SIDEBAR
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In This Issue...

MEDICARE REPORTING AND REPAYMENT IN TORT RECOVERY

By Miriam Dole, Esq.

The Medicare Secondary Payer Act (MSP), enacted on December 5, 1980, established that Medicare would always be a secondary payer where another entity is obliged to pay medical expenses. Since that date, Medicare has had the right to seek reimbursement from the proceeds of settlements that include recovery for the expense of medical treatment, but for many years, this right was not enforced. In 2007, Congress enacted new rules to enhance enforcement of the repayment obligation with the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA).

There are two separate obligations that arise from MMSEA and the MSP: the MMSEA establishes the obligation of settling defendants to report any settlement that meets certain criteria to the Centers for Medicare & Medicaid Services (CMS), and the MSP created the separate obligation of plaintiffs having to repay benefits paid out by Medicare or Medicaid for treatment of the injury that is the subject of the litigation and settlement.

While the duty to repay Medicare has existed for many years, the duty to report the settlement of tort lawsuits is new.

Although the deadline for reporting has been delayed several times, insurers and self-insured entities will be required to report lump sum settlements of tort claims made by Medicare-eligible claimants/plaintiffs that are settled on or after October 1, 2011. Substantial penalties will be imposed for failing to properly report. Failure to report and ensure that repayment has taken place could leave Responsible Reporting Entities (RRE) (defendants) in the position of having to repay Medicare themselves, even if they have already paid the plaintiff/claimant for those expenses in settlement or satisfaction of a judgment or award. Furthermore, it could lead defendants to be subject to a $1,000 per day plus interest penalty for any late reporting. In seeking reimbursement, Medicare will follow the Taxpayer Recovery Offset Program (TROP). Under this program, Medicare will first look to Social Security

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payments (claimant), then tax refunds (claimant), and then it will look to plaintiff's attorneys. Only after failing to recover would they look to insurers or defense counsel (if they held the funds at some time).

Thresholds for Reporting

There are certain thresholds relating to the obligation to report.

1. There is no reporting obligation for settlements agreed upon prior to October 1, 2011. The applicable date is the date the agreement to settle is put into writing, or the date of court approval of a settlement, if required.

2. There is no reporting obligation for exposures that pre-date December 5, 1980. The CMS User Guide has also very clearly set forth that the applicable dates of exposure are to be evaluated on a defendant by defendant basis:

Additionally, please note that application of the December 5, 1980, is specific to a particular claim/defendant. For example, if an individual is pursuing a liability insurance (including self-insurance) claim against "X", "Y" and "Z" for asbestos exposure and exposure for "X" ended prior to December 5, 1980, but exposure for "Y" and "Z" did not; a settlement, judgment, award or other payment with respect to "X" would not be reported.

User Guide 3.0, at pp. 86-87. This level of clarity is rare, however, as there remain many unanswered questions as to proper compliance. Another User Guide has been expected for quite some time, but has not yet issued.

Questions remain as to what constitutes "uncontroverted evidence" that the last date of exposure pre-dates December 5, 1980. Generalized allegations of exposure during a plaintiff's entire work history, continuing beyond that date, could be problematic. Neither a Stipulation between the parties nor a state court determination that all exposure pre-dates 1980 is likely to be sufficient. Affidavits executed at or near the time of settlement, declaring no exposure post-1980 will be considered suspect. So far, deposition testimony seems to be key. Additionally, any Release that does not exclude post-1980 exposures would create a reporting obligation, even where one does not already exist.

3. At present, there is no reporting obligation for settlements or payments totaling $5,000 or less. This threshold drops in the future: on or after January 1, 2013, settlements or payments totaling $2,000 or less need not be reported; on or after January 1, 2014, settlements or payments totaling $600 or less need not be reported. All settlements or payments in satisfaction of a claim that includes the cost of medical expenses (and meets the other thresholds) must be reported after December 31, 2015.

4. There is no reporting obligation where the claimant/plaintiff is not Medicare-eligible. It is estimated that 50-80 percent of mass tort claimants are Medicare-eligible (as compared to the approximately 15 percent of the general population that is Medicare-eligible). Note that one need not be of a certain age to be Medicare-eligible. Those on Social Security Disability become Medicare-eligible after 24 months. Railroad employees subject to FELA also become Medicare-eligible after 24 months. The recently-passed health care bill also decrees that persons afflicted with mesothelioma or asbestosis, or who live in a "federal disaster zone" are automatically eligible for Medicare. Some believe that a "no action" letter from CMS indicating that Medicare will not be asserting any liens should be enough to satisfy defendants that the payee is not Medicare-eligible. Others feel that reporting should still take place, since it is not yet completely clear that this is sufficient. For instance, the reporting of Worker's Compensation payments to CMS would re-open a case, even after such a letter has issued. It has become imperative that those involved in third-party liability claims be fully aware of Worker's Compensation claims that may also exist.

