[J-113-2010]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

CASTILLE, C.J., SAYLOR, EAKIN, BAER, TODD, McCAFFERY, ORIE MELVIN, JJ.

CROZER CHESTER MEDICAL CENTER,	:	No. 59 MAP 2008
	:	
Appellant	:	Appeal from the Order of the Commonwealth Court at No. 251 MD 2008, Dated July 28, 2008
v.	:	
	:	955 A.2d 1037 (Pa. Cmwlth. 2008)
	:	
DEPARTMENT OF LABOR AND INDUSTRY, BUREAU OF WORKERS' COMPENSATION, HEALTH CARE SERVICES REVIEW DIVISION,	:	ARGUED: December 1, 2009 RE-SUBMITTED: December 21, 2010
	:	
Appellee	:	

OPINION

MR. CHIEF JUSTICE CASTILLE* **DECIDED: May 25, 2011**

In this direct appeal, we decide whether the Commonwealth Court should have compelled appellee Department of Labor and Industry (the "Department") *via* a writ of *mandamus* to reach the merits of a fee review petition filed by appellant Crozer Chester Medical Center ("Crozer") pursuant to Section 306(f.1)(5) of the Workers' Compensation Act ("Act"), 77 P.S. § 531(5). The Commonwealth Court declined to issue the writ, concluding that the Department correctly dismissed as premature Crozer's application for fee review. The issue, as phrased by Crozer, is:

> Whether the lower court erred in granting the [Department]'s demurrer even though: (a) the complaint [in *mandamus*] averred that, in a notice of compensation payable, [a

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* This case was re-assigned to this author.

> claimant]'s workers' compensation insurer admitted that [the claimant]'s injury was compensable and that the insurer was liable therefor; and (b) the [c]omplaint [in mandamus] did not aver that the insurer disputed liability or compensability.

Crozer's Brief at 4. For the reasons that follow, we affirm.

On April 28, 2008, Crozer filed with the Commonwealth Court a petition for review in *mandamus*,[1] seeking to compel the Department to decide the merits of a fee review application rejected by the Department as premature. According to the *mandamus* petition, in December 2005, claimant William Radel suffered a work-related injury while lifting a bundle of rebar for employer Re-Steel Supply Company, Inc. In January 2006, employer issued a medical-only notice of compensation payable ("NCP"), voluntarily accepting liability for an injury described as a hernia. Radel underwent surgery to repair an umbilical hernia at Crozer in February 2006. On March 20, 2007, Crozer sent records and billed employer's insurer, Zurich North American Insurance Company ("Zurich"), for the treatment it provided Radel. Zurich did not pay the medical care provider's bill. See Crozer's Petition at ¶¶ 5-9 & exh. A (paragraph 9 states: "In violation of 34 Pa. Code § 127.208, within thirty-three (33) days after said submission,[[2]] Zurich neither paid [Crozer]'s bill nor did it issue a denial of payment.[[3]]") (footnotes added).

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[1] Crozer's initial filing is captioned "*Mandamus* Complaint." But, pursuant to Rule of Appellate Procedure 1512, the filing should have been styled a petition for review in *mandamus*. Pa.R.A.P. 1512(c) & note. We use the correct designation.

[2] The Act provides that the insurer must make payment to the medical care provider within thirty (30) days of the provider's submission of bills and records. 77 P.S. § 531(5). Regulation 127.208 provides that "[f]or purposes of computing the timeliness of payments, the insurer shall be deemed to have received a bill and report 3 days after mailing by the provider," *i.e.*, thirty-three days after submission. 34 Pa. Code § 127.208.

[3] Although Section 306(f.1)(1) does not require written notice to the provider explaining the denial of payment, the Department's regulations impose that obligation. See 77 P.S. § 531(5); 34 Pa. Code § 127.209(a) ("If payment of a bill is denied entirely, insurers shall provide a written explanation for the denial."). No claims are before us regarding the (continued…)

According to the *mandamus* petition, Crozer filed an application for fee review on May 23, 2007. In March 2008, the Department rejected and returned the application as premature, because it found that there was "an outstanding issue of liability/compensability for the alleged injury." The Department also denied Crozer's request for a *de novo* administrative hearing. Consequently, the medical care provider filed its *mandamus* petition with the Commonwealth Court. See id. at ¶¶ 4-5, 7-11, 13 & exh. C.

