Workers Compensation Claim
State Environmental Guide - Pennsylvania

PENNSYLVANIA – http://www.dli.state.pa.us/

Indemnity issues

Temporary Total Benefits	Temporary total benefits are based on the calculation of an average weekly wage. All wages, including overtime and vacation are averaged over the highest three 13-week periods during 52 weeks prior to date of injury, to compute the average weekly wage. Bonuses are to be averaged separately. There is a seven-day waiting period before an employee would become eligible for temporary total benefits. An injured employee must be out of work fourteen days or more before becoming entitled to receive retroactive payment for the first seven-day waiting period. Benefits are payable based on a chart provided by and revised annually by the Bureau of Workers' Compensation. Maximum Comp Rate for 2024is $1,325.00.00, for AWW of $1,987.50 and above. Two/thirds of AWW is paid for AWW from $993.76 to $1,987.50. Minimum Comp Rate is 90% of AWW below $736.10. A flat rate (50% of the Statewide AWW) is $662.50 for AWW between $736.1107.22 and $993.7554.75. with varying degrees of payment between the max and min as outlined in the state table. Maximum duration: there can be exposure for lifetime, open to resolution, return to work, full recovery or modification of benefits to temporary partial.
Temporary Partial Benefits	Temporary partial benefits are paid when an employee is working either reduced hours or at a lower rate of pay due to the injury. Employee is entitled to 66 2/3 of the difference between his average weekly wage and the gross wages earned. Maximum duration: 500 weeks
Permanent Partial Benefits	When an employee sustains permanent loss, loss of function (including loss of function in the extremity and digits), hearing loss, scarring and disfigurement to the head, face and neck as a result of a work-related injury, specific loss benefits are payable based on the schedule as outlined in Section 306 (c) (22) of the Act.
Permanent Total Benefits	There are no statutory Permanent Total Benefits, with the exception that total disability is presumed in the case of loss of both arms and/or both legs and total blindness.

Indemnity issues

Fatality Benefits	$7,000 burial benefit. Weekly benefits payable are based on a percentage of the deceased employee's average weekly wage, not to exceed the statewide average weekly wage. Dependent children are eligible for benefits up to the age of 18 or 23 if they are full-time students in an accredited educational institution. A dependent child is also eligible for benefits after age 18 (even if not a student) if, due to the child's own disability, the child is dependent on the decedent as of the date of death. If a widow/widower remarries, they are no longer eligible to receive benefits. There is a 104 week dowry. If there are no dependent children under the age of 18, widow/widower receives weekly benefits of 51% of the average weekly wage; if there is one child 60%, two or more children 66 2/3%. If the decedent had dependent children who were not living in the decedent's household, the widow/widower and non-custodial child split 60% of the average weekly wage; if there are more non-custodial children, the widow/widower receives 33 1/3% of the average weekly wage and the non-custodial children share the other one-third of the wages. If there is no widow/widower but dependent children, benefits are paid to the guardian or the Board appointee: one child 32%, two children 42%, three children 52%, four children 62%, five children 64%, six or more children 66 2/3%. If there is no widow/widower or dependent children and the deceased employee's parents depended upon him/her in part for their support weekly benefits are payable at 32% and if supported in whole by the deceased employee 52%. If there is no widow/widower, dependent children or parents and there are brothers/sisters who were totally dependent on the deceased employee for support, weekly benefits are payable as follows: one brother/sister 22% and 5% for each additional brother/sister to a maximum of 32% payable to their guardian or the Board appointee.
Vocational Rehabilitation	Vocational Rehabilitation is not mandatory in PA. There is no reimbursement for retraining. Vocational experts are utilized to secure a Labor Market Survey to prove earning capacity or to conduct traditional job development to show work is available. This information is required in order to proceed with a modification or suspension petition.