A Change In Focus

Until this reporting obligation became law, it was standard practice to leave compliance issues to the plaintiffs. There has been a shift away from reliance on simple indemnification clauses in Releases, to an affirmative obligation on the part of defendants to ensure that Medicare is repaid for payments for medical expenses that result from the injury or illness that is the basis for the lawsuit or claim (Indemnification Plus).

Defendants are considering a number of strategies in order to avoid the double recovery penalty should plaintiffs fail to comply with the repayment obligation. It is a difficult situation, since defendants are held responsible, yet have no power to effectuate the required repayment. RREs have begun to establish procedures to deal with this reporting obligation. Where some defendants have coverage from a number of insurance carriers, there are multiple sets of procedures, some conflicting, relating to the same defendant. Some jurisdictions, notably Madison County, Illinois and a Michigan jurisdiction, have attempted to deal with this issue via Case Management Order (CMO).

Protections for Defendants

The proposed CMOs reflect the change of focus away from indemnification clauses and toward proof of resolution. Some of the proposed clauses of these CMOs require that plaintiffs' counsel hold in trust sufficient funds to satisfy any amount due to Medicare. Some provisions also require that if plaintiff fails to

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POST KOKEN TRIALS: A CASE STUDY

By James C. Haggerty, Esq.
and Jordan S. Derringer, Esq.

(a) Overview

Until 2005 in Pennsylvania, the Insurance Department would not approve for use any personal or commercial automobile policy unless it contained a clause requiring arbitration of uninsured (UM) and underinsured (UIM) motorist claims. In IFP v. Koken, 889 A.2d 550 (Pa. 2005), the Insurance Federation of Pennsylvania challenged the authority of the Insurance Commissioner to mandate the inclusion of a mandatory arbitration clause for resolution of uninsured and underinsured motorist disputes in auto policies. The Supreme Court found that the Insurance Commissioner exceeded her express and implied authority in requiring arbitration of such claims. In so holding, the Court determined that insurers need not include mandatory arbitration clauses in auto policies in Pennsylvania. Koken, 889 A.2d at 555. As a result most (if not all) insurers in Pennsylvania removed mandatory arbitration clauses from their personal and commercial automobile insurance policies. Accordingly, uninsured and underinsured motorist claims are now litigated in Court and not in arbitration.

(b) Issues

(1) Generally

With the advent of direct claims filed in the Court, the UM or UIM insurer now becomes a named defendant in a personal injury claim. As a result, numerous issues, not heretofore addressed in UM and UIM claims, must be faced. A brief overview of some of these important issues is set forth below.

(2) Insurance

In UM or UIM claims filed in Court, an issue arises regarding whether the jury is entitled to learn of the existence of insurance. Customarily, evidence of insurance is inadmissible at trial. See Greenwood v. Hildebrand, 515 A.2d 963, 968 (Pa. Super. 1986), appeal denied, 528 A.2d 602 (Pa. 1987). In the UM or UIM motorist case, however, the insurer is often the only defendant. Thus, a question exists as to the manner in which insurance is to be handled at the time of trial. From the insurer's point of view, there should be little or no mention of insurance coverage. Ideally, the matter should be tried as a standard tort action, much the same way that UM and UIM claims were handled in arbitration. At trial, however, the insurance company defendant must be identified, at a minimum, in voir dire.

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IT DOES NOT PAY TO DISOBEY THE JUDGE, BUT YOU MAY HAVE TO

By Nicole L. Graham, Esq.

The misconduct of plaintiffs' counsel took center stage at a February 2010 jury trial in a wrongful death and survivorship action in the United States District Court Eastern District of Pennsylvania. On the second day of trial, plaintiffs' counsel gave his opening statement and questioned two witnesses. Throughout the questioning, plaintiffs' counsel violated several of the court's evidentiary rulings, incurred more than 30 sustained objections, violated the court's rulings and instructions at trial, and exposed the jury to a number of excluded evidentiary issues, improper questions and inflammatory statements. Defense counsel moved for a mistrial following the opening statements, and the court admonished plaintiffs' counsel. Plaintiffs' counsel assured the court that his conduct would not be repeated, and the motion was withdrawn. However, despite his assurances and after numerous sustained objections and sidebar conferences, plaintiffs' counsel continued to violate the court's evidentiary orders, ask improper questions, and disregard the court's prior instructions.

On the third day of trial, the court granted defendants' unopposed request for a mistrial based upon plaintiffs' counsel's violation of several of the court's prior orders and rulings, resulting in prejudice to defendants.