In June 2008, the Department filed preliminary objections requesting dismissal of Crozer's petition on several grounds, including that *mandamus* was not an appropriate remedy here because the medical care provider failed to establish a clear right to relief, and the medical care provider sought to compel an exercise of discretion rather than a ministerial act. Crozer responded with its own preliminary objections, asserting that the Department was seeking demurrer relief on the basis of documents supplementing the petition for review, contrary to the prohibition against speaking demurrers. Crozer's Objections at 2 (citing Hall v. Goodman Co., 456 A.2d 1029, 1035 (Pa. Super. 1983)). Specifically, Crozer objected to the Court's consideration of a letter and two faxes from Zurich's claims adjuster and to a February 2006 notice from the Department, which informed Crozer that Radel's claim had been denied. Department's Objections at exh. A. Following a hearing, the Commonwealth Court sustained Crozer's preliminary objections and stated that it would not consider any exhibits attached to the Department's filing. But, the Court also sustained the Department's substantive objections and dismissed Crozer's *mandamus* petition. Crozer filed a direct appeal to this Court. See 42 Pa.C.S. § 723(a).[4]

(…continued)
legal effect of any failure by Zurich to notify Crozer of its decision in writing, pursuant to Regulation 127.209(a).

[4] This Court, upon dispositional review of the parties' briefs, see I.O.P. § 3(A)(3), ordered additional briefing on the issue of whether the NCP constitutes a dispositive (continued…)

Crozer claims on appeal that its *mandamus* action was improperly dismissed because the averments in its petition established the Department's mandatory duty to issue (and Crozer's clear legal right to receive) a determination on the merits of the fee review application. Crozer argues that Zurich issued a medical-only NCP, which had not been modified or terminated at the time of the medical treatment and, thus, pursuant to the Act, the NCP constituted a voluntary and binding admission of liability for Radel's umbilical hernia. According to Crozer, because Zurich is precluded from terminating benefits unilaterally or retroactively, the existence of an "open" NCP at the time of Radel's treatment is an "unequivocal admission" that Zurich must pay Crozer. Thus, the medical care provider disputes the Department's conclusion that an unresolved issue of liability remained at the time of the fee review application. In view of the "open" NCP, Crozer offers, the Department was not faced with making any legal determination of Zurich's liability as part of its fee review. Crozer therefore requests that we reverse the Commonwealth Court's decision and order the Department to resolve the merits of the fee review application.

The Department responds that Crozer improperly sought *mandamus* to compel exercise of the Department's discretion in a particular manner. Specifically, the Department argues that Zurich denied liability, but that Crozer nonetheless sought to force the

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(…continued)
admission of liability and what effect the decisions in Beissel v. W.C.A.B. (John Wanamaker, Inc.), 465 A.2d 969 (Pa. 1983), Barna v. W.C.A.B. (Jones & Laughlin Steel Corp.), 522 A.2d 22 (Pa. 1987), Mahon v. W.C.A.B. (Expert Window Cleaning), 835 A.2d 420 (Pa. Cmwlth. 2003), and Section 406.1(d) of the Act, 77 P.S. 717.1(d), have on the Department's obligation to decide Crozer's fee review application on the merits. The parties complied. In their supplemental briefs, both parties stated that the issue subject to supplemental briefing is collateral to their dispute and that the caselaw cited is inapposite. See Crozer's Supp. Brief at 4, 6; Department's Supp. Brief at 2. Upon review, we agree. Although this may not always be the case, it appears that here the parties are correct in attempting to refocus the disputed issue before the Court. We note, moreover, that the supplemental briefs assisted the Court in understanding how the Department's fee review process operates.

Department to decide that the "open" NCP estopped Zurich from denying liability. The Department notes that these decisions are not as simple as Crozer believes. According to the Department, deciding whether the NCP is "open," whether Zurich's denial was proper, and whether Crozer was entitled to payment under the circumstances, "far exceeds the jurisdiction and administrative capabilities of the fee review authorities." Department's Brief at 7. The Department further notes that, although ill-equipped to do so, the Department's hearing officer would be required to determine the credibility of insurers and providers, inquire into whether the NCP included the treatment billed by the provider, resolve whether the NCP was rescinded, accurate, or authentic, and determine issues of estoppel. The Department maintains that, in view of these inherent practical challenges, the regulatory prohibition against litigating liability within the context of the fee review process is sensible. The Department argues that issues of liability, even where an "open" NCP exists, are better litigated before workers' compensation judges, pursuant to the Act and relevant regulations. Crozer, the Department concludes, failed to establish a clear legal right to a determination on the merits of its fee review application and, therefore, the Commonwealth Court properly dismissed Crozer's action.