Indemnity issues

Settlement Allowed	Lump sum settlements via Compromise and Release. May resolve claim for medical or indemnity only or both. Settlements may be structured. Medicare has established thresholds for the review of agreements settling work related future medical expenses. The thresholds for review of a WCMSA proposal are only Centers for Medicare and Medicaid Services (CMS) workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer Act. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation insurance. Accordingly, we must consider Medicare's interests when settling any workers compensation case even if review thresholds are not met. Pursuant to the thresholds, Medicare approval is required for all settlements where the employee is receiving Medicare benefits at the time of the settlement and the settlement is $25,000 or greater. If less than $25,000, the WCMSA does not have to be submitted to CMS, however, the allocation should be completed by the Claim Professional and the methodology of allocation should be set forth in the settlement documents. Medicare approval is also required if the employee has a reasonable expectation of Medicare within 30 months of the date of the settlement and the anticipated total settlement amount for future work related medical expenses and indemnity is greater than $250,000. The WCMSA should be completed by an in-house MSA Consultant or Vendor and submitted to CMS for review. A claimant may have a reasonable expectation of Medicare enrollment within 30 months if any of the following apply: The claimant has applied for Social Security Disability Benefits; The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision; The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits; The claimant is 62 years and 6 months old; The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD; The claimant is legally blind in both eyes; The claimant has significant spinal cord injury and/or significant brain trauma (Travelers internal guidelines). It is recommended that settlements $200,000 to $250,000, although not required to be submitted to CMS, should have a WCMSA allotment completed by an in-house MSA Consultant or Vendor.

Indemnity issues

Cap on benefits, Act 111	An Impairment Rating Evaluation (IRE) is a medical examination requested by the insurer to determine a worker's whole body impairment due to the compensable injury after the worker has received 104 weeks of total disability compensation. On October 24, 2018, Governor Wolf signed into law Act 111 of 2018, which reestablished the Impairment Rating Evaluation (IRE) process in Pennsylvania. In pertinent part, the new IRE provisions, which will be found in Section 306(a.3) of the Workers' Compensation Act, require IREs to be performed under the 6th edition (second printing April 2009) of the AMA Guides to Evaluation of Permanent Impairment, and set the threshold for the presumption of total disability at thirty-five percent (35%). If the rating is 35% or less, disability status will change from total to partial disability at the same rate for TTD and capped at 500 weeks of temporary partial disability. Modification petitions must be filed in order to convert status from total to partial disability unless the IRE exam is requested and completed within 60 days of the payment of the 104 weeks of TTD.

Medical issues

Initial Choice of Provider	Provided an employer establishes a panel list of at least six designated health care providers (no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians) and the employee has signed a Rights and Duties form at the time of hire and at the time of the injury, the employee shall be required to visit one of the physicians or other health care providers (can include chiropractors) so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit.
Change of Provider	Following termination of the 90 day period, the employee may choose his or her own practitioner and must notify the employer within five days of the first visit to the new physician.
Medical Fee Schedule	Providers are required to file periodic medical reports with employer within 10 days of commencing treatment and at least once a month (30 days) thereafter. Provider's compensation is based on 1994 frozen Medicare rates times 113%, plus an annual fee increase equal to the average weekly wage percentage increase each year as the injured workers. Hospitals are compensated based on DRGs based on 1994 frozen Medicare rates times 113%. Drug reimbursement limited to 110% above the average wholesale price.
Managed Care	Medical services may be provided through a coordinated care organization certified by the Secretary of Labor. Where the Secretary certifies that the coordinated care organization within which all of the designated physicians or other health care providers are members, the Secretary shall ensure that all of the following requirements are met: The coordinated care organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the Act and an appropriate flexibility to workers in selecting providers. Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers. The Secretary shall certify an entity as a coordinated care organization if the Secretary finds that the entity: possesses the capacity to provide all primary medical services as