Defendants then filed a motion for sanctions against plaintiffs' counsel and plaintiffs' counsel's law firm pursuant to 28 U.S.C. § 1927 and the court's inherent power to discipline attorneys who appear before it. To violate § 1927, an attorney must be found to have multiplied proceedings in an unreasonable and vexatious manner; thereby increasing the cost of the proceedings and doing so in bad faith or by intentional misconduct. Defendants requested that (1) plaintiffs' counsel and his firm pay defendants' attorneys' fees, expenses and costs; (2) plaintiffs' counsel and his firm pay the court's costs for two days of trial; and (3) plaintiffs' counsel be disqualified from representing plaintiffs.

The court found that plaintiffs' counsel's conduct violated § 1927. The court noted that a trial has very specific rules, and it is fundamentally unfair for one party's lawyer to disobey the rules to the detriment of the other party.

The court granted defendants' request for attorneys' fees, costs and expenses associated with the trial and the motion for sanctions. The court denied defendants' request for the court's costs and expenses. The court also denied as moot defendants' request for disqualification of plaintiffs' counsel because plaintiffs represented that he will not take part in the upcoming trial. The court ordered defendants to submit a petition, setting forth an itemization of their claim for attorneys' fees, costs and expenses.

On March 28, 2011, the court entered an order which required plaintiffs' counsel and his firm, jointly and severally, to reimburse defense counsel by check in the amount of $100,436.25 within 30 days of the date of the order. On April 1, 2011, plaintiffs filed a motion to stay the court's March 28, 2011 order in order to pursue an appeal. In any event, plaintiffs' counsel and his law firm have learned a costly lesson.

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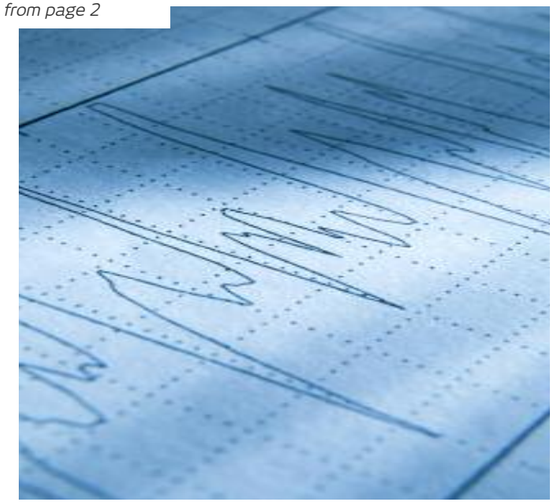

satisfy Medicare's final demand, and further, if defendant is sued for these Medicare funds, that plaintiff will also be responsible for all attorney's fees and expenses for defending the suit. However, plaintiffs' attorneys are refusing to personally guarantee repayment, and many plaintiffs' firms are refusing to even include language that plaintiffs themselves will indemnify. One local plaintiffs' attorney is even refusing to provide ICD9 (treatment) Codes required by Form B, used for reporting, since he is not a medical doctor, and cannot know what treatment was related to the disease at issue.

Release language has again become the focus of much debate. Defendants must ensure that it is clear that it is plaintiff's obligation to repay amounts paid for medical bills by Medicare, and that repayment is a condition precedent to settlement. Most plaintiffs' counsel will agree to language that requires settlement funds to be held in escrow until a final demand from CMS is received and paid in full (minus the allowed "costs of procurement" that include plaintiff's counsel's fees and costs). Many plaintiffs' counsel will agree to language that their clients will indemnify for any failure to properly repay Medicare. While many RREs also seek to include language that requires plaintiff's counsel to personally indemnify settling defendants and their insurers, such requirements raise ethical issues. The New York City Bar has determined that such a personal guarantee is unethical, since it puts plaintiffs' attorneys in conflict with their clients. This requirement has also been found not to be permissible in New York, Florida, Illinois, Missouri and Michigan. It was noted that the ethics rules in those states are nearly identical to those in Pennsylvania and New Jersey. Further, it is considered a violation of ethical rules for defense counsel to even attempt to induce plaintiffs' counsel to violate ethical rules by being in conflict with their own clients. Accordingly, this approach is likely to be rejected.

It is hoped that a future User Guide will specifically address issues on which there is as yet no clear guidance, including methods for reporting partial payments and possibly clarification of procedures relating to mass tort claims, bankruptcy and insolvency. On March 14, 2011, the Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act) (H.R. 1063) was introduced in the U.S. House of Representatives. The SMART Act proposes amendments to the Medicare Secondary Payer Statute (MSP), relating to obtaining CMSs conditional payment amount, MSP appeal rights, the $1,000 a day penalty provision, threshold exemptions and a Statute of Limitations relating to MSP claims, and other provisions.