In dismissing Crozer's petition for *mandamus*, the Commonwealth Court explained that Crozer's petition (paragraph 11 and exhibit C) indicated that Zurich was disputing liability for the injury. According to the court, Crozer essentially argued that "when an insurer's denial of liability appears to violate the [Act], the Department should be required to make a determination." Crozer Chester Med. Ctr. v. Dep't of Labor & Indus., 955 A.2d 1037, 1042 (Pa. Cmwlth. 2008). Specifically, in the court's view, Crozer maintained that Zurich's denial violated the Act in light of the "open" NCP. The court rejected Crozer's *mandamus* argument, concluding that to grant Crozer relief would entail requiring the Department to exercise legal judgment and evaluate the credibility of witnesses, the legal effect of documents and of other evidence. Thus, the panel recognized that Crozer "[was]

not attempting to enforce a right which ha[d] been established beyond peradventure, but [was] seeking to have [the court] direct the Department to determine the issue of liability in [Crozer]'s favor." Id. The Commonwealth Court therefore held that Crozer had failed to plead a legally cognizable claim in *mandamus*. Id.

Preliminarily, it is important to recognize that the claim before us involves a request for *mandamus* relief. The controlling question is whether the factual averments in Crozer's petition for review are legally sufficient to state a cause of action for *mandamus* in light of the relevant provisions of the Act and the regulations of the Department. A *mandamus* action lies only "to compel official performance of a ministerial act or mandatory duty where there is a clear legal right in the plaintiff, a corresponding duty in the defendant, and a lack of any other adequate and appropriate remedy at law. . . . While *mandamus* will not ordinarily lie to compel a series of particular acts or conduct or to compel the performance of a particular discretionary act, it is available to direct that discretion be exercised." Delaware River Port Auth. v. Thornburgh, 493 A.2d 1351, 1355-56 (Pa. 1985) (internal citations omitted). The affected governmental entity may test the legal sufficiency of a *mandamus* complaint by filing preliminary objections in the nature of a demurrer. See Pa.R.C.P. No. 1028(a)(4). A demurrer is properly sustained if it is clear and free from doubt that the facts pleaded in the complaint are legally insufficient to establish a right to relief. Werner v. Zazyczny, 681 A.2d 1331, 1335 (Pa. 1996).

For the purpose of determining whether a lower court properly sustained a demurrer, this Court must regard as true all well-pleaded material facts set forth in the *mandamus* petition and all reasonable inferences that may be drawn from those facts. Id. But, this Court "need not accept as true conclusions of law, unwarranted inferences, allegations, or expressions of opinion." Bayada Nurses, Inc. v. Commonwealth, 8 A.3d 866, 884 (Pa. 2010). Our review of the lower court's decision is *de novo* and plenary. Mazur v. Trinity Area Sch. Dist., 961 A.2d 96, 101 (Pa. 2008).

Here, the Commonwealth Court sustained the preliminary objections of the governmental entity, the Department, holding that Crozer's petition failed to plead a legally cognizable claim in *mandamus*. The court found that the Department acted properly in dismissing Crozer's fee review application as premature pursuant to the Department's Regulation 127.255(1). In its totality, Regulation 127.255 provides that:

> The Bureau will return applications for fee review prematurely filed by providers when one of the following exists:
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> (1) The insurer denies liability for the alleged work injury.[5]
>
> (2) The insurer has filed a request for utilization review of the treatment under Subchapter C (relating to medical treatment review).
>
> (3) The 30-day period allowed for payment has not yet elapsed, as computed under § 127.208 (relating to time for payment of medical bills).

34 Pa. Code § 127.255 (premature applications for fee review). We review the pertinent provisions of the Act to determine whether Crozer's application was indeed premature and properly dismissed.