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	designated by the Secretary in a manner that is timely and effective; maintains a referral capacity to treat other injuries and illnesses not covered by primary services but which are covered by this Act; provides a case management and evaluation system which includes continuous monitoring of treatment from onset of injury or illness until final resolution; provides a case communication system which relates necessary and appropriate information among the employee, employer, health care providers and insurer; provides appropriate peer and utilization review and a care dispute resolution system; meets quality of care and cost-effectiveness standards based upon accepted standards in the profession, including health care effectiveness measures of the PA Health Care Cost Containment Council and recommendations on quality of care by the Worker's Compensation Advisory Council; complies with any other requirements of law regarding delivery of health care services; establishes a written grievance procedure for prompt and effective resolution of patient grievances.
Utilization Review	Questions as to the reasonableness or necessity of treatment by a health care provider are resolved by a utilization review at the request of an employee, employer or the insurer. The Bureau assigns the reviews to a review organization on the basis of like specialty to like specialty. If either party disagrees with the determination, a petition may be filed for review.
Treatment Guidelines	There are no specific statutes or regulations requiring the development of treatment guidelines.
Generic Drug Substitution	The state does not mandate generic substitution.
Medical Mileage Reimbursement Rate	$0.21 per mile – Source IRS-2022, and is only paid when treatment is not available in the normal geographical area where the injured worker resides. The IRS business rate of $0.67 as of January 1, 2024per mile must be paid when we set up an IME or other mandatory appointment.
Network Information	Coventry Integrated Network
Ability to Terminate Medical Treatment	Medical treatment can be terminated only by Judge's Order or via the Utilization Review process.
Settlement Allowed	Lump sum settlements via Compromise and Release. May resolve claim for medical or indemnity only or both. Settlements may be structured. Medicare has established thresholds for the review of agreements settling work related future medical expenses. The thresholds for review of a WCMSA proposal are only Centers for Medicare and Medicaid Services (CMS) workload review thresholds, not substantive dollar or "safe harbor" thresholds for complying with the Medicare Secondary Payer Act. Under the Medicare Secondary Payer provisions, Medicare is always secondary to workers' compensation insurance. Accordingly, we must consider Medicare's interests when settling any workers compensation case even if review thresholds are not met. Pursuant to the thresholds, Medicare approval is required for all settlements where the employee is receiving Medicare benefits at the time of the settlement and the settlement is $25,000 or greater. If less than $25,000, the WCMSA does not have to be submitted to CMS, however, the allocation should be completed by the Claim Professional and the methodology of allocation should be set forth in the settlement documents. Medicare approval is also required if the employee has a reasonable

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	expectation of Medicare within 30 months of the date of the settlement and the anticipated total settlement amount for future work related medical expenses and indemnity is greater than $250,000. The WCMSA should be completed by an in-house MSA Consultant or Vendor and submitted to CMS for review. A claimant may have a reasonable expectation of Medicare enrollment within 30 months if any of the following apply: The claimant has applied for Social Security Disability Benefits; The claimant has been denied Social Security Disability Benefits but anticipates appealing that decision; The claimant is in the process of appealing and/or re-filing for Social Security Disability benefits; The claimant is 62 years and 6 months old; The claimant has an End Stage Renal Disease (ESRD) condition but does not yet qualify for Medicare based upon ESRD; The claimant is legally blind in both eyes; The claimant has significant spinal cord injury and/or significant brain trauma (Travelers internal guidelines). It is recommended that settlements $200,000 to $250,000, although not required to be submitted to CMS, should have a WCMSA allotment completed by an in-house MSA Consultant or Vendor.
Cap on benefits, exceptions	Medical benefits are capped by obtaining a favorable Utilization Review or a favorable decision from a Judge on a Termination Petition.

Other Issues

Compensability Decision Timeframe	A bureau document must be issued within 21 days of notice of a work injury. No other requirement.
WC Hearing Docket Speed	Hearings are scheduled within 30 - 60 days of assignment to a Judge

Other Issues

Staff Counsel	Law Offices of William J Ferren 801 Lakeview Drive Ste 301 Blue Bell, PA 19422 215-274-1700 1500 Market Street, Suite 2920 29th Floor, West Tower Philadelphia, PA 19102 267-675-3017 Glenmaura Professional Plaza 50 Glenmaura National Boulevard, Ste 300 Moosic, PA 18507 570-343-6570 Two Chatham Center, Suite 975 Pittsburgh, PA 15219 412-338-3184
Hearings require attorney or claim handler participation	Attorney presence required. Some hearings are conducted in person, however, most hearings are now conducted virtually via MS Teams.
Occupational Diseases	Yes – as defined under Section 108 of the PA Occupational Disease Act.
Second Injury Fund availability	N/A
Other Offset Opportunities	Subsequent Injury Fund: Where the employee suffers a second specific loss of certain types after suffering a similar previous loss (even if non-work related, and total disability results, compensation for total disability is paid by the Commonwealth during the period of total disability following the expiration of the specific loss payments for the second injury. The Fund is maintained by the Commonwealth out of annual assessments on insurers. Net Unemployment Compensation on benefits received since date of injury. Pension benefits may be offset to the extent funded by the employer directly liable for the payment of compensation. 50% of Social Security Retirement Benefits (characterized as Old Age benefits in the Act) received after the date of injury.
EDI	Claims EDI Release 3: FROI & SROI (9/9/2013)
In-State Adjusting Required	None
License or Certification Required	None