Negotiating With Medicare

These issues should be clearly on the table during settlement negotiations. Without information as to the amount of the repayment obligation, neither party will know how much money the plaintiff will be able to keep from a settlement. It is common that a case will be settled for less than full value, or for less than the amount of the medical bills that have been paid by Medicare and must be reimbursed, due to contested liability and damages or limited insurance coverage. It is possible to negotiate with Medicare to have the amount of the final demand reduced. One case that does lend precedent to a reduced demand is Arkansas v. Ahlborn, 547 U.S. 268 (2006), in which Medicaid settled for a pro-rata share of the medical bills paid. Plaintiffs only recovered 1/6th of the damages alleged, and it was held that Medicaid should likewise only be reimbursed for 1/6th of the medical payments. Medicare has accepted lower amounts or has waived reimbursement altogether if full repayment would leave no money for the injured plaintiff. Plaintiffs can argue financial hardship if the plaintiff lives below poverty level or if there are unforeseen severe financial circumstances. Plaintiffs can also seek Allocation Orders, apportioning damages between Wrongful Death (which does not include medical bills) and Survival damages (which do cover medical expenses). Apportionment can also be requested, either as a percentage or in a dollar amount, between medical bills and other damages, such as pain and suffering. The amount allocated for medical bills would represent the total amount of recovery that is subject to the repayment obligation. This is supported by the Ahlborn case referenced above.

The primary effect of the new reporting requirement is that the parties must deal with these issues very early in the litigation, long before settlement negotiations begin. It is clearly to the benefit of both plaintiffs and defendants to work together to resolve these issues, since variations in reporting can lead to a myriad of difficulties.

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Efforts need to be taken to eliminate any other references to the insurance company or the availability of insurance during trial.

(3) Tort v. Contract

An UM or UIM claim is essentially contractual in nature. See Boyle v. State Farm, 456 A.2d 156 (Pa. Super. 1983). However, in the UM or UIM claim, the insurer stands in the shoes of the uninsured or underinsured tortfeasor. Thus, the claim essentially sounds in tort. From the point of view of the insurer, therefore, the case should be tried much the same as a standard tort action. Contractual principles should not be involved. There should be no reference to the existence of the insurance contract, the limits of coverage, the payment of premiums, etc. Similarly, other evidence, regarding slogans, duties of insurers, etc., should similarly be precluded from admission at the time of trial.

(4) Molding of the Verdict

In the UM or UIM case at trial, the jury should not be given any information regarding the existence of a policy or the limits of coverage. In the UIM context, the settlement of the underlying tort case, and the credits to be applied, should similarly be withheld from evidence. Instead, an agreement should be sought between counsel to try the case as a traditional tort action, with the jury fully evaluating the case as a standard negligence claim. In such cases, the Court should then mold the verdict to account for the applicable credits (in the UIM claim) and the limits of coverage (in the UM and UIM matter). In this way, insurance information is kept from the jury, thereby eliminating prejudice.

(c) Case Study

Recently, Swartz Campbell, LLC served as trial counsel in one of the first post-Koken cases to be tried in Philadelphia County. In Johnson v. Nationwide Insurance Company of America, Court of Common Pleas of Philadelphia County, June Term, 2009, No. 3375, the plaintiff sought recovery of UIM benefits under a personal automobile policy of insurance. The tort action had been settled for $14,500. Thus, the UIM insurer was the sole defendant in the action.

Jordan S. Derringer and James C. Haggerty handled the matter on behalf of Nationwide. In this regard, a Motion in Limine was prepared. In that Motion, the following positions were asserted on behalf of the insurer:

- the UIM claims should be tried as a standard auto tort action;
- information regarding the existence of an insurance policy, the applicable policy limits and the terms of coverage should be excluded from evidence;
- no information regarding the underlying tort action should be given to the jury;
- premium payments and advertising slogan were irrelevant and inadmissible;
- any verdict should be molded to reflect the credits from the settlement of the tort action and the limits of UIM coverage.

These legal issues were presented to the Court prior to trial.

At trial, the Court accepted the position set forth by the insurer. Insurance was not mentioned at trial. Nonetheless, since the defendant was an insurance company, the insurer was identified in voir dire. Prospective jurors were questioned regarding their attitude toward insurance companies. During trial, however, there was no mention of insurance, policy limits, premiums or slogans. Similarly, the jury charge did not contain any mention of the presence of an insurer defendant. In fact, no charge was even given on the nature and existence of UIM coverage.