Pursuant to Section 306(f.1) of the Act, the employer of a qualified injured employee, or claimant, "shall" pay for the reasonable surgical and medical services provided by

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[5] We recognize that the language of Regulation 127.255(1) appears to contain a latent ambiguity insofar as it refers to the insurer denying "liability for the alleged work injury." See 34 Pa. Code § 127.255. Indeed, Section 306(f.1)(5) of the Act, which the regulation addresses, indicates that it is sufficient if the insurer denies liability for a "particular treatment," as explained further infra. See 77 P.S. § 531(5); 77 P.S. § 991(a)(v) (Department to promulgate regulations "reasonably calculated to . . . explain and enforce the provisions of th[e] [A]ct"). In this case, the Department is interpreting the Regulation consistently with the Act, as required, and there is no issue before us regarding the overall validity of Regulation 127.255(1) in light of the latent ambiguity. See 77 P.S. § 991(a) (Department to promulgate regulations "consistent with th[e] [A]ct").

physicians or other health care providers as and when needed. 77 P.S. § 531(1)(i). The Act shields a claimant with a compensable work injury from liability to a medical care provider for the cost of treatment, and places the onus on the employer, acting independently or through its insurer, to make timely payments to medical care providers for such costs. 77 P.S. § 531(5), (7).[6] Additionally, Section 306(f.1)(5) protects the financial interests of both claimants and medical care providers by mandating payment for any undisputed treatment in a timely manner. 77 P.S. § 531(5). Indeed, insurers are required to pay interest on untimely payments to the medical care provider, and may be subject to penalties to the claimant for unreasonable delays in paying compensation. <u>See</u> 77 P.S. § 991(d) (penalties); 34 Pa. Code § 127.210 (interest on untimely payments); <u>Hough v. W.C.A.B. (AC&T Companies)</u>, 928 A.2d 1173, 1179-81 (Pa. Cmwlth. 2007), <u>appeal denied</u>, 940 A.2d 367 (Pa. 2007) ("Section 306(f.1)(5) . . . does not require that [p]rovider seek fee review before [c]laimant may proceed on a penalty petition alleging untimely payment of medical bills").

The Act also foresees the most likely scenarios giving rise to disputes: (1) between insurers and claimants over liability, *i.e.*, whether compensation is due for medical care or for a particular treatment, and (2) between insurers and medical care providers over the amount billed or the timeliness of payment for a covered treatment.

Notably, where the insurer issues an NCP, the insurer may still contest liability for medical care or for a particular treatment on several grounds. For example, an insurer may seek to modify, suspend, or terminate the NCP, including a claimant's medical benefits, if the incapacity of a claimant has decreased, or temporarily or finally terminated. 77 P.S. §§ 732, 772; <u>see</u>, <u>e.g.</u>, <u>Henry v. W.C.A.B. (Keystone Foundry)</u>, 816 A.2d 348, 349, 354 (Pa.

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[6] Because the employer here acted through its insurer, Zurich, we analyze the relevant provisions as they apply to the insurer.

Cmwlth. 2003). If the NCP and the insurer's accompanying liability for medical compensation has not been modified or terminated, the insurer may nonetheless question liability for a particular treatment. 77 P.S. § 531(5). A common scenario is one in which the insurer questions the "reasonableness or necessity" of a treatment offered for an accepted work-related injury, *i.e.*, whether the treatment is appropriate for the injury. See, e.g., Gallie v. W.C.A.B. (Fichtel & Sachs Indus.), 859 A.2d 1286, 1288 (Pa. 2004). In that event, immediate payment is not required, but the insurer must make a timely request for treatment utilization review. 77 P.S. § 531(5), (6). In other instances, the insurer may also question liability for a particular treatment because: the billed treatment is not related to the accepted work-related injury as described by the NCP, the NCP is fraudulent or contains a material misrepresentation or error, or the issue of liability for medical costs is subject to an agreement supplementing or replacing the NCP. 77 P.S. § 771 (modification of materially incorrect NCP); see, e.g., Cinram Mfg., Inc. v. W.C.A.B. (Hill), 975 A.2d 577, 582 (Pa. 2009) ("workers' compensation judge 'may' at any time correct a notice of compensation payable"); Barna v. WCAB (Jones & Laughlin Steel Corp.), 522 A.2d 22, 24 (Pa. 1987) (compensation may be terminated if timely investigation reveals that NCP is materially incorrect); Waugh v. W.C.A.B. (Blue Grass Steel), 737 A.2d 733, 737-38 (Pa. 1999) (claimant supplied documents containing material misrepresentation regarding residency to obtain NCP); Gregory v. W.C.A.B. (Narvon Builders), 926 A.2d 564, 565 (Pa. Cmwlth. 2007) (compromise and release agreement replaced NCP). In cases in which liability for a particular treatment is at issue, the claimant, not the medical provider, must pursue compensation before a workers' compensation judge in the regular course. See 77 P.S. § 531(6)(iv) (utilization review); 77 P.S. § 710 (liability for compensation generally).

