the pool of medical expenses is insufficient to compensate counsel, this "fee of last resort" may be the only way for counsel to be paid for his or her effort in securing a client ongoing medical treatment.

This writer suggests a better approach to Sec. 442 fees would be an amendment that extends the language already in place that specifically applies to situations like post-settlement UR petitions—“where counsel’s result produces a result favorable to claimant but where no immediate award of compensation is made.” A post-settlement UR petition should cast the dye in favor of the employer if it prevails in the WCJ adjudication, but if a WCJ determines that the claimant’s medical evidence is more credible than the employer, then employer should be imputed the burden of paying a reasonable quantum meruit fee. Sec. 440 already allows the WCJs to assess the amount, length of time, the complexity of the factual and legal issues, the duration of the proceeding and the time and effort required and actually expended. 77 P.S. Sec. 999(b); Sec. 440(b). It seems a logical extension of the attorney fee provisions to allow it to pass to Sec. 442 rather than force claimants to expend money for this repetitive litigation that can occur with every provider should the employer choose to do so, and result if suspension after suspension after suspension of medical treatment. Additionally, this change in the statute will cause the employers to carefully analyze the medical cases and tactically determine what cases to fight and which ones to resolve with a reasonable settlement, or simply follow the statute and continue to make reasonable and necessary medical payments with the allowable fee schedule reductions.

The Medical Expense Settlement

As mentioned, Sec. 449 of the Act allows the parties to settle medical expense claims either concurrently or subsequent to the settlement of indemnity claims. 77 P.S. Sec. 1000.5. Frequently, though, the parties have wide differences of opinion as to the value of the future medical expenses and thus settlement is illusory. Also, if the claimant is Medicare-eligible, then an unwanted third party, Claims Management Services (CMS),

intervenes and demands approval of a set-aside trust for claimant’s future medical treatment. See, 42 CFR 411.46. While some practitioners have had success negotiating a livable set-aside trust that adequately considers the future medical treatment without exhausting all of claimant’s residual lump sum on the wage loss settlement, many have found CMS an intrusion, if not a complete obstacle to the settlement of the future medical expense claim.

C. Conclusions

Injured workers deserve protection of their medical rights, particularly in light of the unilateral stoppage of their treatment that has been sanctioned by the Pennsylvania Legislature since 1993 and affirmed, after constitutional challenge, by the U.S. Supreme Court in *American Manufacturers Ins. Co.* Unless Section 442 of the statute is amended to allow for quantum meruit fee assessments even in potential reasonable contest situations, claimant’s counsel will necessarily be fighting an uphill battle to search out ancillary penalty petitions, subrogation possibilities, provider fee agreements, and other alternate fee methods. In the meantime, more than ever skilled workers’ compensation counsel should be representing injured workers throughout the UR process from the beginning of the Initial Request stage until the insurer pays the putative medical expenses, settles the future medical claim of the worker, or is compelled to make payment by the governmental units or courts. In the litigated context of a post-settlement UR petition for review, wide latitude should be given by the Board and appellate courts to judicial determination of whether a reasonable contest occurred in a specific case. Vigorous enforcement by the Board and appellate courts of *Universal Cyclops Steel Corp. v. WCAB (Krawczynski)*, 305 A.2d 757 (Pa. Cmwlth. 1973) on all unreasonable contest awards in Medical Review Petition cases, “puts teeth” in the reasoned determinations of the trial

judge who is, by law, the “ultimate fact-finder.” No harm inures to the insurers and employers because if a decision is reversed on appeal, and the medical expenses under review are found unreasonable and unnecessary, Supersedeas Fund reimbursement is allowable. *Insurance Company of North America v. WCAB (Kline & Packard Press)*, 586 A.2d 500 (Pa. Cmwlth. 1991), *aff’d*, 619 A.2d 1356 (Pa. 1993). Without allowing counsel remuneration for its labor to preserve claimants’ medical rights, injured workers’ will be effectively deprived the right to counsel in this important area of litigation and could suffer ongoing medical complications that may affect other non-work injured parts of their bodies or their mental health.

These suggestions for procuring a counsel fee will enable the workers’ compensation specialists that travel daily the nuances of this complex statute to provide the most zealous representation for their clients, control aggressive claims handlers from abusing the Act’s medical review provisions, and also allow the workers’ compensation system to function fairly and achieve the humanitarian and rehabilitative goals for Pennsylvania workers that this state’s Legislature contemplated in 1915, as well as 2003. n

¹ In a recent article that appeared in the *Journal of the American Medical Association*, one serious problem is the under-use of opioid medication with chronic nonmalignant patients due to the exaggerated fear of addiction both by patient and physician. *JAMA*, 5/14/03—Vol. 289, No. 18, 2347-2348.

² The 20% counsel fee limitation in Sec. 440 of the Act does not necessarily apply to third party fee arrangements such as the fee agreement between a provider or third party insurer and claimant’s counsel.