In this matter, the plaintiff had demanded $100,000 in settlement of her claims. No offer was extended. An issue also existed at trial as to the satisfaction of the limited tort threshold. In this regard, the plaintiff contended that she sustained a serious injury, thereby entitling her to damages for pain and suffering. The verdict slip presented to the jury stated:

Question 1: Was [the tortfeasor's] negligence a factual cause in bringing about any harm to the Plaintiff?
Yes No

If your answer to Question #1 is "Yes", proceed to Question #2. If your answer to Question #1 is "No", the Plaintiff cannot recover and you should not answer any further questions and you should return to the Courtroom.

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Mitigating Long Term Narcotic Prescription Exposure in Workers' Compensation Claims

By John P. Zeigler, Esq.

Within the last two decades, the costs associated with pharmaceuticals have risen more rapidly than any other type of medical cost. It is estimated that in 2011, prescription drugs will comprise nearly 15 percent of total national health care spending. In workers' compensation cases painkillers represent 55 percent of the costs of prescriptions with 25 percent of those specifically narcotic-based prescriptions.

In 2009, the FDA in public meetings noted the following: Despite existing efforts to address the risk associated with opioid drugs, misuse and abuse are increasing. Data from multiple sources, including the Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), indicate increasing misuse and abuse of prescription opioid analgesic medications over the past decade. For example, SAMHSA's National Survey on Drug Use and Health estimates that 11 million Americans over the age of 12, or 4.7 percent of that population, took pain relievers for non-medical use in 2002. In 2007, that number increased to 12.5 million or 5.0 percent of the population over [the age of] 12. Likewise, data compiled by SAMHSA show a significant increase from 2000 to 2006 in admissions to substance abuse treatment services for individuals abusing opioid analgesics. Much of this misuse has involved the extended-release opioid analgesics and methadone. To address this public health problem, the agency has indicated [that] it will require REMS [(Risk Evaluation and Mitigation Strategies)] for certain opioid products.

In addition to the obvious public health concerns, the financial costs associated with this problem specific to workers' compensation are significant. While Group Health Insurance as a whole pays 72 percent of the average wholesale price of prescription drugs, workers' compensation pays roughly 125 percent of the average wholesale price. Additionally, while generic equivalents are prescribed when available 79 percent of the time for workers' compensation claims, over 56 percent of workers' compensation prescription costs are associated with drugs that have no generic equivalent. Finally, when again compared with group health insurance, workers

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"So what should the Pennsylvania Employer/Insurer do insofar as attempting to mitigate this potential long-term prescription exposure in a workers' compensation claim?"

compensation has much more of a long term cost consequence in that substantial quantities of medical service are routinely delivered for many years following the date of injury. As a result, estimates of the annual cost for the costs and reserves on serious claims must fully account for the compounding effect of medical inflation. Such inflation could double the cost of these services within just eight years from the initial first year cost.

Despite the escalated costs of narcotic prescriptions, chronic pain treatment is often the last issue addressed from a mitigation standpoint in workers' compensation cases. Indemnity wage loss exposure has perhaps been settled or alternatively the claim languishes on due to chronic pain treatment becoming the final resort for what has otherwise been labeled failed treatment. Narcotic prescription levels are increased as claimants become tolerant to high level of opioids, requesting higher levels to ease their chronic pain. Vocational efforts such as return to work offers and labor market surveys are complicated by claimants whose narcotic prescription use may make them unfit to drive, unable to function for full work shifts or incapable of working with or around equipment.

So what should the Pennsylvania Employer/Insurer do insofar as attempting to mitigate this potential long-term prescription exposure in a workers' compensation claim? Particularly, when facing a claim which might ultimately require approval of a lifetime-calculated prescription Medicare Set Aside mitigating these costs becomes critical before the chance to do so may pass. This article summarizes one mitigation strategy combining an appropriate Independent Medical Examination with the URO process and ultimately, if necessary, a Petition for Review of a UR Petition before a workers' compensation judge.

A. Selection of an Independent Medical Examiner

One mistake commonly made with workers' compensation claims is that even after the specific injury has been litigated and/or accepted, surgery or conservative remedies have been exhausted and the claim has morphed into primarily prescription-focused chronic pain management. Nevertheless, the Independent Medical Examiner (IME) selection continues to be referred specifically to a practitioner who specializes in the area of the original work injury. For example, a claimant who suffers from a multi-level discogenic condition with one or more resultant fusion surgeries is repeatedly scheduled to an orthopedic or neurosurgery expert, despite the fact that claimant's treatment became exclusive to chronic pain management through primarily of Actiq or Fentynl. The patient has become dependant upon the medication for what is often described as maintaining some level of functionality, but otherwise treatment specific to the discs themselves is not occurring.