But, under the Act, if an insurer accepts that compensation is due for a particular treatment, a medical care provider may file an application for fee review to dispute the "amount or timeliness" of the payment. 77 P.S. § 531(5); Catholic Health Initiatives v.

Health Family Chiropractic, 720 A.2d 509, 511 (Pa. Cmwlth. 1998) (commencement of fee review process "presupposes" that liability has been established). For example, an application for fee review is appropriate if payment to the provider was partial or late. See, e.g., Enterprise Rent-A-Car v. W.C.A.B. (Clabaugh), 934 A.2d 124, 128 (Pa. Cmwlth. 2007), appeal denied, 948 A.2d 805 (Pa. 2008) (fee review, not utilization review, was appropriate where provider challenged insurer's payment of initial estimate rather than of higher final cost of retrofitting claimant's home). The application for fee review is due "no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment." 77 P.S. § 531(5). The Department may reject the application as premature, 34 Pa. Code § 127.255; otherwise, the Department's hearing officer is required to decide the merits of a fee review application within thirty (30) days of its filing. 34 Pa. Code § 127.256. In the Department's description, which Crozer does not dispute, the fee review process "is administered by nurses who determine whether employers' payments are timely paid or properly calculated under the workers' compensation fee schedule and medical billing protocols. While these personnel are experienced and knowledgeable about the workers' compensation fee schedule, their skills are markedly distinct from [workers' compensation judges], who [as attorneys with a mandatory minimum of five years' workers' compensation law experience] are trained to conduct hearings and make credibility determinations." Department's Supp. Brief at 2-3.

It is apparent that the fee review process has a very narrow scope within the broader legislative and regulatory scheme of compensating claimants for work-related injuries. Understandably, the General Assembly directed that most disputed compensation issues be litigated between claimants and insurers before skilled workers' compensation judges in the first instance, and reserved few narrow issues to be litigated by the medical care provider before a fee review hearing officer. The Department's Regulation 127.255, which fills procedural gaps within the fee review legislative scheme, enforces this understanding

by explaining that the Department will reject a medical care provider's application for fee review if the "insurer denies liability for the alleged work injury" or a request for utilization review is pending. 34 Pa. Code § 127.255(1), (2); see also 77 P.S. § 991 (Department to promulgate regulations reasonably calculated to explain and enforce provisions of the Act.).

In its *mandamus* petition, Crozer pled that Zurich refused to pay its bill for treating Radel, contrary to the Act's mandate. According to Crozer, the Act establishes that an "open" NCP is Zurich's "unequivocal admission" of liability for Radel's December 2005 injury. Crozer concludes that, as a result, the Department should have reached the merits of its fee review application, presumably to order Zurich to pay Crozer's bill. At the center of Crozer's claim is the assumption that the so-called "unequivocal admission" of liability to Radel absolutely establishes Zurich's liability to Crozer for the medical costs of the February 2006 treatment, as well as the settled nature of Crozer's claim, whose merits the Department should have reached. We disagree.

Initially, it is apparent from Crozer's own averments that Zurich was disputing liability. Paragraph 9 of the *mandamus* petition describes Zurich's refusal to pay Crozer for the February 2006 surgery, which, in light of the Act's mandate that insurers pay "timely for any treatment or portion thereof not in dispute," is essentially a denial of liability for the treatment.[7] This averment, though adverse to Crozer's legal interest, must be accepted as true, on par with all other allegations in the petition. See Werner, 681 A.2d at 1335 ("Court must consider as true all the well-pleaded material facts set forth in appellant's [pleading]"). Crozer seeks to overcome Zurich's denial of liability by claiming that an "open" NCP is irrebuttable evidence of liability for the cost of the February 2006 surgery. This is a legal

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[7] As noted supra, Regulation 127.209 required Zurich to provide Crozer with a written explanation of its denial. 34 Pa. Code § 127.209(a). This notice requirement, however, is distinct from the question of whether an insurer's refusal to pay the entire bill effectively constitutes a denial of liability in the distinct context of the fee review process.

argument, sounding in estoppel, which simply adds another layer to the dispute over liability.

