# Workers Compensation Benefit Overview – Pennsylvania

Major Developments: Last major legislation in 2004 (SB899), affected indemnity rates, disability rating, medical treatment, medical-legal disputes, penalties, and apportionment. 2007 legislation affects caps on TD and post-surgical treatments.

## Indemnity Issues

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| Temporary Total Benefits | Temporary total benefits are based on the calculation of an average weekly wage. All wages, including overtime/vacation/ and bonuses, are averaged for a specified number of weeks, 52 weeks prior to date of injury, to compute the average weekly wage. 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 seven day waiting period. Benefits are payable based on a chart provided by and revised annually by the Bureau of Workers' Compensation. **The minimum weekly amount $464.44or less – 90%, maximum weekly amount $836.00.** Maximum duration: there can be exposure for lifetime, open to resolution, return to work 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, scarring and disfigurement to the 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 of the Act. |
| Permanent Total Benefits | There are no statutory Permanent Total Benefits. |
| Fatality Benefits | $3,000 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. If a widow/widower remarries, they are no longer eligible to receive benefits. 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 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%. |

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| | 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 | Pre-Act 57 cases 06/24/96 - benefits entitle the employee to educational and vocational assessment, job placement assistance or retraining. It is not mandatory to participate.<br>Post-Act 57 cases – performance of a labor market survey by a vocational expert to prove earning capacity is all that is required in order to proceed with a modification or suspension petition. |
| Settlement Allowed | Lump sum settlements via compromise and release. May resolve claim for medical or indemnity only or both. Settlements may be structured. Medicare approval required for all settlements where the employee is (a) receiving Medicare benefits at the time of the settlement or has applied for SSDI/Medicare benefits or has a reasonable degree of enrolling for Medicare within 30 months of the date of the settlement; (b) has been denied SSDI but anticipates appealing or is in the process of appealing/re-filing; (c) employee is 62.5 years of age and settlement is under $250,000; (d) settlement is over $250,000 |
| Cap on benefits, exceptions | Benefits may be capped by obtaining an impairment examination after 104 weeks of temporary total benefits are paid. If the impairment rating is less than 50% of whole body, benefits are capped at 500 weeks at the temporary total weekly rate. Temporary total benefits may be modified to temporary partial benefits and capped at 500 weeks or suspended by performing a labor market survey to prove earning power, filing a Suspension/Modification Petition and receiving a favorable decision by a Judge. |

## Medical Issues

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| 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 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% and they receive the same average weekly wage percentage increase each year as the injured workers. Hospitals are compensated based |

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| | on DRG's 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 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. |
| Medical Mileage Reimbursement Rate | **$.24** per mile – Source IRS **IR-2009**-168 Applicable period 2008 |
| Ability to Terminate Medical Treatment | Medical treatment can only be terminated 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 approval required for all settlements where the employee is (a) receiving Medicare benefits at the time of the settlement or has applied for SSDI/Medicare benefits or has a reasonable degree of enrolling for Medicare within 30 months of the date of the settlement; (b) has been denied SSDI |

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| | but anticipates appealing or is in the process of appealing/re-filing; (c) employee is 62.5 years of age and settlement is under $250,000; (d) settlement is over $250,000 |
| 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

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| Hearings require attorney or claim handler participation | Attorney presence required |
| Occupational Diseases | Yes – as defined under Section 108 of the PA Occupational Disease Act. |
| Second Injury Fund availability | N/A |
| Other Offset Opportunities | N/A |

State workers compensation website link: http://www.dli.state.pa.us/

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