The reality is that this type of claim is beyond the point of re-litigating the original injury, and there is little chance of a full recovery opinion based on the severity of the original injury and resultant surgery. Thus, the focus should be looking for an assessment of the reasonableness and necessity of the chronic pain management regimen, and a determination of whether this treatment is in fact assisting this patient with goals of returning to work and eliminating pain and disability associated with the injury. This requires an appropriate selection of an IME physician with a specialty and board certification specific to pain management and/or physical rehabilitation. Certainly the pain management/physical rehabilitation specialist could be subject to qualification cross-examination relative to lack of surgical experience. Nevertheless, while the IME has been determined to focus on mitigation of the chronic pain treatment, the pain management specialist is better positioned to provide a reasoned report regarding what constitutes appropriate pain management treatment for the specific condition and circumstance.

In seeking such an opinion, it is important that the inquiry letter to the IME practitioner note that an opinion within a reasonable degree of medical certainty as to the reasonableness and necessity of the specific treatment is sought following the medical history, the record review, and the examination. This examination should be initiated with the understanding that a utilization review will also be filed as soon as possible following the issuance of an IME report.

B. The Utilization Review - Forming the basis for possible subsequent WCJ review

Although an IME opinion may provide support that some or all of narcotic prescriptions are not reasonable and necessary, the IME report does not in and of itself provide a mechanism to alter payment of the prescription. However, it will become critical following the filing of a Utilization Review and receipt of a report from the assigned Utilization Review Organization (URO). The Pennsylvania Workers' Compensation Act provides that an employer/insurer can request review of a bill prospectively, concurrently, and retrospectively by filing an application for utilization review and it will be reviewed by a provider of licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review [Section 306 (f.1)(5), 77 P.S. § 531(5)]. The Utilization Review LIBC-601 form must be filed within 30 days of receipt of the medical bill in question. It is important to note that utilization reviews are provider-specific, so if there are multiple providers prescribing narcotic medications, separate utilization reviews are necessary. Within 30 days thereafter, the URO will issue a report as to the reasonableness and necessity of the treatment under review. Should the utilization review determine that the treatment is not reasonable or necessary, the Workers Compensation Act provides an automatic supersedes for only those bills in dispute. Thus, the appropriately worded UR request seeking prospective review with a resultant favorable determination allows denial of continuing bills for that provider.

C. The Review of a UR Petition before a Workers Compensation Judge (WCJ)

Win or lose in the URO determination, if there is an IME report specific to the treatment at issue there is a mechanism for the employer/insurer to successfully litigate the issue of reasonableness and necessity of narcotic prescription before a workers' compensation judge. Following a UR determination, either party has 30 days to file a Petition to Review UR determination with the Bureau of Workers' Compensation. Obviously, should employer/insurer succeed in the UR determination and the claimant does not file a Petition to Review, benefits have been mitigated insofar as limiting that provider's treatment. Should the claimant file a timely appeal, the presence of the IME report provides a potential separate opinion from that of the URO in support of that treatment being unreasonable and unnecessary. This will likely create the leverage of a "two against one" posture when litigating the issue before the judge, which can be critical when dealing with WCJ's who might look to a treating doctor with more deference than a non-treating examiner.

Should the URO determination be unfavorable, if there is an IME prior that contradicts the determination the employer/insurer could be the one to file the Petition to Review challenging that determination by taking the deposition testimony of the IME physician. While the employer/insurer runs the risk of having the "two against one" situation reversed with claimant providing testimony from both the URO reviewer and the provider at issue, nevertheless employer/insurer gets a chance to present these issues where otherwise they could not have been before a WCJ with the chance of a reversal of

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Question 2: State the amount of recoverable lost-wages sustained by the Plaintiff as a result of the accident. $_____ Proceed to Question #3.

Question 3: Do you find that the Plaintiff sustained a serious impairment of a body function as a result of the accident? Yes No

If your answer to Question #3 is "Yes", proceed to Question #4. If you answer to Question #3 is "No", the Plaintiff cannot recover any non-economic damages and you should not answer any further questions and should return to the Courtroom.

Question 4: State the amount of non-economic damages, if any, sustained by the Plaintiff as a result of the accident.

$_____

Following deliberations, the jury returned a verdict in favor of the plaintiff, awarding $2,000 in economic loss, i.e. lost wages and $2,150 in non-economic damages, i.e. pain and suffering. Accordingly, a Motion to Mold the verdict was presented to the Court, seeking to apply the credit from the settlement of the tort action. The Motion was granted and the verdict was molded to zero.

The ultimate result was favorable. The plaintiff received no UIM benefits. The result was facilitated by the identification of potential issues and the presentation to the Court of reasonable legal arguments by way of Motion in Limine prior to trial. Absent the adoption of uniform rules for the handling of post-Koken cases by the Supreme Court, the issues will be individually addressed by the trial courts in each county. Consideration should be given to a uniform set of rules to govern the litigation in Court of post-Koken cases. In the meantime, insurers need to closely monitor and carefully handle these cases in order to avoid unexpected results.