Even if we were to assume that black letter law deems an "open" NCP to be an "unequivocal admission" of liability, the inquiry into Crozer's allegations cannot stop there. The NCP is an agreement between an employer or an insurer and a claimant regarding liability for the claimant's injury. See 77 P.S. § 731 (NCP issued to "employe or his dependent"). But, liability for an injury is distinct from liability for a particular treatment or its cost. The NCP, even if "open" and binding with respect to liability for the injury, is not dispositive as to the medical care provider's claim for reimbursement for the cost of a particular treatment. As a result, here, the so-called "open" NCP does not bar Zurich from disputing liability for payment to Crozer for Radel's February 2006 surgery. See, e.g., Gallie; Waugh; Gregory, supra. Thus, the "open" NCP simply cannot be construed as compelling a fee review on the merits if an insurer, rightly or wrongly, refused payment. See Catholic Health Initiatives, 720 A.2d at 511; 34 Pa. Code § 127.255.

Moreover, it is apparent from Crozer's *mandamus* petition that the present dispute is not capable of resolution through the Section 306(f.1)(5) fee review process. Fee review is a process for medical care providers to dispute "the amount or timeliness" of an insurer's payment for a particular treatment, which are relatively simple matters. 77 P.S. § 531(5). But, Crozer's petition contains no allegations that the medical fee had not been paid timely or had not been calculated in accordance with the compensation fee schedule or medical billing protocols. See 34 Pa. Code §§ 127.208, 127.210 (timeliness provisions); 127.101-127.135, 127.151-127.162, 127.205-127.207 (amount calculation provisions). Crozer is seeking, instead, to establish the broader legal proposition that Zurich's failure to pay was unwarranted and that the Department's fee review personnel were obliged to make that

determination.[8] Such a decision is outside the scope of what is designed to be a simple fee review process.

Ultimately, the Department did not err in construing Zurich's refusal to pay Crozer's bill for Radel's February 2006 surgery to be a denial of liability for the treatment. Thus, the Department did not err in concluding that Crozer's application did not raise either of the two narrow issues appropriate for fee review. Rather, Crozer sought a legal decision from non-qualified personnel within the Department on whether it was entitled to payment at all in view of the so-called "open" NCP. This type of decision is properly viewed as the province of specially qualified workers' compensation judges, to be rendered within the context of claimant-insurer litigation. Crozer's *mandamus* petition seeking to compel a decision on the fee review application was properly rejected by the Department pursuant to the Act and Regulation 127.255(1).

For the foregoing reasons, we hold that Crozer did not have a clear right to a decision of its fee review application on the merits because: (1) the provider alleged that Zurich disputed liability by refusing payment; and (2) the provider challenged the propriety of Zurich's denial rather than the amount or timeliness of payment for a particular treatment. Thus, the allegations in Crozer's petition for review did not state a cause of action in *mandamus*. The Department did not err in applying Section 306(f.1)(5) of the Act and Regulation 127.255, and thereby dismissing as premature the application for fee review filed by appellant Crozer. The Commonwealth Court's decision is affirmed. Jurisdiction is relinquished.

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[8] Zurich accepted liability via the NCP for Radel's work-related hernia and Crozer repaired an umbilical hernia. Under these circumstances, Zurich's reasons for denying liability are not immediately obvious. The fee review process, however, is not designed to encompass either an inquiry into the insurer's reasons for denying liability or an evaluation of estoppel arguments like Crozer's. Yet, Crozer sought resolution of both issues in the fee review context, as a prerequisite to reaching issues of amount or timeliness of payment, which are within the proper scope of that process.

Messrs. Justice Saylor and Eakin and Madame Justice Orie Melvin join the opinion.

Mr. Justice Baer files a dissenting opinion in which Madame Justice Todd and Mr. Justice McCaffery join.