James C. Haggerty is a partner in the firm's Philadelphia office and Jordan Derringer is an associate in the firm's Philadelphia office. Both practice in the field of uninsured/underinsured motorists' coverage.

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the URO determination. It is important to note that no matter which party files the Petition to Review a UR determination, the burden before the WCJ rests at all times with the Defendant to prove that treatment is not reasonable or necessary.

When litigating issues specific to long-term narcotic prescription use before the WCJ, it is important for the defendant/employer to emphasize whether that treatment is actually helping that claimant be functional. Often, the claimant's own testimony will work against their position because narcotic-dependant claimant's often testify that no matter how much they take, the pain is not improving. In describing their activities, they candidly admit their lives revolve around taking their medications and the effects those medications have on them, including sleepiness, nausea or limitations as to physical activities. The claimant's try to show the judge that they are not getting better and thus need the regimen to continue.

The defense can show that in reality there is no actual quantifiable functional improvement from this treatment. In combination with testimony from the IME physician detailing that standard practices dictate that if a treatment regimen is not working it should be either changed or discontinued, the claimant's own testimony can hurt their position. Additionally, many pain management providers are careful to consistently document the subjective complaints of pain throughout the years on each and every visit. The defendant can thus argue, for example, that in the course of five years the complaints of pain never changed from what was referenced to be an eight out of a possible 10 on a pain scale, despite narcotic prescription levels being titrated upwards over time.

Another possible attack could be focused on off-label use of certain opioid medications. Some pain management physicians prescribe simultaneous short-acting and long-acting Actiq, which through accepted practices is arguably only approved for terminal cancer patients. Additionally, pain management IME physicians can address dependence issues relative to possible other factors such as prior evidence of prior non-work injury-related drug dependence or emotional or psychological pre-existing issues.

In creating a three-step game plan for IME, UR and WCJ review of long-term narcotic prescription treatment, the employer/insurer can take a proactive position towards ultimately mitigating what can be problematic long-term exposure in a workers' compensation claim.

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NEWS & FIRM NOTES

Jonathan C. Deisher, Esquire, of the Allentown office, obtained judgments in favor of property owners in cases venued in Monroe and Lehigh Counties, in January and March 2011. Both cases involved slip and fall accidents with serious injuries requiring cervical and lumbar disc surgery. Mr. Deisher developed deposition testimony from both Plaintiffs, establishing that they subjectively appreciated the danger posed by the alleged property defects prior to the accidents, and that alternate safe paths of travel were available to them. In the Monroe County case, Judge Patti Worthington granted the property owner's Motion for Summary Judgment, and held that the Plaintiff assumed the risk of her injuries as a matter of law pursuant to the Pennsylvania Supreme Court case of Carrender v. Fitterer, 469 A. 2d 120 (Pa. 1983). Judge Michele A. Varricchio entered a similar order in the Lehigh County case. The Monroe County case is on appeal to the Pennsylvania Superior Court.

- In Davis v. Allstate Insurance Company, Judge Anderson of the Court of Common Pleas of Lycoming County entered Summary Judgment in favor of the insurer. **James C. Haggerty, Esquire**, successfully handled the case on behalf of the defendant. In that case, the plaintiff made claim for recovery of underinsured motorist benefits under a policy of insurance issued to her parents. The plaintiff premised her claim upon: (1) her designation as a driver on the policy; and (2) her residence in the household of her parents. A Motion for Summary Judgment was filed on behalf of the Allstate Insurance Company. Oral Argument was conducted. The Court found in favor of the insurer, determining that the plaintiff had no viable claim for recovery of underinsured motorist benefits under the policy of insurance issued to her parents.

- In Walters v. Allstate Insurance Company, No. 2009-140, the Court of Common Pleas of Wyoming County entered Summary Judgment in favor of the insurer. In so doing, the Court determined that the household exclusion was valid, enforceable and applicable to the claims. In the case, the plaintiff sought recovery of underinsured motorist benefits under a policy of insurance issued to his son and daughter. The Court found that the household exclusion barred recovery under these family policies. The case was successfully handled by **James C. Haggerty, Esquire.**

- On March 9th, 2011, **James C. Haggerty, Esquire**, spoke on March 9, 2011 in Philadelphia at the Pennsylvania Bar Institute Civil Litigation Update. Mr. Haggerty presented an overview and analysis of developments with respect to motor vehicle insurance law. The same presentation was then made on March 23, 2011 in Mechanicsburg, Pennsylvania. That presentation was telecast to 25 remote locations throughout the state.

- In Nationwide Mutual Insurance Company v. Catalini, Docket No. 923 EDA 2010, the Superior Court determined that a new election of underinsured motorist coverage was not needed when the liability limits under a personal auto policy were increased. The Superior Court affirmed the favorable decision entered on behalf of the insurer following a non-jury trial in the Court of Common Pleas of Bucks County. For the first time, the Superior Court applied the rationale of Blood v. Old Guard, 934 A.2d 1218 (Pa. 2007) to a factual situation where there was an increase in liability coverage. Jim Haggerty and Suzanne Tighe of Swartz Campbell LLC handled the case on behalf of the insurer.

- In Catalini, the insured had elected $25,000/$50,000 in liability coverage and $25,000/$50,000 in UM/UIM coverage. The elections were made in accordance with the requirements of the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa.C.S.A. § 1701 et seq. Thereafter, the plaintiff leased a new vehicle. The leasing company required $100,000/$300,000 in liability coverage. The plaintiff requested that the liability coverage limit be increased. The insurer did not require the signing of a new § 1734 election with the increase of the liability limit from $25,000.00/$50,000.00 to $100,000/$300,000. Following a motor vehicle accident, the insured contended that he was entitled to recover $100,000/$300,000 in UIM benefits.

- In Catalini, the Superior Court found that a new § 1734 election was not needed. In this regard, the Superior Court, for the first time, applied the rationale of the Blood decision to the situation where liability coverage limits were increased. In Blood, the Supreme Court determined that a new § 1734 election was not needed where there was a decrease in liability limits. In Catalini, for the first time, the Superior Court applied the Blood holding to an increase of liability coverages. Thus, the Court determined that no new § 1734 election was needed. **For more information and copies of the briefs, contact Jim Haggerty at: (jhaggerty@swartzcampbell.com) or Suzanne Tighe (stighe@swartzcampbell.com)**

- Swartz Campbell LLC is sad to note the passing of **Richard D. Harburg**, a former Managing Partner of the firm. Dick Harburg, a graduate of the Wharton School of the University of Pennsylvania and the Harvard University School of Law, joined Swartz Campbell LLC in 1958. He soon specialized in workers' compensation matters and became the pre-eminent practitioner in this area of the law in the Commonwealth of Pennsylvania. Clients often looked to Dick to handle difficult claims and to handle cases of first impression in the appellate courts. He was a skilled litigator and an excellent appellate court advocate. At the same time, Dick served as a mentor to several generations of attorneys at the firm. In addition to his extensive knowledge of the law, Dick was also a literary scholar, with demonstrated expertise in the works of Shakespeare, Proust and Joyce. The entire Swartz Campbell family is saddened by the passing of Richard D. Harburg. He will be missed.

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NEWS & FIRM NOTES: CONT.

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- **David Henry** presented "Gender Issues in Mediation" for the Central Florida Association of Women Lawyers on March 4th, 2011 in Orlando. Additionally, he presented "Agency Management Based Errors and Omissions Prevention" for the Kansas Association of Independent Agents in Overland Park, KS, on March 16th, 2011

- **Suzanne Tighe, Esquire**, of the firm's Scranton office, presented an update and overview of motor vehicle law insurance issues at the Pennsylvania Bar Institute Civil Litigation Update in Pittsburgh, Pennsylvania on March 16, 2011. Ms. Tighe reviewed and discussed all developments with respect to claims arising under the Pennsylvania Motor Vehicle Financial Responsibility Law over the past year and discussed matters pending in Pennsylvania Appellate Courts.

- On March 10th, 2011, **Beth Valocchi** from the firm's Wilmington, DE office spoke at the 2011 Delaware Asbestos Conference in Wilmington and provided insight related to the three cases tried to verdict in Delaware in 2011. Beth represented CertainTeed, Corporation and Dana Companies, LLC in those trials, and she spotlighted the pretrial preparation, evidence and testimony presented.

- Swartz Campbell LLC is proud to announce that **Stephen J. Harlen**, a partner in its Workers' Compensation Department, has been appointed a Workers' Compensation Judge in the Commonwealth of Pennsylvania. Mr. Harlen, a 1974 graduate of the Villanova University School of Law, worked with Swartz Campbell LLC for 35 years until his appointment to the bench. As a respective and experienced member of the Workers' Compensation Bar, Steve Harlen brings knowledge, experience, intelligence and an even temperament to the bench. Having litigated workers' compensation matters for nearly 40 years, Mr. Harlen knows all aspects of workers' compensation practice. Swartz Campbell LLC is proud to have its partner appointed to the bench to serve in this capacity. We wish him well and know that he will be as fine a jurist as he was a litigator.